

Chapter 12

MENTAL HEALTH CONSULTATIONS

12-1. Purpose. For purposes of child protection assessment and interventions, it is important for investigators to consult with mental health professionals to accurately identify mental health conditions in parents, caregivers, children and adolescents in order to determine the extent, if any, the condition has on the caregiver's ability to parent and, in extreme circumstances, the direct impact on child safety.

a. Despite the social stigma associated with mental illness, the vast majority of individuals experiencing or caring for a child under psychological distress parent very capably. At times, however, an undiagnosed or undermanaged mental illness can result in conditions, behaviors, and situations in the home which cause the individual to be a danger to themselves or others.

b. By the conclusion of the Family Functioning Assessment, it is critical that the child welfare professional accurately assesses if the caregiver's untreated or improperly managed mental health condition has seriously harmed a child or will likely result in serious harm to a child.

c. By the conclusion of the Family Functioning Assessment, it is critical that the child welfare professional accurately assesses if the alleged child victim's mental health condition is beyond the caregiver's protective capacity, or willingness to manage, which has seriously harmed the child or will result in serious harm to the child.

d. Screening questions which must be discussed during a mental health consultation related to how a caregiver's behaviors may represent a danger threat to a child can be found in the "Assessing for Maltreatment" section for Inadequate Supervision within CFOP [170-4](#), Child Maltreatment Index.

12-2. Procedures.

a. When information available at pre-commencement or obtained during the Family Functioning Assessment indicates that a mental health condition is believed to be significantly impacting any household member, the child protective investigator must consult with a mental health professional to:

(1) Assess whether the mental health condition is out-of-control to the point of having a direct and imminent effect on child safety.

(a) Identify specific harm(s) caused by the parent's behavior, emotions, perceptions, or attitudes toward the child.

(b) Provide input on what safety actions need to be incorporated into a safety plan to manage safety tied directly to the parent/caregiver's poorly managed or out-of-control condition, or mental health status that creates concern regarding his or her ability to provide care and supervision to the child.

(c) Determine the need for crisis stabilization through Baker Act proceedings.

(2) Review the child or parent/caregiver's current medication use (regarding compliance and effectiveness) and treatment regimen, if any, being particularly sensitive to mothers recently having given birth who might be struggling with post-partum depression.

(3) Explore additional treatment options and interventions to better control or manage the existing condition.

(4) Explore the feasibility of the mental health professional accompanying the investigator to the interview site when “crisis response teams” are available, based upon local protocols and working agreements.

b. The investigator will also seek substance abuse expertise when there are concerns that a co-occurring substance abuse problem is present in order to ensure that services for both conditions are provided at the same time, to avoid triggering the symptoms of the co-occurring condition that is not being addressed.

c. When a child or adolescent has been placed under the Baker Act and **is pending discharge from the facility** the child welfare professional shall request notice of, and subsequently attend, any scheduled discharge planning or multidisciplinary staffing for the child.

(1) If the child welfare professional is aware of additional therapeutic disciplines working with the child or family (e.g., child or family therapist, behavior analyst, school social worker, psychologist or psychiatrist, etc.), the child welfare professional should share this information with the treatment provider so these individuals may participate in the multidisciplinary staffing as well.

(2) The child welfare professional shall request that individuals participating in the discharge planning conference or multidisciplinary staffing review, discuss, and to the extent possible, reach consensus on the following issues:

(a) The factors or circumstances which contributed to or resulted in the child or adolescent’s hospitalization;

(b) Recommendations to address any child safety, permanency, or well-being needs identified; and,

(c) Develop a plan to ensure ongoing therapeutic and placement needs are met.

d. When a child or adolescent has been placed under the Baker Act and **has already been discharged from the facility, or the discharge planning conference or multidisciplinary staffing is conducted without the child welfare professional in attendance**, the child welfare professional will complete the following activities:

(1) Immediately attempt to obtain and review the receiving or treatment facility’s discharge plan and/or multidisciplinary staffing notes and any recommendations for aftercare;

(2) **Schedule a follow-up multidisciplinary staffing with all therapeutic disciplines working with the child or family as soon as possible, but no later than 72 hours from the child’s or adolescent’s discharge from the treatment facility;** and,

(3) Review, discuss, and document circumstances leading to the child’s or adolescent’s hospitalization, recommendations to address newly identified safety, permanency, and well-being issues, and develop a plan to ensure ongoing therapeutic and placement needs are met.

(4) For families under the jurisdiction of the court, the child welfare professional will notify the court of the child’s or adolescent’s emergency mental health admission in keeping with the statutory intent to keep the court “*updated throughout the judicial review process*” relative to “any other relevant health, *mental health*, and education information concerning the child” [emphasis added].

e. Child protective investigators will be responsible for initiating the multidisciplinary staffing for any child in an active investigation not concurrently opened for case management services. Case managers will be responsible for initiating the multidisciplinary staffing for all ongoing services cases

including those with an active investigation (although the child protective investigator is required to attend and participate in the staffing in an active investigation).

12-3. Supervisor. When initiated, supervisor consultations are provided to affirm:

a. The child welfare professional is successfully achieving collaboration and teamwork with professionals during the Family Functioning Assessment to assess for poorly managed or out-of-control mental health issues or indicators of mental health status that creates concern regarding the parent/caregiver's ability to provide care and supervision to the child.

b. The child welfare professional's understanding and adherence to local protocols.

12-4. Documentation.

a. The child welfare professional will document the information provided to mental health professionals to assist in the assessment process and any recommendations resulting from the consultation activities in a case note within two business days.

b. The child welfare professional will document the supervisor consultation, if conducted, using the supervisor consultation page hyperlink in the investigation module within two business days.

