Medical/Mental Health Issues in Child Welfare:
Child Protective Services
Foster Care
Adoption

SECTION 1: BEFORE FAMILY COMES TO DHS ATTENTION

Prevalence and Risk Factors for Childhood Abuse

- Prevalence (reported in adulthood)
  - Physical Abuse: 23%
  - Sexual Abuse: 22%
  - Emotional Abuse: 19%

- Risk factors
  - Gender (female for sexual abuse, male for physical abuse)
  - Race/ethnicity (Caucasian/African-American men report more across lifespan, Hispanic men report lowest, similar trends for women)
  - Poverty is not a differentiating factor in males, is an additional risk in females
  - Abuse in childhood increases chance of victimization in adulthood

How families accommodate to maltreatment

• Maltreatment is often intergenerational
  – Perpetrators have been victims – different frame of reference for interpersonal interactions
• Cycle of violence within family affects capacity of members to report and live with results of reporting
• Family relationships are rarely uni-dimensional
  – even when abuse, often caring as well
• Associated family member characteristics (e.g. substance use disorders, mental health) may affect capacity to make change

Challenges for CPS/Foster/Adoption

• Child Protective Services (CPS) –
  – Investigation challenged by the accommodations within the family
  – Investigations challenged by limitations in medical evidence associated with maltreatment
• Foster Care –
  – Reunification planning impacted by factors associated with maltreatment and by impact of maltreatment on well-being, family relationships
• Adoption –
  – Success in achieving a stable adoption impacted by short and long-term impact of maltreatment on children

SECTION 2: HOW MALTREATMENT IS DISCOVERED
Mandated Reporters

- Medical personnel, therapists, teachers, protective services, foster care, adoption professionals etc:
  - When they see/hear any indicators of maltreatment
    - Lack of clean clothing, evidence of poor hygiene, low weight, evidence of injury, evidence of sexualized behavior
  - Threshold is low - purpose is to not miss any maltreatment
  - Therefore some reports will not be substantiated after thorough investigation

Self-report by perpetrators

- Parents might experience an event that causes them enough distress to report, though indicators may be subtle
  - Physicians, case work professionals and other child-caring personnel need to be attuned to any messages from perpetrators and assist with obtaining interventions
  - Aware of the risk factors related to maltreatment and ask about these in the course of regular care

Self report by victims

- Children can spontaneously report to adults (including extended family, teachers, case work professionals, therapists, physicians, teachers, coaches, others)
  - All allegations need to be investigated
  - There is some potential for youth to make false allegations - challenge to investigation
SECTION 3: MEDICAL DESCRIPTION OF MALTREATMENT – NEGLECT, PHYSICAL ABUSE, SEXUAL ABUSE

Neglect

• Definition:
  - Harm or threatened harm to a child’s health or welfare by a parent, legal guardian, or any other person responsible for the child’s health or welfare that occurs through either of the following:
    • Negligent treatment, including the failure to provide adequate food, clothing, shelter or medical care
    • Placing a child at an unreasonable risk to the child’s health or welfare by failure of the parent, legal guardian or any other person responsible for the child’s health or welfare to intervene to eliminate that risk when that person is able to do so and has, or should have, knowledge of the risk

Neglect

• Prevalence:
  - Most common form of maltreatment – nearly 60% of substantiated cases in the US.

• Types:
  - Physical – failing to provide basic necessities and/or supervision – associated with multiple consequences: failure to thrive, malnutrition, illness, injury. Can also be associated with psychological abnormalities
  - Educational – failing to ensure access to education (enrollment in school or home schooling) – associated with failure to develop skills, life-long consequences
  - Emotional – failing to provide psychological nurturing, or actively engaging in insults/belittling – can be extremely challenging to prove, can result in life-long consequences (early attachment disorder, life-long relational difficulties)
Neglect

Types:
- Medical - failing to access necessary medical care (not because of lack of financial resources) - can present as refusal and/or ignoring medical advice or recommendations
  - Parents may raise cultural/religious considerations
  - Sometimes courts become involved
  - More common when child has medical condition requiring higher level of care: cystic fibrosis, diabetes, seizure disorder, cerebral palsy, heart disease, prematurity

Neglect

Signs
- Hunger, inadequate growth/low weight, unmanaged obesity
- Inadequate attention to hygiene, cleanliness
- Clothing inadequate to season
- Lack of follow through on needed medical care
- Poor social skills, poor school performance (note there are clearly other causes for these that would need to be investigated)

Neglect

Failure to Thrive –
- Child not growing normally, not developing normally (physical, developmental, emotional, social)
- Can have multiple causes - not all related to neglect
- Height and/or weight well below expected for age, present over time
  - Can't "eyeball" this reliably, growth charts are a necessity -
Neglect

• Failure to Thrive –
  – Evaluation includes:
    • Social History
      – Who is in home, who are caregivers, child temperament, stressors, presence of domestic violence, any history with child protective services, any substance use problems
    • Birth History
      – Maternal health, gestational age, birth weight, birth trauma, prenatal exposures (tobacco, alcohol, drugs)
    • Medical History
      – Prior growth, recurrent infections, vomiting/reflux, abnormal sweating (substance withdrawal, heart disease), abnormal bowel movements, parasitic, parasites, HIV exposure

Neglect

• Failure to Thrive –
  – Evaluation includes:
    • Diet History
      – Food log, formula use, timing of feeding, who feeds, what tools used, what other ingestion (liquids etc.) – sense of quality and quantity of calories
    • Family History
      – Medical conditions (that may affect nutrition), FTT history in any siblings, short stature in family members
Neglect

• Failure to Thrive –
  - Evaluation includes:
    • Physical Examination /Laboratory Studies
      - Identify genetic disorders
      - Identify any underlying disease
      - Assessment for abuse
      - Assessment for malnutrition

Neglect

• Failure to Thrive –
  - Consequences of FTT
    • Acute
      - Slow growth
      - Increased risk of infection
      - Risk for developmental delays (will be affected by cause, how much social environment also impoverished)
    • Chronic
      - Decreased full height/size
      - Impaired learning
      - Behavior problems
      - Death

Neglect

• Failure to Thrive –
  - Physical symptoms
    • Prominent ribs/bones
    • Thin limbs, wasted buttocks
    • Sparse, fragile hair
    • Protruberant belly
    • Decreased activity, apathy
    • Dull vacant stare, poor eye contact
    • Eventual loss of appetite
Neglect

• Failure to Thrive –
  - Common Causes of FTT
    • Incorrect preparation of infant formula
    • Unsuitable feeding habits
    • Behavior problems (that impede feeding)
    • Poverty
    • Neglect
    • Disturbed parent/child relationships (intergenerational)
    • Mechanical feeding difficulties
    • Central Nervous System disorders
    • Severe reflux

Neglect

• Failure to Thrive –
  - Addressing FTT with parents
    • Discuss home environment
    • Teach appropriate feeding approaches
    • Teach developmental expectations
    • Assist/engage in appropriate medical follow-up
    • NOTE: this is one of many examples where the MiTEAM practice model can be put to specific use.

Physical Abuse

• Definition:
  - Contact intended to cause feelings of pain, injury, suffering or bodily harm

• Physical indicators:
  - Varied because depends on mechanism of injury
    • Bruising pattern
    • Burning pattern
    • Bone injury pattern
    • Behavior changes
Physical Abuse

• Bruising (contusion):
  - Pattern can indicate method of injury
  - Matching hand/fingers
    - Slapping/Grasping might show finger pattern
    - Small patterns indicating pinching
  - Matching implement used (linear, curved may indicate strike with cord, belt, buckle etc)
  - Location on body critical to method, e.g.
    - For an ambulating youngster, bruises on shins probably explained by normal activity, but such bruises on a child who can’t yet walk wouldn’t make sense.

• Bruising:
  - Color can indicate age of injury – changes in state of blood over time
    - Red/purple color – more recent to the injury
    - Yellow/green/brown – indicate older injury
  - Bruising can be difficult to see under certain tones of skin

• Bruising:
  - Some changes might be mistaken for bruises/abuse
    - Birth marks (café au lait spots, large freckles, capillaries close to skin surface, mongolian spots)
    - Rashes (insect bite or infections)
    - Bruising in someone with a bleeding/clotting disorder
    - Allergic shiner (darkness/swelling under the eye)
    - Sphylils
    - Phytophotodermatitis (sun sensitivity after certain foods)
    - Cultural practices (cupping, coining, fomentation)
Physical Abuse

- Fractures:
  - Bones (medical and common names):
    - Cranium – skull
    - Vertebra – spine
    - Clavicle – collar bone
    - Scapula – shoulder blade
    - Sternum – breastbone
    - Patella – kneecap
    - Femur – thigh bone
    - Humerus – arm bone
    - Tibia – shin bone
    - Fibula – small leg bone

- Causes of fractures – not abuse
  - Accidental trauma
  - Birth trauma
  - Prematurity-related osteopenia (weak bones)
  - Nutritional deficiency (rickets, scurvy)
  - Metabolic disorders
  - Drug toxicity
  - Infection
  - Neuromuscular disorders (causing disability and non-mobility)
  - Skeletal dysplasias (abnormal bone development)
  - Cancer
  - Genetic bone disease (osteogenesis imperfecta – “brittle bone”)

- Causes of fractures – higher suspicion of abuse
  - Classic metaphyseal lesion (break between the shaft and end of bone)
  - Rib fractures (especially posterior)
  - Multiple fractures, especially when bilateral
  - Fractures at different ages (indicates multiple injuries over time)
  - Complex skull fracture
Physical Abuse

• Burns
  – Prevalence
  • More than 2,000 children die annually from burns of all causes, approximately 20% in children under 2 are inflicted
  • Estimated to be about 10% of physical abuse cases
  • Peak age of occurrence 13-24 months

Physical Abuse

• Burns
  – Patterns are important to mechanism
  • Abusive immersion involves buttocks, arms, lower legs, ankles or feet, doughnut shape on buttocks, no burns in folds of thigh
  • Accidental splash burns – upside down tree appearance (liquid cools as it flows down body)

Physical Abuse

• Burns
  – Time-Temperature-Severity

<table>
<thead>
<tr>
<th>Temperature</th>
<th>Time to mild burn</th>
<th>Time to severe burn</th>
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</thead>
<tbody>
<tr>
<td>127+</td>
<td>60 second</td>
<td></td>
</tr>
<tr>
<td>130+</td>
<td>30 second</td>
<td>10 second</td>
</tr>
<tr>
<td>140+</td>
<td>5 second</td>
<td>1 second</td>
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<tr>
<td>150+</td>
<td>2 second</td>
<td>&lt;1 second</td>
</tr>
<tr>
<td>160+</td>
<td>1 second</td>
<td></td>
</tr>
</tbody>
</table>
Physical Abuse

• Bums
  - Temperature-Activity

<table>
<thead>
<tr>
<th>Temperature Range (F)</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>90-105</td>
<td>Infant/toddler bath</td>
</tr>
<tr>
<td>93-113</td>
<td>Adult bath</td>
</tr>
<tr>
<td>101-106</td>
<td>Adult shower</td>
</tr>
<tr>
<td>105-108</td>
<td>Hot tub</td>
</tr>
<tr>
<td>108-113</td>
<td>Too hot - pain threshold</td>
</tr>
</tbody>
</table>

Physical Abuse

• Abusive Head Trauma
  - May be the result of shaking – if there is clear evidence, would term this cluster of symptoms “shaken baby syndrome” – resulting from intracranial injury
    • Fussiness and crying
    • Unable to feed or vomiting
    • Excessive sleepiness/unable to wake
    • Abnormal breathing or no respiratory effort
    • Seizures
    • Coma
    • Death

Physical Abuse

• Abusive Head Trauma
  - Results of injury:
    • Bleeding inside the skull
      - Subdural hemorrhage – between the layer adhering to the skull and layer covering the brain
      - Epidural hemorrhage – between the layer adhering to the skull and the skull
      - Subarachnoid hemorrhage – in the space around the brain, under the layer adhering to the skull
    • Damage to brain tissue
      - Ischemia (loss of blood supply)
      - Diffuse injury to nerve cells
Physical Abuse

• Abusive Head Trauma
  - Results of injury:
    • Retinal hemorrhage
      - Bleeding on the back surface of the eye
      - Can be related to shaking (could be other causes - these other causes not too likely in infants)
    • Fractures
      - Ribs
      - Metaphyseal fractures

Sexual Abuse

• Definitions:
  - Abuse - engaging in contact/penetration
  - Exploitation - allowing, permitting or encouraging prostitution, photography, filming or depicting engagement of a child in a sexual act

• Physical signs
  - Injuries
    • To genital and anal area
    • Infection

• Behavioral signs
  - Sexualized behaviors - distinguish common (normal) behaviors from less common (normal), uncommon (possibly abnormal) and rare (likely abnormal) behaviors
    • Common: touching/masturbation (public/private), looking at/touching peer/new sibling genitals, showing genitals to peers, try to see adult nudity - note: transient, can be redirected
    • Less common: rubbing against others, tongue during kissing, touching genitals (peer/adult), crude mimic of sexual acts - note: transient, but moderately responsive to redirection
Sexual Abuse

- Behavioral signs
  - Sexualized behaviors: distinguish common (normal) behaviors from less common (normal) uncommon (possibly abnormal), and rare (likely abnormal) behaviors
    - Uncommon: asking peers/adults to engage in specific sexual acts, inserting objects into genitals, explicit imitation of intercourse, touching animal genitals - note: behaviors are persistent, resistant to redirection

Sexual Abuse

- Behavioral signs
  - Sexualized behaviors: distinguish common (normal) behaviors from less common (normal) uncommon (possibly abnormal), and rare (likely abnormal) behaviors
    - Rare: sexual behavior involving children >4 years different in age, sexual behavior resulting in emotional or physical pain, sexual behavior associated with aggression/coercion - note: persistent, child angry with redirection

SECTION 4: PHYSICIAN’S ROLE AT INVESTIGATION STAGE - PARTNERSHIP WITH DHS AND LAW ENFORCEMENT
The Medical System

• Providers
  - Physicians – licensed, scope of practice is assessment, diagnosis and treatment of a broad range of medical conditions – multiple specialty areas, some interact more with child welfare than others
  - Physician Assistant – practices in the context of the medical team, under the supervision of physicians – can engage in some practices independently, but has some limitations (prescribing certain pharmaceuticals)
  - Nurse Practitioner – nursing degree with additional training, capacity for independent practice varies from state to state
• Settings
  - Emergency Department
  - Inpatient Hospital
  - Outpatient Clinic

The Medical System

• Rules/Culture of medical setting
  - Privacy/security – Health Insurance Portability and Accountability Act (HIPAA)
  - Rules for information transfer – who/where/when
  - Child abuse investigations trump HIPAA (not all know this)
  - Best interest of patient
  - Informed consent process
• Realities of most medical settings
  - Limited time
  - Challenges in making time when other issues need to be addressed (court reporting etc)

The Medical Role in Child Abuse/Neglect Investigation

• First address and treat medical needs connected to events
• Second investigate the circumstances and impact of injuries – partnership with other investigators
  - Do circumstances as reported match injuries
  - Do physical findings shed any light on likelihood of intentional vs. accidental injury
  - Determine what additional investigation is needed
• Third convey findings appropriately to authorities
The Medical Role in Child Abuse/Neglect Investigation

- Medical role is complimentary to other systems – need to find a way to work as a team
  - Protective Services
    - Investigation – information sharing to/from medical team within rules of confidentiality
  - Law Enforcement
    - Investigation, legal proceedings – also requires information sharing within rules of confidentiality

Specific questions relating to type of alleged maltreatment:

- Neglect:
  - Measures of height, weight
  - Assessment of development
  - Assessment of specific medical conditions in need of treatment – urgency of need, evidence of prior/ongoing treatment
  - Assessment for conditions that may mimic neglect (e.g., failure to thrive) – genetic diseases, other medical conditions
  - Treatment needed for any of the above

- Physical Abuse:
  - Musculoskeletal assessment (physical examination, x-ray and other imaging) – may include “skeletal survey”
  - Neurological assessment
  - Full body system assessment
  - Assessment for other factors that might explain injuries (besides abuse), or factors that might be connected to abuse
  - Assessment for evidence of prior injuries
The Medical Role in Child Abuse/Neglect Investigation

- Specific questions relating to type of alleged maltreatment:
  - Physical Abuse:
    • Assessment of information provided by caregiver
      - Does this fit with injuries or not?
      - Does information change over time with additional questioning?
      - Are piece of information left out or falsified?
      - Are there any witnesses to events?
      - Are there other pieces of information? Past reports of maltreatment? Presence of other risk factors?

- Sexual Abuse:
  • Note differences between medical history and forensic interview – information provided in medical interview is not held under hearsay restrictions on evidence
  • Interview/examination is also specialized – need to fully consider developmental stage of child when interpreting their statements about events
  • Laboratory testing – STI (chlamydia, gonorrhea, hepatitis B and C, HIV, syphilis, others)
The Medical Role in Child Abuse/Neglect Investigation

Specific questions relating to type of alleged maltreatment:

- Sexual Abuse:
  - Examination may need to be specialized (internal examination)
  - Note: this type of examination falls outside of the scope of "routine care" so foster parents are not allowed to provide consent
  - Will need to seek parental consent
  - If parents are not able/willing to provide consent, will need to seek court order - note that the timing need to be on accelerated time frame depending on need - medical necessity for child, concern about integrity of evidence

Medical Resource System (MRS Contract)

- Recommend web-based resources
  - Darkness into Light
  - WebMD

- Medical Triage System – 24/7 availability
  - CPS, Law Enforcement, Medical Providers
  - Verbal consultation regarding medical needs (questions about conditions, syndromes)
  - Referral to additional resources/providers (appropriate pediatric subspecialists)

Medical Resource System (MRS Contract)

- Statewide Physician Network
  - Identification of existing medical resources
  - Assist in establishment of local/regional medical providers for abuse/neglect examinations
  - Ongoing peer review, mentoring and support to local providers
  - Community resources for rural areas re: abuse/neglect

- Case Reviews/Second Opinion
  - Triage current concerns
  - Necessary records submitted for review
  - Verbal and written report of second opinion
The Medical Role in Child Abuse/Neglect Investigation

• Medical Resource System (MRS Contract)
  – Does not include
    • Court testimony
    • In depth reviews general
    • Medical Abuse evaluations
    • Medical examination of children

SECTION 5: PHYSICIAN’S ROLE DURING CARE – PARTNERSHIP WITH FAMILIES AND DHS

Medical Needs During DHS Care

• Well child care
  – Initial and periodic comprehensive medical examinations
    • Assess existing medical and mental health needs
      – Youth entering foster care more likely to have experienced a number of risks
        » Adverse Childhood Experiences
        » Potential lack of access to routine health care
        » Potential early (in utero exposures)
    • Examination of all body systems, mental health screening, full physical examination, additional assessments depending on age (laboratory tests)
Medical Needs During DHS Care

• Well child care
  – Initial and periodic comprehensive medical examinations
  • Mental Health Screening –
    – DHS takes responsibility for bringing data on mental health to the primary care encounter
      » Ages and States Questionnaire - Social Emotional (ASQ-SE)
      » 3 months to 6 years
      » Self report by caregiver - birth parent at time of removal, birth parent and/or foster parent thereafter
      » Engage in completing the tool at/near family team meetings.

Medical Needs During DHS Care

• Well child care
  – Initial and periodic comprehensive medical examinations
  • Mental Health Screening –
    – DHS takes responsibility for bringing data on mental health to the primary care encounter
      » Pediatric Symptom Checklist (PSC)
      » 6 to 16 years (can extend to 18 years)
      » Youth report available for ages 11 and up
      » Self-report by caregiver - birth parent at time of removal, birth parent and/or foster parent thereafter
      » Engage in completing the tool at/near family team meetings.

Medical Needs During DHS Care

• Well child care
  - Maintain medical home whenever possible
  • Continuity is critical to good care
  – Maintain connection to family of origin unless there is a clear reason not to – will require close partnership between DHS/PAFC and primary care
  • Arrange for presence at medical appointments
  • Arrange for presence at mental health appointments
  • Use MiTEAM principles to engage and mentor families to build skills and promote health
Medical Needs During DHS Care

• Recognize problems in need of specialty consultation/care
  – Pediatric sub-specialty referrals
    • Neurologic
    • Orthopedic
    • Pulmonary
    • Developmental
    • Genetic

• Recognize problems in need of specialty consultation/care
  – Mental Health Care
    • Assessment must account for multiple factors
      – Genetic risk
      – Prenatal risk (i.e. substance exposure, poor prenatal care, intimate partner violence)
      – Impact of adverse experiences
        » Interpersonal/attachment
        » Psychiatric disorders
        » Cognitive/language/learning abnormalities

• Recognize problems in need of specialty consultation/care
  – Mental Health Care
    • Treatment must account for the factors discovered during assessment
    • Interdisciplinary treatment is critical
      – Limited data for using psychopharmacology in some of the mental health disorders
      – Some psychotherapeutic interventions have strong evidence base (Trauma Focused Cognitive Behavioral Therapy – TF-CBT, Parent-Child Interaction Therapy – PICT)
Medical Needs During DHS Care

- Recognize problems in need of specialty consultation/care
  - Mental Health Care
    - Challenges related to access-referral process
      - One point of access is the child’s Medicaid health plan behavioral health services - best if likely that mental health issues are mild
      - Second point of access is Community Mental Health provider, children must meet level of severity to be eligible for services

Medical Needs During DHS Care

- Recognize problems in need of specialty consultation/care
  - Mental Health Care
    - Challenges related to access-referral process
      - DHS-DCH partnership to improve access to care
        » DHS Incentive Payment (DHIP) – when CMH serves foster or CPS (cat 1 or 2) children in addition to usual reimbursement they are given an incentive payment – intended to help the CMH provider build systems to increase access
        » SED waiver pilot - DHS provides limited CMH to help with providing array of services anchored by the Wraparound process

SECTION 6: SPECIAL SITUATIONS AND TRANSITIONS
Transitions in Geography

• If small changes in geography (different neighborhoods within broader community)
  - Need to engage family of origin and foster family in maintaining continuity for medical/mental health care
  - Need to make treatment providers (all) aware of transition – may be associated with stress and change in symptom picture

Transitions in Geography

• If big changes in geography several miles within county or out of county
  - Still need to engage family of origin and foster family in maintaining continuity for medical/mental health care
    • This will likely mean working to address release for and transfer of information to new providers
  - Need to make treatment providers (all) aware of transition – may be associated with stress and change in symptom picture
    • This will be more challenging if new providers involved, argues for continuity of information

Transitions to different levels of care

• To-from inpatient psychiatric care
  - Typically urgent/emergent circumstance
  - Time line for mental health assessment, adjustments in treatment tight
  - Will need very careful coordination/engagement between individuals who know/responsible for child, inpatient providers, outpatient providers
  - Critical to use existing mechanisms/policies
    • Updating medical passport
    • Consent for release of information
    • Consent processes for psychotropic medication
Transitions to different levels of care

• To-from inpatient medical care
  - Typically urgent/emergent circumstance
  - Time line for health assessment, adjustments in treatment tight
  - Will need very careful coordination/engagement between individuals who know/responsible for child, inpatient providers, outpatient providers
  - Critical to use existing mechanisms/policy
    • Updating medical passport
    • Consent for release of information
    • Attention to policy re: consent for procedures

Transitions to different levels of care

• To residential care
  - Not as time-urgent; however, cannot assume that situation is not urgent
  - Prior to transition, planning should have occurred – what is purpose of residential care?
    • Specific treatment not available elsewhere?
    • Alternative to current living circumstances?
    • Avoid potential dangerousness in community?
  - Based on the above, what is needed to achieve the purpose
    • Medical, mental health, educational information

Transitions to different levels of care

• From residential care
  - What will the living arrangement be?
  - What supports (medical/mental health) are needed –
  - How will transition from fee for service Medicaid back to Medicaid health plan
    • How does this time line affect services.
    • If a change in health plan assignment – will this affect continuity/medical home.
Transitions home to family of origin

- First step to address directly the issues that led to the child being in care
  - Issues/factors related to initial complaint and removal
- May need considerable problem-solving related to the underlying issues –
  - Child’s mental health problems
  - Parental mental health/substance use
  - Material needs

Transitions home to family of origin

- Regardless of issues that led to removal, must address:
  - Health care issues that have arisen and/or were addressed in the time the child was not in parents’ care
    - If care location shifted, how to ensure that medical information gets back to where care will be ongoing after reunification
      - New provider, new community
      - Prior provider, prior community

Transitions home to family of origin

- Regardless of issues that led to removal, must address:
  - Impact of removal on family relationships
    - If removal was brief and problems were straightforward, may not be too complex
    - If removal was protracted and problems were complex, graded visitation will probably not be sufficient, may also need to target specifically
      - Trauma
      - Attachment
Transitions to adoptive family

• May need considerable problem solving and adoptive parent education to address child needs – both short term and long term
  - Health/mental health
  - Trauma
  - Attachment
• Should carefully assess the need for transitional services
  - Insurance coverage will be important to account

Summary

• DHS (CPS, Foster Care, Adoption) will intersect with medical professionals throughout a child’s time in care
• Medical professionals are responsible for
  - Assessment – ongoing and acute events
  - Treatment – ongoing and acute events
  - Mandated reporting
  - Investigation related to maltreatment

Summary

• Medical professionals are bound by certain rules/realities that sometimes challenge DHS processes
  - Confidentiality
  - Busy practices
  - Limited knowledge of DHS systems
• Developing and maintaining relationships will enhance teamwork and improve investigation and care
Summary

- Children and families have medical and mental health needs throughout the entire process
  - Reporting
  - Investigation
  - Removal
  - Placement
  - Reunification/Adoption
- Addressing these through the MiTEAM practice model will improve care regardless of phase in process

Helpful resources/links

- National Child Traumatic Stress Network
- American Academy of Child and Adolescent Psychiatry
- American Academy of Pediatrics
- American Academy of Family Physicians
- Child Welfare League of America
- Association for Children’s Mental Health
- National Alliance on Mental Illness