TEXAS
Department of Family and Protective Services

Child Protective Investigations

Mental Health

Resource Guide

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INTRODUCTION

The purpose of this resource guide is to assist investigators to effectively work with families affected by mental health conditions.

Gathering Information about Caregiver's Mental Health

Experiencing a mental health condition does not disqualify a parent from the duty of parenting. Caregivers who experience mental health conditions can effectively parent their children and their children can, in turn, grow up in healthy, fulfilled households. Although not every child is affected negatively by a parent experiencing a mental health condition, when a caregiver's mental health adversely affects their ability to parent or when a caregiver's mental health compromises the safety of their children, it is important to recognize the warning signs and to assess their ability to safely parent (*CPS Policy 2270*).

We can gather information about a caregiver's mental health history and current functioning through a number of sources:

- Caregiver – The caregiver is the expert in their own life and has a wealth of information related to their own mental health history. There are instances when a caregiver is not cooperative and will not provide or allow access to their mental health history. In these cases, you can refer to *CPS Policy 2210 or Texas Family Code §261.3031*.
- Family/ Support system - The family or support system are closest to the caregiver and often interact with them on a regular basis. They may be able to provide information related to changes in behavior, treatment compliance, and safety concerns for the individual and the child(ren).
- Mental health providers – Mental health providers can provide insight into the caregiver's mental health history, current compliance with treatment and prescription medications, clarification on symptoms and diagnosis, and can answer questions related to risk and safety concerns.
- Evaluations or assessments – Evaluations or psychological assessment can assist us to gain insight into the caregiver's diagnosis, treatment recommendations, cognitive ability, and social history,
- Information from the case record – Reviewing case history can help to establish a timeline, reveal trends and patterns, and help to identify collaterals who might be helpful in obtaining relevant information regarding the caregiver's current mental state (CPS Policy 2152).

Relying on observation when it comes to assessing caregiver's mental health can be difficult especially when it may be the first encounter with the caregiver and/ or there is no history or any others to refer to for guidance. Although you should not rely on observations alone to assess a caregiver's state of mind here are some warning signs that a caregiver may be experiencing a mental health crisis:

- Erratic behavior/ mood swings
- Agitation/ Aggression
- Substance use
- Disconnected thought process
- Paranoia

- Isolation/ social withdrawal
- Sadness/ hopelessness

While this list is not comprehensive, it provides you with common warning signs you might see when working with a caregiver experiencing a mental health crisis.

If you need assistance learning about the different mental health disorders and how they may affect parenting, you can refer to the Mental Health Tip Sheets or contact the state office mental health mailbox at SOMH@dfps.texas.gov for further assistance.

Processing Concerns with Caregivers

Our work is to help create opportunities for child safety to occur within families and communities. In order to achieve this goal, we often partner with caregivers and their families to help them come up with ways to mitigate risk factors and ensure the safety of their children. According to the National Alliance on Mental Illness (NAMI), one in four adults in America experience mental illness each year.

Key Elements of Family Engagement:

- Respect the family and allow for family input.
- Be hopeful and honest in your communication.
- Establish the purpose of involvement with each family member.
- Explore how culture, faith, community, economics, or language come into play.
- Older youth can provide valuable perspective and insight into family functioning.
- Engage and involve non-custodial parents and extended family.
- Focus on family strengths and build from there.
- Encourage the family to come up with a plan that best works for them as a unit
- Set mutually acceptable goals.
- Ask the family what resources are needed, make recommendations, and provide information on accessing resources.
- Model healthy coping skills by establishing and maintaining boundaries.

In processing our concerns with caregivers, we should begin with open communication providing an honest description of what the concerns are and explaining how everyone's input will be needed to ensure child safety. In approaching each person, you will be most effective if you use a respectful, professional, and patient tone. How you engage with the family on the onset of the case can affect the direction and outcome.

Reviewing the case history can be helpful when engaging with caregivers. It can be used to help prompt caregivers in providing accurate information regarding their social history as well as help in identifying potential collaterals or alternative caregivers, should a parent need to seek mental health treatment for an extended amount of time (*CPS Policy 2152*). A review of case history can also help to identify gaps in services, changes in treatment regimen, and history of compliance with treatment or medications.

Through engagement with their family, culture, and community, people who experience mental health conditions respond in a healing way to people who support their recovery and wellbeing (NAMI, 2022). Being supportive, hopeful, and encouraging with the families you work with while being honest and direct will lay the foundation for a trusting and positive working partnership.

Engaging Children

National Alliance on Mental Health (NAMI) report seventeen percent of youth ages 6-17 in the United States live with a mental health disorder (NAMI, 2022). While the Center for Disease Control (CDC) report one in 14 children ages 0-17 live with a parent who experiences a mental health condition and who, in turn, were more likely to experience an emotional, mental, or developmental disability, suffer adverse childhood experiences, and live in poverty (CDC, 2022)

Children may be exposed to a caregiver's mental health conditions in a variety of ways:

- Seeing it
- Hearing it
- Intervening or trying to support the caregiver
- Seeing the effects (parent arrested, witnessing paranoia, agitation)
- Living in poverty
- Being maltreated directly

What might children learn because of exposure to a caregiver's mental health condition:

- Poor coping skills
- Mimic self-harming behaviors
- Dangerous environments
- Role reversal or parentification (when a child takes on the role of an adult)

Not all children respond the same way. Their responses may be based on:

- The strength of parent-child relationships,
- The parent's maltreatment of the child(ren),
- The child's age,
- The child's developmental stage,
- The child's role in the family
- The child's personal characteristics (i.e., sense of self, mastery of tasks, security)
- Other support system available to the child(ren)

Children may be affected by exposure to the parent's mental health condition in varied ways:

- The child may experience developmental delays
- The child may struggle academically
- The child may struggle with developing or maintaining social relationships/skills
- The child may develop emotional or behavioral disturbances at an early age

When engaging with children

- Encourage them to discuss their feelings with you or a trusted adult.
- Help them identify trusted adults who they feel comfortable to go to when they are feeling unsafe or are in an unsafe situation.

CAREGIVER MENTAL HEALTH AND CHILD SAFETY

Safety Assessment

In assessing the child's immediate safety, the caseworker considers the following:

- Behavior of the caregiver – Does the caregiver's mental health and associated actions pose a risk to the safety of the child in their care? Are the symptoms associated with the diagnosis consistent with the displayed behavior (mental health vs. substance use)? Is the caregiver able to control their emotions enough to care for the child without causing harm?

- Thought and Perception of the caregiver – Is the caregiver showing signs or symptoms of paranoia, delusions, hallucinations or delirium? Are these symptoms posing a threat to the safety of the children? For example: The caregiver stating the child is possessed by demons and the need for the child to be protected from the illusionary demons. Is the caregiver aware of and able to tend to the child's basic needs?

- Support system and alternative caregivers- Are their supportive caregiver's in the home willing to keep the children safe and able to meet their basic needs? Does the caregiver have a support system that is protective and is the caregiver willing to allow supportive caregivers to step in when needed?

- Compliance with mental health treatment – Is the caregiver taking the prescribed medication as recommended and are they compliant with mental health treatment recommendations? Does their non-compliance with medication and treatment recommendations pose a safety risk to the children? Do the treating mental health professionals have any concerns with non-compliance?

- Consider child vulnerability- Does the child's age, mental capacity, disability, or mobility affect their ability able to self-advocate, self-protect or access their safety support network? Are the children's basic needs being met?

In assessing the information you have gathered related to the caregiver's mental health and child safety, consider recent or current life events that may be impacting the caregiver's ability to maintain treatment compliance such as loss of medical insurance, employment, support network, access to community resources, or other factors. Being able to identify possible causes of non-compliance or on-set of mental health crisis' can with identifying resources that can assist the caregiver in addressing and finding solutions to their situation.

Determining Child Safety

The safety assessment is a tool used to help guide you in determining whether a child is in imminent danger of abuse/ neglect. Utilizing the information gathered during the engagement phase will help you to assess and determine child safety.
Here, you are assessing for Danger Indicator #11: Caregiver's emotional stability, developmental status, or cognitive deficiency seriously impairs his/her current ability to supervise, protect, or care for the child. Examples of this danger indicators may be:

- The caregiver's refusal to follow prescribed medications impedes his/her ability to care for the child.
- The caregiver's inability to control his/her emotions impedes his/her ability to care for the child.
- The caregiver's mental health status impedes his/her ability to care for the child.
- The caregiver expects the child to perform or act in ways that are impossible or improbable for the child's age or developmental stage (e.g., babies and young children expected not to cry, or expected to be still for extended periods, be toilet trained, eat neatly, care for younger siblings, or stay alone).
- Due to cognitive delay, the caregiver lacks knowledge related to basic parenting skills, such as:
    - Not knowing that infants need regular feedings
    - How to access and obtain basic/emergency medical care
    - Proper diet
    - Adequate supervision based on the child's age and developmental status

Questions to consider: *Does the caregiver's mental health lead to inattentiveness (i.e., unsupervised time inside/outside the home where injury or death can occur), poor judgement (i.e., allowing unsafe people around the children, not seeking or not following through with mental health treatment recommendations), not being able to supervise children or participate in daily living (caregivers are withdrawn due to depression, anxiety, or other untreated mental health condition), or the caregiver's inability to regulate their emotions (increasing the risk of violence and emotional trauma)?*

Safety Planning

If we are completing a safety plan with a family due to concerns for the caregiver's mental health the following should be present:

- A protective parent/legal guardian or alternative caregiver
- A safety support monitor who understands how the caregiver's mental health may pose a safety risk to the children and is willing to intervene appropriately to clear instructions provided during implementation of the plan in the event of a mental health crisis.
- A periodic re-evaluation of the safety plan to determine if the plan is still appropriate to keep the children safe.

Planning goes beyond implementing the safety plan and includes ensuring the interventions are tailored to the family's needs. The short and long-term success of the intervention depends on how well the interventions address the identified safety concerns.

Family-centered interventions should ensure child safety by building upon the family's existing strengths and available resources. While making an appointment with a mental health provider is a good short-term goal and likely will lead to the caregiver being assessed for the proper long-term treatment, it does not immediately create a safe environment for the child. When determining your intervention, you should explore what contributed to the disruption in mental health treatment or identify the event that exacerbated the mental health crisis.

Protective capacity is the caregiver's behavioral, cognitive, and emotional ability to ensure their child's safety, while protective factors are factors found within a person, family, or community that reduces risk and improves child wellbeing. Incorporating both protective capacity and protective factors when assessing, intervening, and serving families is recommended for promoting child safety and family wellbeing. While we've indicated that caregiver's protective capacity includes their ability to act in ways that keep their children safe (behavioral), understand and perceive danger (cognitive), and demonstrate self-control enough to protect their child (emotional), here is a list of protective factors that promote child safety:

- Nurturing attachment
- Social support
- Parenting skills
- Caregiver resilience
- Social/ emotional competence
- Access to community resources (food, housing, health care, etc.)

The goal of the intervention is to work in partnership with families to aid them in the process of developing their protective capacity and increasing the amount/ quality of protective factors . Providing them with the tools and access to supports or resources will empower them toward long-term success. Although each case will look different and each family may require a tailored approach, the goal of child safety will remain constant.

you should articulate to the caregiver the child safety threats present in the home including the connection between child safety and the caregiver's mental health. A safety assessment can help you determine if the child(ren) can/ cannot remain in the home while the parent is actively experiencing a mental health crisis.

The chart below provides the child safety concern with a corresponding possible safety intervention. Remember that each case and family are unique:

Child Safety Concern	**Protective Measures**	**Possible Safety Intervention**
Active mental health crisis that threatens the child's immediate safety and family is **not** compliant with DFPS recommendations.	Ensure the child's immediate safety. Seek judicial oversight	• Motion to participate • Order in aid of investigation • Petition for temporary managing conservatorship • Conservatorship removal
Active mental health crisis that threatens the	Ensure the child's immediate safety.	• Safety assessment • Safety plan

child's immediate safety and family is compliant with DFPS .		• Parental-child safety placement (PCSP) • Referral to crisis intervention services – Mobile Crisis Outreach Team (MCOT) or local psychiatric hospital
Active mental health crisis that does **not** threaten the child's immediate safety	Help family access mental health resources and identify supports	• Refer to resources - Local Mental/ Behavioral Health Authority (LMHA), private insurance • Identify family and social supports willing to step-in to protect the child.
Recent but not currently in a mental health crisis that does not threaten the child's safety **but presents a potential risk.**	Help family access mental health resources and identify support system.	• Identify family and social supports willing to step-in to protect the child. • Refer to community resources - Local Mental/ Behavioral Health Authority (LMHA),
History of mental health condition that does not threaten the child's safety but presents a potential risk.	Develop reliable sources of support. Guide parenting and child development.	• Community Referrals and Resources such as: Local Mental/ Behavioral Health Authority (LMHA), Parenting class, and/o Participation in ECI (Early Childhood Intervention) DFPS supported resources: Protective day care

Documenting in IMPACT

In your initial contact with the caregiver alleged to experience a mental health condition, the following information should be gathered based on the caregiver's report:

- The mental health history including history of diagnosis, medications prescribed, and history psychiatric hospitalizations,
- Current treatment providers, last date seen by the provider, and frequency of appointments,
- Any history of suicidal or homicidal ideations or attempts,
- Reasons given for non-compliance with treatment or discontinuation of treatment
- Efforts being made to re-engage in treatment services, if applicable
- Does the caregiver have any concerns with the safety of the child/ren in their care? If so, what are those concerns.
- Is the caregiver willing to sign a release of information to allow you to speak with their treatment providers?

After you have gathered information, assessed safety, engaged with the family, and completed safety planning, be sure your hard work is documented!

When documenting about mental health concerns remember to document the specifics in your case:

- Include the facts gathered around the caregiver's behavior. Has there been any specific actions taken by the caregiver that places the children at risk such as acts of violence, threats, or even a lack of response that places the children at risk?

- Is the caregiver expressing any concerning thoughts or ideas that are not grounded in reality that may place the children at risk?
- Document contacts with relevant collaterals who have knowledge of the caregiver's behaviors, mental health condition/ or treatment.
- Document discussions with doctors or mental health providers. When you obtain information from treatment providers and be specific in your discussion with them about your concerns with the caregiver and children's safety. If you have questions about the caregiver's symptoms as they relate to the specified diagnosis it is okay to ask. For example, if the parent is reporting a diagnosis of anxiety disorder but showing signs of hallucination, you can ask the provider if the symptoms are consistent with the diagnosis.
- Ask the provider about the caregiver's history of compliance with treatment and whether they have any concerns related to the caregiver's treatment compliance.

After you've gathered and documented all the relevant information, it is ***very important*** that you include when/if you referred to mental health resources, whether the caregiver followed through with the referral, or whether they declined the referral.

Dispositions and Safety

Remember: Dispositions do not equal safety. It is important to remember that a disposition does not equal safety. We may not have the preponderance of evidence to confirm child abuse or neglect on any given investigation, but the disposition does not determine the case outcome. For example, a reason to believe disposition on an investigation does not automatically indicate that the family must receive further services or that legal intervention is needed. Conversely, a ruled out finding on an investigation where we are unable to meet the burden of proof ("immediate danger of harm") does not preclude a family from receiving or needing further services or intervention.

A caregiver's mental health history alone is not evidence of child abuse or neglect. Collaterals can give us *some* information, but it is up to the caseworker to gather sufficient information to obtain a clear picture of each family's situation. Caseworkers should look at the totality of the circumstances from the information gathered and assess if further intervention is warranted.

- Individual case circumstances drive decisions regarding next steps.
- When investigating abuse and neglect the standard that must meet for confirming dispositions is as follows:
  - A parent/legal guardian knew of harm to a child (abuse or neglect) and
  - Demonstrated "*blatant* disregard for consequences" which
  - Posed an "immediate danger of harm" to the child. *(CPS Policy 2113.2)*

COMMON MENTAL HEALTH DISORDERS

Mental Health Tip Sheets for the most common Mental Health Disorders that affect the families you serve:

•Anxiety Disorders
•Bipolar Disorders
•Depressive Disorders
•Disruptive Disorders

•Dissociative Disorders
•Factitious Disorder (Münchhausen)
•Personality Disorders
•Schizophrenia and other Psychotic Disorders
•Substance Use Disorder and Co-Occurring Mental Health
•Trauma and Stress Disorders

CHILDREN'S MENTAL HEALTH

There are times when we encounter families who struggle with obtaining mental health services for children with mental health conditions or who experience Serious Emotional Disturbance (SED). Serious Emotional Disturbance is defined by the Substance Abuse and Mental Health Services Administration as affecting a person age 0-18 diagnosed with a mental, behavioral, or emotional disorder (within the past year) that substantially disrupts or limits that child or persons ability to function in family, school, or community.

Children designated with Serious Emotional Disturbance require comprehensive treatment intervention services. In an effort to prevent families from having to relinquish their parental rights to obtain mental health services for their children with SED, legislatures worked with DFPS and HHSC through Senate Bills 44 and 642 to open other avenues for families to receive these services and avoid parental relinquishment.

It is important that families first exhaust available personal and community resources before attempting to place their child out of the home or relinquish their parental rights. Taking children out of their homes can be disruptive and traumatic for them. When families approach seeking mental health services for their child with SED, the caseworker must determine if the family has exhausted their access to mental health services, including community resources and private health insurance.

CPS policy 2390 instructs us to assess if the family has exhausted their access to mental health services:

- Is the family unable to access appropriate mental health services or treatment due to a lack of financial or other resources?
- Are the appropriate mental health services not available in the family's community?
- Has the parent followed the recommendations of mental health professionals who have treated the child, including complying with any recommendations about actions the parent, child, or family need to take?
- Does the parent disagree with the professional recommendation? If so, has the parent discussed their concerns with the provider or sought a secondary assessment with an alternate mental health professional for assistance or treatment?

If it has been determined the family has not exhausted all the resources available to them, there is an array of mental health services recommended for families to attempt prior to seeking to relinquish their parental rights. The caseworker must make reasonable efforts to prevent

removal of a child with serious emotional disturbance. Assessing the child for eligibility into the HHSC Residential Treatment Center Project or RTC Project is one effort that should be discussed with the family (*CPS Policy 2390.2*).

Residential Treatment Center (RTC) Project

The RTC Project provides access to intensive mental health services for children with serious emotional disturbance whose families have exhausted less restrictive options or for whom other less restrictive services have not been successful. The RTC Project works with the family's local mental health authority or local behavioral health authority (LMHA/ LBHA) to provide mental health services and to cover the cost of an RTC. The eligibility requirements for the RTC Project are:

- The child must be a resident of Texas.
- The child is between the ages of 5-17.
- The child has a qualifying serious emotional disturbance.
- There is no current abuse or neglect occurring in the home.
- The family is at risk of relinquishment.
- The goal of the family is to allow the child to return home after treatment.
- The family agrees to participate and follow through with treatment recommendations.
- Post-adopt services have been exhausted.
- The child has an IQ of 70 or above.
- The child has had a psychological within the last 6 months.

How to make a referral to the RTC Project

Senate Bill 642 allows for local mental and behavioral health authorities to refer children directly to the RTC Project without the need for DFPS to conduct an abuse or neglect investigation. In prior years, families could only access the RTC Project though DFPS making a referral to HHSC on the family's behalf. With this change in legislation, families can receive needed mental health services within their community without DFPS intervention or involvement. However, when there is an open investigation with a family at risk of relinquishment needing RTC services the assigned caseworker will be responsible for making the referral to the state office mental health mailbox on the family's behalf.

Before making a referral to the state office mental health mailbox the caseworker should verify the family meets the above-mentioned criteria and verify (CPS Policy 2390.2):

- A mental health professional has made the recommendation for an RTC.
- The caseworker advises the family of he
- The family is aware a psychological evaluation conducted within the last 6 months is needed before the child will be placed on the waitlist.
- The family has expressed the possibility of relinquishment if they are not able to obtain the needed mental health services.
- The family is aware the treatment team will make the decision of when the child is ready for discharge and the family is expected to allow the child to return home at that time.
- The family is aware placement into an RTC is not guaranteed and the child must be accepted into an RTC facility that is able meet their therapeutic needs.

- Verify post-adopt services have been exhausted for children adopted through DFPS.

Referral Process (CPS Policy 2392):
Once determine by the caseworker and supervisor the family meets the eligibility criteria, the worker will need to submit Form 2037 to the state office mental health mailbox at SOMH@dfps.texas.gov and include any mental health records, psychological evaluation, and psychiatric assessments in your attachment. When filling out Form 2037, be detailed about the current behaviors of the child, prior hospitalizations, and treatment history.

Once the referral is received by the mental health specialists, it will be reviewed and forwarded to the RTC Project. The RTC Project Coordinator will then forward the information to the LMHA/ LBHA who will contact the family within 72 hours to set up a Child and Adolescent Needs and Strengths (CANS) Assessment. The CANS Assessment will help verify RTC Project eligibility and the level of care for the child. The LMHA/ LBHA will also connect the family with additional supports and mental health resources such as Community Resource Coordination Groups (CRCG) and YES Waiver services who will, in-turn, connect the family with a Certified Family Partner (CFP). The CFP can assist the caregiver with navigating the mental health system and help to advocate on the child's behalf.

HHSC begins the RTC Bed search once they have received a complete packet which includes the CANS assessment, psychological evaluation, and RTC application for placement (Form 2037). There is a 6-8 week waiting period for an RTC however the child and family will receive mental health services and crisis intervention services through the LMHA and YES Waiver during the waiting period. Once the child has been placed in an RTC the family will continue to work with the LMHA and RTC treatment team to ready the family for the child's return home. The LMHA and YES waiver case managers will remain in frequent contact with the family.

The DFPS investigation can be closed once the family has been connected with the LMHA/ LBHA and all investigative tasks have been completed. To learn more about RTC Project visit: https://www.hhs.texas.gov/services/mental-health-substance-use/childrens-mental-health/childrens-mental-health-residential-treatment-center-project

Local Mental Health Authority Resources

What is Youth Empowerment Services (YES) Waiver?
The YES Waiver provides wraparound services or strength-based intensive mental health services delivered via a team planning process that utilizes family and community supports. The YES Waiver is used to help grow the family's support network including community supports. To learn more about YES Waiver visit: https://www.hhs.texas.gov/services/mental-health-substance-use/childrens-mental-health/yes-waiver

What is a Community Resource Coordination Group (CRCG)?
CRCGs are designed to address the complex needs of families that require multi-agency coordination efforts to be successful. A CRCG works to connect families with public and private

agencies efficiently and comprehensively. To learn more about CRCG visit: https://crcg.hhs.texas.gov/index.html

Crisis Services During the Referral Process
When there is a mental health crisis with the child while the family is awaiting placement into an HHSC RTC, the caseworker should reach out to the Mental Health Specialist for guidance in obtaining crisis services (*CPS Policy 2397*). The Mobile Crisis Outreach Team (MCOT), LMHA or YES Waiver case manager, or 911 are other ways families can seek emergency assistance. To learn more about MCOT visit: https://www.hhs.texas.gov/services/mental-health-substance-use/mental-health-crisis-services/mobile-crisis-outreach-teams

Joint Managing Conservatorship (JMC)

Senate Bill 44 was implemented in 2013 and introduced JMC to aide families who were seeking to relinquish their parental rights for the "sole purpose of obtaining mental health services for the child" and who had exhausted their resources or who could not access needed mental health resources otherwise.

When the caseworker determines the family has exhausted all the resources available to them Texas Family Code Sec. 262.352 states the worker should then discuss the possibility of a court order entering into a JMC agreement with DFPS. Notably, the caseworker does not discuss JMC of the child with the parents unless the Program Director has approved removal of the child and approved the caseworker discussing JMC with the parents (*CPS Policy 2393*). The worker should consider the following factors when considering JMC

- Is the child designated as having a serious emotional disturbance?
- Is the sole purpose for relinquishment to obtain mental health services?
- Is joint managing conservatorship in the best interest of the child?
- Is the family's goal for the child to return to the home after treatment?
- Is the family willing to participate in the treatment recommendations?
- Is there confirmed or suspected abuse or neglect?
- Are there any alternative caregivers willing to accept the child?
- Has the family exhausted community resources and insurance benefits?

Documenting in IMPACT

The caseworker must document all discussions regarding JMC in Impact (*CPS Policy 2394*). More specifically, the worker must document:

- The JMC staffing.
- Whether JMC was discussed with the parent.
- Why JMC was or was not determined as the best option for the child and family, and
- Whether the parent agrees with accepting JMC. If not, why not.

Also, be sure to document:

- The mental health professional clinical recommendation.
- The services the child has received and is currently engaged in.

- The mental health history including history of diagnosis, medications prescribed, and history psychiatric hospitalizations,
- Current treatment providers, last date seen by the provider, and frequency of appointments,
- Any history of suicidal or homicidal ideations or attempts,
- Are there any safety concerns? If so, how are they being addressed.
- History of compliance with treatment recommendations.
    - Had the family previously been referred to resources for the child?
    - Did the family access the resources for the child they were referred to?
    - If the family did not engage in the services, what were the barriers to accessing the resources for the child?
    - Reasons given for non-compliance with treatment or discontinuation of treatment.
    - Efforts being made to re-engage in treatment services, if applicable

As previously noted, it is *very important* that you include when/if you referred the family to mental health resources, whether the caregiver followed through with accessing the resources for the child they were given the referral for, and/or whether they declined the referral. In the person detail list, the caseworker should also enter appropriate diagnosis associated with the child's mental health condition.

Dispositioning for Families Seeking Access to Mental Health Services (*CPS Policy 2395)*

Families seeking to relinquish their parental rights solely for the purpose of seeking mental health services for a child with serious emotional disturbance should not receive a disposition of reason to believe (RTB) if:

- the parent refuses to allow the child to remain in or return to the home because a licensed mental health professional evaluated the child and found the child to pose a danger to himself or others; and
- the parent has tried but been unsuccessful in arranging for the necessary care for the child because the parent states:
- he or she has exhausted community resources and insurance benefits; or
- no appropriate mental health treatment facility, family member, or fictive kin would accept the child; and
- Abuse or neglect cannot be proven by a preponderance of evidence.

When the family has exhausted their resources and agrees to enter into joint managing conservatorship agreement with DFPS, the caseworker will "Rule Out" the allegations of abuse or neglect and will answer "yes" to the question "Is the primary caregiver seeking to relinquish custody of this alleged victim solely to obtain mental health services for the child? "

When a parent has been found to have abused or neglected their child, the caseworker cannot determine that the parent is seeking to relinquish their rights to the child solely for the purposes of seeking mental health treatment and therefore the parent would not be appropriate to enter into a joint managing conservatorship agreement with DFPS.

When a child is receiving treatment in a psychiatric hospital and the caregiver is refusing to pick up the child when ready for discharge the caseworker should consider the following:

- Establish the reason for refusal of the caregiver to pick up the child.
- What are the discharge recommendations?
  - How can we help the family fulfill recommendations?
- Are there any alternative caregivers willing to care for the child?
- If there are safety concerns, how can they be addressed?
- Has the family exhausted accessible resources?
- How is the hospital responding to the caregiver's feelings the child is not ready for discharge?

When working with a family with a child in a psychiatric hospital, learning what treatment recommendations are being made is crucial to helping the family access needed resources. This may require collaborating with multiple agencies and working with the hospital liaison who can assist with obtaining records, testing, and clarifying clinical recommendations.

Subject Matter Experts

Subject Matter Experts (SMEs) can be a valuable resource and save you lots of time when working with families where time is of the essence. As you work with families, you will find that many of them have complex needs that will require a comprehensive approach in implementing the most effective intervention plan. Recognizing the purpose and value of the various SMEs available to you will enhance your ability to work with families most effectively. Below is a description and list of SMEs with a link to their contact information:

- Psychiatric Hospital Liaison – Can assist with obtaining records, discharge recommendations, and providing resource recommendations.
- Developmental Disability Specialist - If the child/youth appears to have a developmental disability, the caseworker can reach out to the Developmental Disability Specialist who can assist with answering questions and accessing resources related to developmental disability.
- Substance Use Specialists - can provide information and resources related to substance use in mental health cases and in general.
- Post-Adopt Liaison - For families who need resources for children who were adopted from DFPS and who are in need of mental health services.
- Education Specialist - Can assist with obtaining school records, including testing such as the ARD or FIE.