WHY ARE WE HERE: OBJECTIVES

- Legal Mandates & Core Practice Model of LA County Department of Children & Family Services
- Risk & Safety Measures, CPS Policies, and Procedures Utilized by CSW's in addressing Maternal Mental Health Issues
- Training by Maternal Mental Health NOW of LA County Children's Social Workers
- Role of LA County DCFS in working with the Maternal Mental Health needs of mothers dealing with Perinatal Mood and Anxiety Disorders (PMAD's)

http://www.youtube.com/watch?v=ilOeQIUwdAJE0
Partnerships : MMH-NOW & DCFS

- MMH-NOW
  - Formation
  - Strategic county partnerships
  - Finding internal champions (line staff to administrative)
  - Consulting outside agencies
  - 3 layered model

- County Counsel – Public Defender
  - Provided training – awareness and sensitivity to MMH, legal perspective to protect children, impact of MMH on child safety, options for care

- ICAN – interagency Council on Child Abuse and Neglect
  - Annual conferences
  - All child abuse councils county-wide

- DCFS – CPS – Population 34,881 (12/15)
  - Internal champion – Line staff to supervisor to training division
  - Half day emergency responder training
  - Full day for social workers, Public Health Nurses, Supervisors, New Hires, licensed staff
  - Consultation group – internal champion offering consultation in house

Source: http://dcfs.lacounty.gov/contactus/index.html

Blue Ribbon Commission

Los Angeles County Blue Ribbon Commission on Child Protection’s 2014 Annual Report stated the following:

“Mental health issues underlie many of the causes of abuse and neglect. Parents often need treatment for mental health disorders and major life stressors, including those related to substance abuse, depression, domestic violence, and poverty. Access and coordination of these services for parents are critical to keeping children safe and enabling their safe return to their parents. These services must be known to social workers and accessible to parents, both geographically and financially.”


CPS Mission Statement & Goals

- CPS Mission Statement:
  The Department of Children and Family Services, WITH public, private and community partners, provides quality child welfare services and supports so children grow up safe, healthy, educated and with permanent families.

- CPS will practice a uniform service delivery model that measurably improves:
  - Child safety
  - Permanency
  - Access to effective and caring service

- CPS GOALS:
  1. Improved Child Safety
  2. Decreased Timelines to Permanence
  3. Reduced Reliance on Out-of-Home Care
  4. Self-Sufficiency: Transitional Age Youth (TAY) & Non-Minor Dependent & AB12 (18-21)
  5. Increased Child and Family Well-Being
  6. Enhanced Organizational Excellence

Source: http://dcfs.lacounty.gov/contactus/index.html
Countywide Span of LA County DCFS

- Twenty Offices:
  - Palmdale, Lancaster, Van Nuys, Chatsworth, Santa Clarita, Glendora, Pasadena, Pomona, El Monte, Compton West, Belvedere, Santa Fe Springs, Torrance, South County

- LA Kids Fact Sheet (Monthly):
  - LA County DCFS Population: 34,881 (December 2015)
  - Birth - 2 Years: 7,181 (20.6%)
  - Gender:
    - Male: 17,398 (49.9%)
    - Female: 17,483 (50.1%)
  - Ethnicities:
    - Hispanic: 20,993 (60.2%)
    - African American: 8,763 (25.1%)
    - White: 4,008 (11.5%)
    - Asian/Pacific Islander: 455 (1.3%)
    - Filipino: 205 (0.6%)
    - Other: 281 (0.8%)
    - American Indian/Alaskan Native: 176 (0.5%)

Source: http://dcfs.lacounty.gov/contactus/index.html

Role of CPS

- Children’s Protection Services Legal Mandate:
  CALIFORNIA WELFARE AND INSTITUTIONS CODE SECTION 300-304.7 (WIC 300)
  a. Physical Harm
  b. Neglect
  c. Emotional Damage
  d. Sexual Abuse
  e. Severe Physical Abuse Age 0-5
  f. The child's parent or guardian caused the death of another child through abuse or neglect
  g. The child has been left without any provision for support; physical custody of the child has been voluntarily surrendered
  h. The child has been freed for adoption by one or both parents
  i. The child has been subjected to an act or acts of cruelty
  j. The child's sibling has been abused or neglected pursuant to (a), (i), (d), (e), or (i)

Source: http://www.leginfo.ca.gov/cgi-bin/displaycode?section=wic&group=00001-01000&file=300-304.7

Responsibilities & Roles of CSW’s

- Child Abuse Hotline (1-800-540-4000): 24/7
  - Receive, Evaluate, & Assign Child Abuse Referrals

- Command Post:
  - Conduct Child Abuse Investigations After 5:00pm, Holidays, Weekends
  - Forward to Regional Offices after initial investigation for follow-up (if necessary)

- Emergency Response (ER)
  - Regional Office CSW's who conduct initial allegations of child abuse and neglect

- Dependency Investigation (DI)
  - Regional Office CSW's who investigate allegations on Court petitions:

- Family Maintenance and Reunification & VFM Units
  - Regional Office CSW's assigned to provide services/support to family
CPS & DMH Shared Core Practice Model: Los Angeles Key Practice Strategies

1. **Engaging**: Creating continuous trustful working relationships with a child and family by increasing their participation, validating their unique cultural perspective, and hearing their voice while providing choices.

2. **Teaming**: Building and strengthening the child and family’s support system, whose members meet, communicate, plan together, and coordinate their efforts in a unified fashion to address critical issues/needs.

3. **Assessment & Understanding**: Collaborating with a family’s team to obtain information about the salient events impacting children and families and the underlying causes bringing about their situation.

4. **Planning & Intervening**: Tailoring and implementing plans to build on strengths and protective capacities in order to meet individual needs for each child and family.

5. **Tracking & Adapting**: Evaluating the effectiveness of the plan, assessing circumstances and resources, reworking the plan, celebrating successes, adapting to challenges and organizing after-care supports.

Overall Goals of Core Practice Model

- Children’s (*Mother*) Underlying Needs
- Individualized Plan
- Outcomes Improvement

Effectively Working with **ALL** Community Partners

- **Engaging**: Creating continuous trustful working relationships with a child and family by increasing their participation, validating their unique cultural perspective, and hearing their voice while providing choices.

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LA County DCFS Policies & Procedures

- Assessing the Safety and Risk of Newborns for Families Already under DCFS Supervision: Open Cases
  - Policy: 0070-548.07

- Structured Decision Making (SDM): Referrals & Open Cases
  - SDM Safety Assessment
  - SDM Risk Assessment

DCFS Policy: Assessing The Safety & Risk of Newborns for Families Already Under DCFS Supervision: Open Cases

- CSW’s Responsibility:
  - The newborn child must be assessed based upon (but not limited to) the following factors:
    - Health/physical condition (including bruises and body marks)
    - Condition of the home
    - Child vulnerability (Commercially Sexually Exploited Children: CSEC & Teen Moms)
    - Family and/or environmental stressors
    - Parenting skills
    - Parent’s substance abuse
    - Availability of daycare
    - Family support system
    - Safe sleeping arrangements
    - Medical/psychological/police reports
    - Collateral contacts
    - Ability of the family to provide for the safety and well-being of the child
    - Risk based upon referral history, case history, etc. (all factors previously listed above)
    - Status of the parents’ visits with their other children

Factor in Knowledge of Perinatal Depression When Assessing Safety Threats as Outlined in SDM Safety Assessment:

- Risk Factor Influencing Vulnerability: Age 0-5 (raises score)
- Current circumstances
- Caregiver fails to protect
- Caregiver’s explanation
- Caregiver does meet child’s needs
- Physical living conditions
- Caregiver’s substance use
- Domestic violence
- Caregiver describes the child in predominantly negative terms – colicky baby?
- Caregiver’s emotional stability

PMAD Identified in Protective Capacities (what to do)

Factor in Knowledge of Perinatal Depression When Assessing Safety Threats as Outlined in SDM Safety Assessment:

- Risk Factor Influencing Vulnerability: Age 0-5 (raises score)
- Current circumstances – SENSITIVITY TO MH ISSUES
- Caregiver fails to protect – DEPRESSION PLAYS A ROLE – DYADIC REFERRAL
- Caregiver does meet child’s needs – PSYCHO-EDUCATION
- Physical living conditions – REFERRAL FOR HOUSING SUPPORT
- Caregiver’s substance use – FOR MH ISSUES? ADDRESS BOTH SUBSTANCE AND MH
- Domestic violence - STRONG CORRELATION WITH DEPRESSION
- Caregiver describes the child in predominantly negative terms – colicky baby? – EMPATHY, TOOLS, SUPPORT, RESPITE

Knowledge of Perinatal Depression in Assessing Safety Threats as Outlined in SDM Safety Assessment:

- Child has the cognitive, physical and emotional capacity to participate in safety interventions – baby?
- Caregiver has the cognitive, physical and emotional capacity to participate in safety interventions
- Caregiver has ability to access resources
- Caregiver has supportive relationships
- There is evidence of a healthy relationship between caregiver and child
- Caregiver has history of effective problem solving
I know there is perinatal depression in this home
*(what to do differently)*

- Knowledge of Perinatal Depression in ADDRESSING Safety Threats:
  - Child DOES NOT have the cognitive, physical and emotional capacity to participate in safety interventions – baby? WHO CAN SUPPORT?
  - Caregiver’s emotional capacity to participate in safety interventions is impacted by PMAD – REFERRAL FOR PSYCH EVAL and COUNSELING
  - Caregiver STRUGGLES to access resources – DETERMINE & ADDRESS BARRIERS
  - Caregiver is isolated – HELP IDENTIFY SOCIAL RESOURCES
  - There is evidence of an Unhealthy relationship between caregiver and child – PSYCHOEDUCATION, DYADIC THERAPIES
  - Caregiver has POOR history of effective problem solving – CBT

SDM Risk Assessment: *(Open Cases & Referrals)*

- Knowledge of Perinatal Depression in Assessing Safety Threats as Outlined in SDM Risk Assessment:
  - Current report for neglect
  - Prior investigations
  - Household has previously received CPS services
  - Number of children
  - Age of youngest child
  - Characteristics of children in home
  - Consistent care
  - Caregiver history of abuse or neglect as child (CSEC)
  - Caregiver has/had mental health problem
  - Caregiver has/had alcohol or drug problem
  - Two or more incidents of DV in household in past year

INTERGENERATIONAL HISTORY *(WHAT TO DO?)*

- Knowledge of Perinatal Depression in ADDRESSING Safety Threats as Outlined in SDM Risk Assessment:
  - Current report for neglect – WAS MH ADDRESSED?
  - Prior investigations – HOW WAS IT RESOLVED?
  - Household has previously received CPS services – DID THESE INCLUDE MH?
  - Number of children – HOME MANAGEMENT, SUPPORT
  - Age of youngest child – HIGHER RISK FOR PMAD – INTERVENTIONS
  - Characteristics of children in home
  - Consistent care – PSYCHOEDUCATION
  - Caregiver history of abuse or neglect as child (CSEC)
  - Caregiver has/had mental health problem
  - Caregiver has/had alcohol or drug problem
  - Two or more incidents of DV in household in past year – SPOUSAL SAFETY
Introduction of Perinatal Mental Health to Children’s Social Workers

- Maternal Mental Health NOW:
  - Training, Policy, Advocacy & Stigma Reduction

CPS TRAINING GOALS INCLUDE:
- Understanding the range of perinatal mental health disorders, prevalence, risk factors
- Main aspects of screening for maternal depression
- How risk assessment and other tools may be used to screen for maternal depression
- How to utilize PMAD knowledge in intervention/referral
- Demonstration of how to link screening results to referrals/resources for perinatal depression in Los Angeles County
  - Resource directory
  - PMAD’s Depression & Suicide Assessment Training (PHQ9)
  - Medications & Perinatal Depression

Maternal Mental Health NOW: PMAD’s Depression & Suicide Assessment Training for CSW’s

I. Patient Healthcare Questionnaire (PHQ9)
- Short, easy to administer
- Based on DSM Criteria
- Used to screen for anxiety, depression, alcohol, eating disorders and somatoform
- Can determine both if there is depression and how severe the depression is.
  - PHQ-9 scores of 5, 10, 15, and 20 represented mild, moderate, moderately severe, and severe depression

II. Sensitivity in Screening
- Fear of judgment – listen to her
- Doesn’t understand reasons for screening - explain
- Stigma - Normalize
- Issues around privacy – explain limits to privacy
- Organizational mistrust – consistency

Intersection of Trauma & PMAD Risk Factors

- Child Abuse & Neglect
  - Grief & Loss

- Multigenerational Transmission of Trauma
  - Complex Posttraumatic Trauma

- Intimate Partner Violence (IPV)/DV
  - Pregnancy Increases Risk of Violence to Mother

- Drug & Alcohol Abuse
  - Positive Toxicology Newborns
  - Illicit/Legal

- Dual Diagnosis
  - Depression & Anxiety
  - Psychosis, Bi-Polar, Schizophrenia

Intersection of Child Welfare Population & Women at Risk for Perinatal Mental Health Issues

- Effects women across income, race, ethnicity, gender, age & sexual orientation
- Low income women are disproportionately impacted
- Per LAMB study, low income or ethnic minority women in Los Angeles had rates of depressive symptoms close to 30-40%
- Mothers with income less than $20,000/year were nearly 3 times as likely to report severe depressed mood in the months after pregnancy compared to mothers with income greater than $60,000/year.
- Mothers with less than a high school education were more than 2.5 times as likely to report severe depressed mood in the months after pregnancy compared to mothers with a college education.
- Mothers who had no partner at the time of their delivery were 2 times more likely to report severe depressed mood in the months after pregnancy

Source: 2012 Los Angeles Mommy and Baby Survey

Barrier or Partnership: Child Welfare

- FEAR
  - Mothers report FEAR of baby being taken away as a MAIN reason for not seeking support and/or treatment for perinatal mental health symptoms.
- Guilt & Shame
  - Mother’s are concerned about being seen as “crazy”
- Immigration Status: Detainment & Deportation/Separation from Children
- Language Barrier’s
- Need for Multicultural Understanding by DCFS & Community Partners
- Apprehension about medical field and medication to screen, treat, diagnose
- Lack of Insurance, Emergency Medical, low fee or free services

How DCFS Can Address Barriers and Build Partnerships with Mothers: Utilization of Core Practice Model

- Reframe Depression: “mother and child wellness” & reduce stigma
- Understand what motherhood means to each woman: “their narrative”
- Build Relationship of Trust
- Portray open, non-judgmental attitude
- Build collaboration with all aspects of community, including faith based communities
- Stay in connection-mom may not be ready
- Universal Message
  - You are not alone
  - You are not to blame
  - With help, you will get better
Overcoming Barriers: Next Steps

- Improved Training of CSW’s on Clinical/Mental Health Issues
  - Maternal Mental Health NOW

- DCFS Training Academy Focus on Perinatal Mental Health
  - Newly Hired CSW’s
  - On-going Training of CSW’s, SCSW’s
  - Incorporate Training of ALL DCFS Staff (Administration)

- Organizational & Culture Change within DCFS
  - Case Management Adherence to Core Practice Model
  - Manageable Case Count for CSW’s
  - Recognizing Vicarious Trauma of CSW’s & Providing Supportive Care (Wounded Healers)

- Training of DCFS Partner’s, Collateral’s, & Community Agencies on PMAD’s
  - County Council (DCFS, Attorney’s)
  - Dependency Court (Judges, Parent’s Attorney’s, Children’s Attorney’s)
  - Law Enforcement, Fire Department, First Responders (EMT), PMRT

The End

Bibliography


When a CSW becomes aware that a mother on his/her caseload has given birth, it is the responsibility of that CSW to assess the safety and well-being of that newborn:

- The newborn child must be assessed based upon (but not limited to) the following factors:
  - Health/physical condition (including bruises and body marks)
  - Condition of the home
  - Child vulnerability
  - Family and/or environmental stressors
  - Parenting skills
  - Parents' substance abuse
  - Availability of day care
  - Family support system
  - Safe sleeping arrangements
  - Medical reports (i.e. prenatal care)
  - Medical/psychological/justice reports
  - Collateral contacts
  - Ability of the family to provide for the safety and well-being of the child
  - Risk based upon referral history, case history, etc. (all factors previously listed above)
  - The status of the parents' visits with their other children (monitored vs. unmonitored, frequency of visits, quality of visits, etc.)
  - All reports, observations or reasonable suspicion of abuse, neglect, caregiver absence/incapacity or exploitation must be immediately reported to the Child Protection Hotline (CPH).
  - The decision regarding whether or not a newborn will be removed from a home, allowed to remain in a home under DCFS supervision or without supervision, should be made in the context of, and in consideration of, the current DCFS recommendation with respect to the siblings. Previous abuse of the newborn's siblings may be sufficient to establish a risk of harm to the newborn, especially where reunification was terminated or not offered. County Counsel should be consulted when CSW is unsure of how to proceed.

- In addition, if the newborn was not detained, CSWs must inform the court of the birth of the newborn at the next scheduled hearing for the newborn's sibling(s) and what services, if any, are being provided to that child and his or her mother.

- Responding to Allegations of Abuse or Neglect
  - CSW Responsibilities
    - If allegations of abuse or neglect come from a source other than the Child Protection Hotline (CPH), (e.g. based on the CSW's own knowledge of the current case situation), immediately contact the CPH to make a referral. In these situations, it is not necessary to have a face-to-face contact with the child.
    - Document in Case Notes the date and time a referral was made to the CPH using the oldest child's case.
    - Consult with your SCSW regarding the newborn and determine a course of action.
    - If the referral is not assigned to you, follow up with the assigned ER CSW to get the results of the ER investigation.
    - If during a home visit, the newborn is at immediate risk of, or is being abused and/or neglected and there is exigency take the child into protective custody. If the newborn is at risk but exigency does not exist:
      - Take the child into protective custody.
      - Contact CPH to make a referral. Document in Case Notes the date and time a referral was made to the CPH, using the oldest child's case.
      - Initiate a Team Decision Making meeting as soon as possible.
Assessing the Safety and Risk of Newborns for Families Already under DCFS Supervision

- If the newborn is not at immediate risk of, or has not been abused and/or neglected, but there are risk factors present, DCFS intervention is warranted:
  - Discuss with parent(s), their willingness to participate Voluntary Family Maintenance (VFM) Services if appropriate.
  - Create a case without a referral to provide services for the newborn.
  - Invite the parent(s) to participate in a Child and Family Team (CFT) meeting and develop a Safety/Action Plan that will enable the newborn to safely remain in the home.
  - Develop the initial case plan and provide ongoing services to the newborn.
  - If a decision is made not to provide services to the newborn, clearly document in detail the reasons why the newborn is not in need of services, using the oldest child's case.
  - This decision must be reevaluated on an ongoing basis as long as child welfare services are being provided to the family.