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THERAPEUTIC  
INTERVENTIONS FOR  
FAMILIES AND CHILDREN  
IN THE CHILD  
WELFARE SYSTEM

SHERI PICKOVER  
HEATHER BROWN

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**Sheri Pickover, PhD, LPC**, is an associate professor and counselor educator at the University of Detroit Mercy in Detroit, Michigan. She has trained clinical mental health, addiction, and school counselors for 11 years and has published several articles on effective clinical interventions. She also founded and acts as the clinical director of the University of Detroit Mercy Counseling Clinic, a training clinic providing free counseling to primarily court-mandated clients. She provides regular clinical supervision, and as former president of the Michigan Association for Counselor Educators and Supervisors, she co-developed and implemented a 30-hour clinical supervision training program.

She began her career in mental health providing crisis counseling at a run-away shelter. After obtaining her master's degree in psychological services, she worked as an in-home family therapist, specialized foster care worker/therapist, foster home licenser, foster care supervisor, clinical supervisor, and delinquency supervisor over the course of 15 years. She testified in court cases, drafted petitions for termination of parental rights, and drove children in foster care to their doctor appointments. Dr. Pickover lives in Southeastern Michigan and enjoys biking and baking brownies for her students and colleagues.

**Heather Brown, MS, LPC, ATR**, is an art therapist and child and family counselor in private practice. She started her professional career in Baltimore over 14 years ago and has worked as a therapist, trainer, artist, and program developer in a range of settings including a family shelter, special education, and youth development programs, in-home services, and community mental health agencies. After graduating from Eastern Virginia Medical School with her master's degree in art therapy, Heather moved to Detroit, where she served in a collaborative program providing for the mental health needs of foster children and their families through program development, assessment, treatment planning, advocacy, therapy, parenting classes, and professional trainings.

She happily resides in Detroit with her husband and children. She loves the water, playing, dancing, making things and traveling with her good friends and family.

# THERAPEUTIC INTERVENTIONS FOR FAMILIES AND CHILDREN IN THE CHILD WELFARE SYSTEM

*Sheri Pickover, PhD, LPC*  
*Heather Brown, MS, LPC, ATR*



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## PREFACE

The purpose of this text is to provide mental health professionals with an understanding of treatment issues unique to children and families who have become involved in the foster care system or children who have been adopted from the foster care system. This text is written for therapists working in multiple settings, including private practice, school settings, child welfare agencies, community mental health, or even juvenile institutions and prisons. The information pertains to any client who has ever had contact with the child welfare system, from adults who grew up in foster care or adopted children, to families who lost their parental rights, to children currently in foster care. These children and families suffer from a variety of mental health and/or substance abuse issues, and a myriad of resources exist to assist the mental health professional in treatment of these issues. However, a resource has not existed, until this text, that speaks to both the mental health needs of children and families and also how to engage families and other professionals. The goal of this text is to provide therapists with information about the child welfare system, explain the worldview of the client and family, and provide treatment interventions to help these clients.

Written as a guide to understanding how the foster care system works, this text explains how all of the parties involved cope and react and how the therapist can intervene at multiple levels to improve outcomes. Each chapter weaves personal examples, ethical issues, multicultural concerns, and current research into a comprehensive and easy-to-follow guide for providing mental health services for the child welfare participant. Many of the interventions described in this text come from clinical experience, trial and error, and evidence-based research. Not all interventions are appropriate for all clients, and not all interventions will work with all clients. Always use clinical judgment and seek supervisory support when needed.

## KALEIDOSCOPE METAPHOR



Humans tend to learn best through the use of a metaphor, painting a picture with words that illustrate a point. In this text, each chapter focuses on treating children in foster care, foster parents, adoptive parents, and birth parents through the lens of a kaleidoscope. Every case involves a complex pattern and ever-changing scene before, during, and after the course of treatment. Each color and

shape represents trauma, attachment, development, grief and loss, cultural contexts, ethical issues, crises, and transitions. Each turn brings a different perspective into view, but all of the features still exist within the kaleidoscope. We want to remind therapists that even though one shape or color may seem prominent at the time of treatment, all of the issues remain within the child and family, and one gentle turn of the kaleidoscope brings another concern into view. The therapist must continue to turn the kaleidoscope throughout treatment so that she is always reminded of the mosaic of the child's and the family's life in order to provide attuned intervention.

## OUTLINE

The text is divided into four sections. First, in Part One, we explain how children enter the foster care system and how child welfare agencies work so that therapists are able to obtain a solid understanding of how to negotiate the child welfare system. Part Two focuses on the worldview of the parties involved in the child welfare system, including the child, the family, the birth parent, and the foster parent. Part Three provides specific information on how to begin treatment, conduct a strength and needs assessment, and understand the role of medication; it provides specific case studies demonstrating how to treat problems related to trauma and attachment and how to develop workable behavior modification plans. Part Three also provides interventions to help clients cope

with their complicated losses and the multiple transitions that are an integral part of the child welfare system.

Part Four focuses on how to engage the birth parent, the foster parent, the child welfare system, and the medical and education systems. An ethical imperative for mental professionals is collaboration with other professionals, but silo thinking and lack of access to information often mean that treatment occurs in a vacuum, and children and families who are already stressed and resource deprived are expected to navigate the labyrinth of professionals to get their needs met. These sections provide specific interventions and strategies to engage adults and address how to negotiate the barriers. The last part of this section addresses how to help therapists become more aware of, and able to cope with, the stressors involved in treating these populations.

### MARY AND TOM

I remember driving to the shelter that day hoping that both children would fit in my car. I worked in specialized foster care only, so I rarely had to place siblings, but my boss had picked up the case of two siblings, a 13-year-old girl (Mary) and a 10-year-old boy (Tom), to be placed together. I felt ambivalent about placing these children in this new foster home. Sheryl was an untested foster parent. She seemed nice enough but had never parented children this old.

Mary and Tom entered care after being abandoned by their mother. Mary and her mother engaged in a physical altercation in their home, and Tom tried to stop the fight by standing in between his mother and Mary. By the time the police arrived, Mary and Tom's mother was gone and never returned to ask about her children. The police placed them in the shelter. These were old children for a first-time placement in foster care, and their demeanor struck all the adults who met them. They were both very polite and quiet. They didn't demand anything and followed rules readily. The referee in charge of the case demanded they be placed together and took a personal interest in their well-being. As a therapist, something about their affect struck me as odd. I remember describing the two children as deer caught in headlights. What everyone else saw as well mannered, I assessed as fear and trauma. These children were in shock and going through the motions, hoping not to be hurt any more. Time would show the amount of trauma they were

trying to cope with; Mary would wet the bed, Tom would explode in rage at his sister.

The foster parent wanted to help them, but she didn't know how to handle a 13-year-old girl who failed to disclose when she was menstruating and a 10-year-old boy who would threaten people with a broken bottle one moment and clean the house out of guilt the next. I worked with this newly formed family for 2 years, watching Mary struggle with her calm foster parent as she tried to get an emotional reaction from her while also desperately trying to help her brother so they could stay together. I often conducted family therapy sessions with the foster parent and Mary, helping the foster parent understand that her minimal reactions to everyday situations made Mary feel that she didn't care. Mary, used to her violent, effusive mother, couldn't read her foster mother, and so she would escalate her behavior to get a reaction.

Although therapy appeared to help Mary, Tom continued to have violent outbursts, and traditional therapy seemed ineffective. I soon discovered that Tom's father had been convicted of homicide and resided in a mental health prison facility not far from his foster home. Tom finally disclosed that his father, a former factory worker, suffered from a closed-head injury and one day, during an argument with his girlfriend, picked up a handgun and killed her. Tom blamed himself for this incident because he had planned to visit his father that weekend and stayed home to play instead; he was 8 years old at the time. I realized that the most therapeutic intervention for Tom was to see his father so he could allay his fears about his father's well-being. I contacted the prison, determined that his father was functioning well in his environment, scheduled a visit, and drove him to see his father. Luckily, the prison allowed visits in an open area, and the search wasn't too intrusive. John and his father could sit next to each other and hug at the end of the visit. I consider myself a pretty good therapist, and I think I've helped many children and families, but as I look back at my career, the most effective therapeutic intervention I ever utilized was taking this child to see his father. I knew that when he got into my car to leave and stated, "I wish my life were a dream and it could just start over."

This book is dedicated to all the foster children, foster parents, adoptive families, and birth families that cannot start over but, with effective therapeutic intervention, can start anew.

## ACKNOWLEDGMENTS

Many individuals helped in the process of creating this text. Four master's level graduate students at the University of Detroit Mercy Counseling Program spent their time finding research and editing information. Thanks to Jessica Elezaj, Namer Zayouna, Christina Arsenault, and Jennifer Schilling for their hard work and dedication to this project. Thanks also goes to Heather and to all the children and families who allowed me into their lives and shared their stories; their courage and resiliency continue to astonish me. Finally, thanks to my family for their support and encouragement.

—Sheri Pickover

I am grateful for Sheri and the many other colleagues I've worked with in child welfare. We have learned from each other and supported one another to do the work we wanted to do. I am thankful for all of the researchers, teachers, and trainers who have worked so hard to pass on invaluable information about how to better understand and help this vulnerable population. I am also grateful to God and my own family for helping me help others, as well as all the families that let me become a part of their lives.

—Heather Brown

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PART ONE

THE CHILD WELFARE SYSTEM

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## CHAPTER ONE

# INTRODUCTION TO THE CHILD WELFARE SYSTEM

Every child who enters foster care will have at least one or more substantiated experiences of abuse or neglect. This chapter discusses current statistics on child maltreatment and provides definitions for physical abuse, sexual abuse, and neglect. Next, it describes how children enter the child welfare system and the steps that occur from initial protective services investigation, to foster care placement, to exiting the foster care system.

### CHILD MALTREATMENT

In 2013, Child Protective Services (CPS) agencies in the United States received 3.5 million referrals and investigated 60% of those referrals (U.S. Department of Health and Human Services, 2013). Most children who were the subject of the reports were young (under the age of 5) and represented White, Hispanic, or African American ethnicities. Eighty percent of the referrals indicated some type of neglect, and 20% were for some type of abuse (U.S. Department of Health and Human Services, 2013). Fifteen hundred children died from abuse or neglect in the United States in 2013 (U.S. Department of Health and Human Services, 2013). Along with the substantiated incidents, foster care children most likely also experience unreported abuse and exposure to domestic violence and substance abuse (Smith, Johnson, Pears, Fisher, & DeGarmo, 2007).

### Physical Abuse

Definitions of physical abuse can include beating; whipping; burning; stabbing; or hitting with hands, feet, and objects (United Nations Children's Fund, 2012). Causing a child intentional physical distress can also be physical abuse, such as forcing a child to hold heavy objects

for long periods of time or exposing the child to extreme temperatures or illegal substances (U. S. Department of Health and Human Services, 2014a). Children are also considered abused if they are exposed to domestic violence. Domestic violence exposure means the child witnesses adults either hitting each other or other children, witnesses the use of weapons, witnesses physical or sexual assaults, and/or witnesses violent verbal altercations (U.S. Department of Health and Human Services, 2014b). Children who attempt to stop one adult from hurting another and become injured in the process are also considered abused (Bourassa, 2007; Christian, Scribano, Seidl, & Pinto-Martin, 1997).

### **Sexual Abuse**

Sexual abuse of a child includes many different behaviors and exposure that ranges from neglectful exposure, such as adults engaging in sexual activity or watching pornography with children present, to ritualistic aggressive penetration and degradation. Much of the sexual abuse of children is perpetrated by a loved one or trusted caregiver, such as a relative, parent, sibling, neighbor, or friend. It often occurs in the context of a “playful” and coercive game initiated by the abuser in a manipulative manner, with specific threats aimed at the child about not being believed, being bad, and hurting the child’s family if the child tells. Penetration involves a body part or object (such as a toy) being placed inside the child’s mouth, vagina, or rectum. Molestation involves nonpenetrating sexual touching. Exposure describes the child witnessing others performing any sexual acts by force or by neglect. Exposure also includes the child being forced to watch or view pornographic material or the child being forced to watch any overtly sexual act between people who are closely related or who perceive themselves as being closely related (as in relationships between in-laws, stepsiblings and stepparents, and close family friends). In addition to physical sexual contact, this can include voyeurism, masturbation in front of the child, suggestive talk, provocative photography, and exposing oneself to the child. Any of these involving two children of differing or the same age is considered inappropriate sexual behavior if both children involved are minors.

Nine percent of children are brought into foster care due to confirmed sexual abuse (U.S. Department of Health and Human Services, 2013), although approximately one in six boys and one in four girls are sexually abused before the age of 18 (Centers for Disease Control and Prevention,

2014). Heterosexual males perpetrate almost all child sexual abuse. Close to two-thirds of all child sexual abuse victims do not tell because they fear being blamed, punished, or not believed (Feiring, & Taska 2005; London, Bruck, Ceci, & Shuman, 2005). Incest, the sexual abuse of a family member, is estimated to occur in 14% of all families (Snyder, 2000).

## Neglect

Neglect is a nebulous construct with several definitions. Children often experience multiple types of neglect rather than one specific type. Neglect either involves directly not caring for children's needs or failing to protect them from an abusive adult in the home (Dubowitz, Pitts, Litrownik, Cox, Runyan, & Black, 2005). Eighty percent of children who are subjects of a protective services complaint have experienced neglect (U.S. Department of Health and Human Services, 2015).

Physical neglect refers to the lack of basic needs, such as a lack of clothing; lack of access to heat, electricity, and water; and lack of access to food. Medical neglect refers to the lack of basic medical and dental care, such as failure to receive well-child visits or not getting medical treatment for an injury or illness. These are two primary types of neglect that lead to placement in foster care. Parents may also commit educational neglect, which refers to the parents' refusal to send a child to school, or emotional neglect, which refers to the parent failing to provide nurturing. Often these types of neglect are not actionable.

Another frequent type of neglect is failure to protect. A parent who allows another adult to cause injury to a child without intervening may be charged with this type of neglect. For example, a mother who allows her partner to harm her children and does not intervene to stop the physical abuse will be charged with failure to protect.

Children exposed to physical abuse and sexual abuse also tend to be exposed to emotional and verbal maltreatment, although such maltreatment is greatly underreported and difficult to criminalize. These types of abuse and neglect can appear as insulting and degrading the child (calling him stupid, insulting his looks, etc.), threatening abandonment, teaching a child antisocial behavior, and rejecting a child's efforts to receive affection and closeness. Emotional maltreatment occurs when an adult consciously conveys to a child that she is worthless, flawed, unloved, unwanted, endangered, or only valuable to meet the adults' needs. Studies also show that the repercussions and effects of emotional

and verbal abuse and neglect on children are much the same as those resulting from physical abuse (Spinazzola et al., 2014).

### **Ramifications of Child Maltreatment**

The impact of abuse and neglect on children is well documented. Exposure to physical abuse, sexual abuse, and/or neglect impacts several areas, including biological, cognitive, and emotional development (Healey & Fisher, 2011). Depending on the age of the child at the time of exposure, brain development may be affected and result in cognitive distortions or delays (Koenen, Moffitt, Caspi, Taylor, & Purcell, 2003). Children may also suffer from nutritional deficits, which impact their growth and development, or may suffer injuries that cause long-term nerve or bone damage (Block, Krebs, American Academy of Pediatrics Committee on Child Abuse and Neglect, & American Academy of Pediatrics Committee on Nutrition, 2005). Young children may demonstrate failure to thrive, which means they do not grow as expected (Block et al., 2005). Older children may begin puberty early or have physical ailments related to the abuse, including sexually transmitted diseases, somatic complaints, or long-term injuries (Tubman, Montgomery, Gil, & Wagner, 2004). Of greatest concern is the impact of abuse on cognitive development. Cognitive developmental deficits occur both due to the stress reactions in the brain and the inability of children to receive educational stimulation because they do not feel safe or lack nutrition (Block et al., 2005; Hildyard & Wolfe, 2002). Typical milestones such as learning emotional regulation, learning to develop empathy, or even making friends can be affected by abuse (Luke & Banerjee, 2012). The biological ramifications of physical abuse and domestic violence also include increases in cortisol, a hormone associated with the stress response that prevents healthy brain development and prolongs difficulties from physical injuries (De Bellis, Spratt, & Hooper, 2011).

Children exposed to neglect also may display problems with hygiene, including not knowing how to bathe or brush their teeth and not knowing how to handle menstruation appropriately. Depending on the severity of the neglect, brain function and normal development may be altered (Glaser, 2000). Infants who do not receive nurturing or basic needs fail to thrive and in some cases die (Block et al., 2005).

Most children entering foster care also enter with a history of educational difficulty. They may have a diagnosed or undiagnosed learning

problem, a history of multiple school placements, or behavioral problems in school. Children may have delayed academic skills or in some cases may be unable to perform age-level grade work. As a result, children entering foster care often enter with a poor relationship with schools and teachers (Hildyard & Wolfe, 2002).

Children entering foster care can also exhibit some form of attachment insecurity, which can manifest itself as either hostility toward a caregiver or avoidance of a caregiver. In some cases, children suffer from having no attachment type and do not have the skills to build a quality relationship with an adult. These children, often diagnosed with reactive attachment disorder per the criteria of the *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed. (*DSM-5*; American Psychiatric Association, 2013), do not demonstrate anxiety around strange adults and also display violent and destructive behavior. Finally, although family and social support issues are not unique to foster children, most foster children come from disrupted families and have witnessed illegal substance use, have often lived with parents who lacked higher education, and did not have access to adequate resources. These children have also witnessed domestic violence. In fact, there is a 30% to 60% overlap between domestic violence and child maltreatment (U.S. Department of Health and Human Services, 2014b).

## HOW CHILDREN ENTER THE FOSTER CARE SYSTEM

### Initial Abuse/Neglect Report

The information discussed in this section is based on clinical experience and information gleaned from the *Child Welfare Policy Manual* (U.S. Department of Health and Human Services, 2015). Generally, there are two ways a child enters the child welfare system: either through a law enforcement entity or through the state protective services agency. Children enter the child welfare system for a myriad of reasons, and each state has individualized laws and procedures, including decision-making rubrics, that illuminate how placement occurs. Not all children who come to the attention of the child welfare system end up in foster care, but often, once a child comes to the attention of CPS, the parents and child are subject to increased scrutiny.

When law enforcement is involved, usually an incident of abuse or neglect has occurred that is so serious that the child's immediate safety

is threatened. The police obtain an emergency court order to remove the child and then call the state CPS worker to put the child in protective custody. When this type of removal occurs, the investigation takes place after the child has been removed from the parent's custody.

The other way a child becomes placed in foster care is through the state protective services agency. This occurs when a mandated reporter or anonymous source reports a suspected abuse and/or neglect allegation to the state agency, and the state agency assigns a caseworker to investigate the veracity of the claim. Investigations should occur within 48 hours of the initial report, but often, due to caseload sizes, the investigation takes longer. This investigation includes speaking to the child; the adult accused of the abuse or neglect; and other parties, such as the reporter, teachers, or neighbors.

Once the complaint has been investigated, protective services either decides to dismiss the allegation, substantiate the allegation and recommend prevention services, or substantiate the allegation and recommend removal. If removal is recommended, the protective services worker must draft a petition for removal and go to court to request that the removal be granted. Ultimately, only the juvenile court system has the power to remove a child from her guardian.

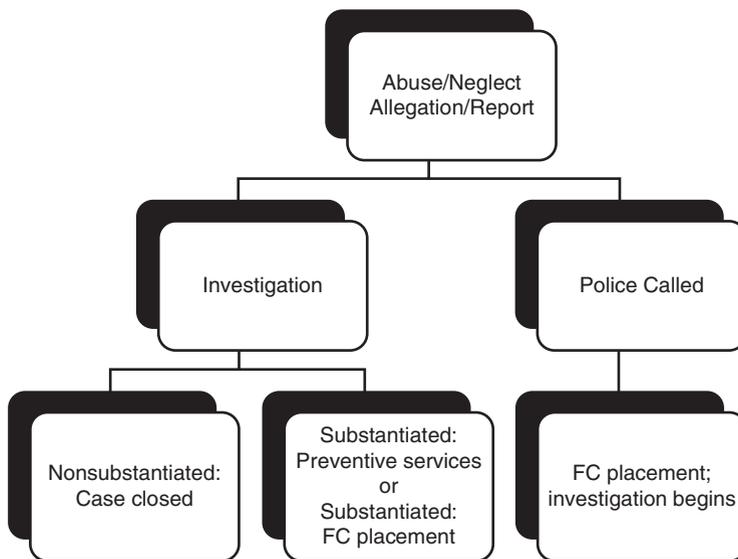
A family may be referred for prevention services prior to removal. These services include requiring the parents to attend parenting classes, obtaining financial support to obtain clean and safe housing, turning on electricity and gas, providing funds for furniture or food, or undergoing intensive in-home counseling services designed to keep the family together and intact. Not all families receive these services, and the decision to use preventative services over removal in most cases depends on the level of risk to the child. If the child is deemed at serious risk, meaning the child's personal safety and life are threatened, then removal occurs. If the threat is less serious, family preservation services attempt to prevent removal.

Families can have contact with a state agency several times prior to removal, or children can be removed on the first allegation. Children can be removed at birth for testing positive for illicit drugs, or, if a parent has had other children removed, some states automatically remove any new children born to that mother even if neglect or abuse has not occurred. Sometimes the court removes only one child from a home if only one child is at risk; other times, all siblings in the home are removed even if only one child is considered the primary victim. Each state and county has its own policies, procedures, and protocols for removing children,

and consistency does not exist throughout states or the country. Therapists should learn the laws in their states and counties to understand the culture of the state agency and court system.

As a mandated reporter, all mental health professionals should know the child protection laws in the states in which they practice, including the definitions for physical abuse, sexual abuse, physical neglect, medical neglect, educational neglect, abandonment, and failure to protect. Some states allow many forms of corporal punishment, whereas other states allow only open-handed spanking on a child's bottom. Learn the reason your client entered foster care from the court records, the case manager, and the client. Rather than focusing on the truth, consider the varied reports as multiple pieces of data to add to your assessment. The reasons a child enters care are often numerous and accompanied by differing accounts, all of which might be useful to the therapeutic process. Assuming prevention services are unsuccessful, or the risk to the child is too high to leave the child with his family, a state protective services worker drafts a petition to request removal of the child from the custody of the guardian. Once the petition is approved, the caseworker then transports the child to foster care placement.

Figure 1.1 provides a summary of the ways in which children enter foster care.



**Figure 1.1** *How Children Enter Foster Care*

## Initial Placement

Once a decision to remove the child has been made, there are several options available for placement (Table 1.1). First, the state agency attempts to locate a biological family member deemed safe and able to protect the child. Often, grandparents, aunts, uncles, or older siblings are asked to take temporary custody. Recently, federal law also allows placement with fictive kin, meaning a nonbiologically related individual the child and family identify as family, such as a very close friend or neighbor. In all of these cases, the state protective services worker needs to visit the home, ensure the home is safe, and ensure the family member agrees to refrain from using physical discipline on the child. Family members and fictive kin historically have not received financial support for agreeing to care for their relatives beyond health insurance and food assistance, but this process has been changing throughout the country.

If no family member is available, the child is placed in either a foster care home or a temporary shelter. Usually only teenagers are sent to shelters. Typically these shelters are multiple-bed facilities staffed by para-professionals who monitor children throughout the day and change shift every 8 hours.

The initial foster home placement could be a temporary placement, meaning it is short term while the agency attempts to locate a more permanent home or approve a family member, or it might be a long-term placement. Almost half of all foster care children placed in the United States return home within 1 year (Child Welfare Information Gateway, 2013), and the median length of stay before replacement is 13.4 months (U.S. Department of Health and Human Services, 2015).

## The State and Court Systems

Once a child is placed in foster care, the protective service worker transfers the case to a foster care worker. Every state handles foster care cases

**Table 1.1** *Initial Placement Options*

---

Biological family	Aunts, uncles, adult siblings, grandparents, cousins
Fictive kin	Neighbors, family friends
Shelter	Residential facility
Temporary foster home	10- to 30-day placement
Long-term foster home	90-day to 1-year placement

---

differently. Some states retain control of the case and assign a state foster care worker to ensure the child's safety, whereas other states contract out these services to a private child welfare agency and have a purchase-of-service caseworker who oversees the financial aspects of the case but not the day-to-day progress.

The court system also varies from state to state, but the process is similar throughout the country. Once an initial petition for removal is granted, the court assigns the guardian an attorney (if the guardian cannot afford her own), a prosecutor represents the state, and the court assigns a lawyer to represent the interests of the child. The petition for removal outlines complaints against the parent based on which child welfare law the guardian allegedly violated. The next step is a pretrial hearing in which the court decides if enough evidence exists to proceed the case to trial and continue the child in placement. The next step is a trial. Rarely do these trials result in an actual jury trial, although the parent can request one. The judge or referee can also decide the facts of the case, but usually the parents plead no contest to the abuse and/or neglect charges. Unlike in a criminal trial, the parent or parents are not innocent until proven guilty, and the rules of evidence are much more lax. Hearsay testimony is common, and decisions are based on a preponderance of evidence. If the parents are found guilty of the charges, the child is made a temporary ward of the court, meaning the parent retains some custodial rights such as the ability to sign medical consents and make educational decisions, but all decisions can be overridden by the court.

The next hearing is an initial dispositional hearing. The caseworker in charge of the case must draft a plan called a parent/agency agreement (PA) that the parent signs and the court approves. This plan includes all of the steps the parent must take in order to regain custody of the child. The court may order the parent to submit to a psychological evaluation, attend parenting classes, attend individual and family therapy, obtain employment, or refrain from using substances and submit to regular urine testing. The child may also be ordered to undergo a psychological or psychiatric evaluation or participate in individual or family therapy. The agency assigned to the case is responsible for providing referrals and services to the parent to help the parent achieve these goals. During this time, the parents also have structured visits with the child. Initially, visits often occur weekly for one hour, with a caseworker monitoring the visit; they possibly progress to weekly unsupervised visits, either for a few hours or an entire day. If the parent continues to progress, visits move to weekend visits in preparation for family reunification.

The court reviews the case every 90 days, and the caseworker presents a court report on the parents' compliance with the PA agreement. Another dispositional hearing occurs at 180 days, and the court determines if the plan remains reunification or should change to adoption. A permanency planning hearing occurs 360 days after the first dispositional hearing. If the parent has made progress, the court usually either returns the child home and orders in-home services or agrees to give the parent more time to comply with the PA agreement.

If the parent has not complied with the PA agreement, the prosecutor and the agency worker might request a change in plan to adoption. Depending on the state or county, either the state (or private agency) caseworker or prosecutor will draft and file a petition to terminate parental rights. The court sets a trial date, and this trial usually occurs in front of a referee or a judge. The caseworker acts as the primary witness, testifying to the services offered to the parent and how the parent failed to comply with services. Sometimes the parent testifies, and sometimes the child does as well. Unlike in criminal cases, the court needs only a preponderance of the evidence to terminate rights; however, there are two stages to a termination trial: presentation of the evidence and a best-interest hearing. The best-interest hearing, which often occurs with the trial, allows the parent to offer proof that although he didn't comply with the parent/agency agreement, the child's best interest is not served by termination of parental rights. Table 1.2 summarizes the court process.

If parental rights are terminated, the parent no longer has custody and can no longer make any decisions for that child. The child's status changes to a permanent court ward. In most cases, the state no longer allows the child to have any contact with the parent, and the state places the child for adoption. Depending on the age of the child, adoption could take up to a year or longer, or the child may not be adopted. Sometimes

**Table 1.2** *Court Process*

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Initial petition/trial	Child returned home Child made temporary court ward
Initial dispositional review—30 days after trial	Parent/agency agreement
Dispositional review—every 90 days	Court report on compliance
Permanency planning hearing—360 days	Plan for reunification Plan for termination of rights

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**Table 1.3** *Permanency Planning Options*

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Reunification with custodial birth parent	Reunification with noncustodial birth parent
Placement with relative	Termination of parental rights (either or both parents)
Adoption by relative	Adoption by nonrelative
Permanent foster family (14 and older)	Supervised independent living (16 and older)
Independent living (18 and older)	Age out of system

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the foster parent adopts the foster child, or a family member adopts the child. According to U.S. statistics, 5% of foster care children age out of the system, never receiving permanent homes (U.S. Department of Health and Human Services, 2013). In cases where the parent has not complied but the child is old enough to request an ongoing relationship with the parent, the child may remain a temporary ward of the court on a long-term basis, with no plan to terminate parental rights, and age out of the system by entering a supervised independent living program, an independent living program (unsupervised), or some type of permanent foster care. Table 1.3 summarizes the permanency planning options.

## CHILD WELFARE AGENCIES

A child welfare agency is either a state or private nonprofit agency that takes responsibility for managing the foster care case once a child enters placement. Child welfare agencies are licensed by a state to license foster homes; to provide case management to foster care and adoption cases; and often to provide other services, such as prevention services, mental health services, and supportive services, once the child returns home.

### Foster Care Case Management

The foster care caseworker is most often an individual with an undergraduate degree in either social work, psychology, or another mental-health-related field. The caseworker tends to be female, young, and inexperienced; 23% have less than 1 year of experience (Zell, 2006).

Caseworker turnover throughout the United States is very high, with 60% of caseworkers leaving their positions each year (U.S. Department of Health and Human Services, 2013). This turnover can result in negative outcomes for children in foster care (Strolin-Goltzman, Kollar, & Trinkle, 2010), such as increased placement instability (Eggertsen, 2008). Most children will experience at least one incidence of caseworker turnover during their time in care because, as noted, 60% of caseworkers leave their positions within 1 year, and the average length of stay in foster care is just over 12 months (U.S. Department of Health and Human Services, 2013).

A foster care caseworker's caseload is determined by guidelines and state mandates. Some have caseloads as high as 40, whereas others have caseloads of 15. Responsibilities include visiting the foster child in the foster home every month; writing reports on each foster child within 30 days of placement and every 90 days thereafter; drafting the PA; meeting with the birth families to provide referrals and ensure the parent follows the agreement; supervising visits or coordinating day and weekend visits; ensuring the foster care child has bi-yearly dental examinations, yearly medical exams, and up-to-date immunizations; coordinating with all mental health professionals; coordinating treatment with the child's school; obtaining report cards; and attending all school conferences. The caseworker also attends all court hearings and drafts court reports to submit to the court. All of these responsibilities have strict timelines that must be met in order to ensure that the agency keeps its license to place children and for payment to the foster parent to occur. The phrase most often used is that the caseworker will "provide quality-of-care assurance" through these activities. In other words, the caseworker must ensure the safety, permanence, and well-being of the child and family in care. Agencies often employ a quality assurance manager to review files on a regular basis; an independent agency or the state also reviews files at least once every 2 years.

A primary role of a child welfare agency is to recruit, train, and license needed foster parents. Both federal and state laws stipulate who can become a licensed foster parent, and it varies by state. A foster home licensing specialist usually has an undergraduate degree in social work, psychology, or another mental health profession. This individual maintains a caseload of about 30 to 60 homes and has responsibility for visiting each home at least one time per year to ensure the home stays in compliance and for addressing any compliance concerns.

Child welfare agencies recruit foster parents in a variety of ways: through multimedia advertising, through referral from other foster parents,

and through individuals seeking adoption. Once recruited, a potential foster parent attends a series of trainings on issues such as behavior management and child abuse or neglect. During this time, the foster parent also submits to an extensive home study. Every member of the family submits to a criminal record check and protective services check. The agency also reviews the family's finances and life history, and obtains marriage certificates, divorce decrees, and any other document to verify the foster parent's claims. The foster parent provides a life story history, and the worker visits the home, measures each bedroom, ensures the home is fire safe, and ensures that a child can access food and the bathroom. Foster parents must agree to never use any form of corporal punishment. A newly licensed foster parent is placed on a provisional license for 6 months; if the parent remains in compliance, the license is renewed for 1 year.

Sometimes during the course of placement, a foster parent violates one or more of the rules she agreed to uphold. This violation might include using physical discipline, refusing to take a child to an appointment, or letting someone move into the home without letting the foster care agency know. When a violation happens, the child welfare agency must file a complaint against the foster parent. The foster care licensing specialist must then conduct an investigation. The investigation involves interviewing all parties involved, visiting the foster home, and drawing conclusions. If the worker substantiates the complaint, the foster parent is either placed back on a provisional license, or the agency can petition to have the foster parent's license revoked. If the agency does not substantiate the complaint, the case is closed. Complaints must be filed any time a child makes an allegation of abuse or neglect, and the report should go to both the state protective services agency and the licensing agency. Anyone can file a complaint against a foster parent, including the child's therapist.

### **Mental Health Treatment**

Some child welfare agencies provide mental health services within the agency itself, but most often agencies contract with other therapists to provide individual, group, and family therapy. In some cases, therapists have dual roles as both caseworker and therapist, providing case management services such as referrals and attending court hearings, while also providing mental health treatment. Therapy can occur in traditional outpatient settings, in the foster home or birth home, or a combination

of both. Therapy can be short term or long term. A therapist could provide therapy to only the foster child, to only the birth family, or to both. Therapists also write court reports but might be prohibited from making specific recommendations in case the recommendations do not align with those of the oversight agency. An ongoing challenge for therapists working within the child welfare system is negotiating boundaries. Normal boundaries become difficult to maintain because the client is often the court or the hiring agency, not the child or birth family. The therapist has a duty to the agency that pays for the service, oftentimes the court or a government agency. The parent and child have fewer rights regarding confidentiality because the treatment occurs within the context of a court order. We discuss this issue in depth throughout this text and provide simple but effective strategies to negotiate these ethical issues.

### **Adoption**

An agency will assign an adoption caseworker once parental rights are terminated. Like the foster care caseworker and the foster home licensor, the adoption worker normally has an undergraduate degree in social work, psychology, or another mental health–related field. The adoption caseworker's responsibilities include recruiting an adoptive home for the child, conducting a home study on the potential adoptive home, and filing court paperwork to process the adoption. The adoption caseworker does not take on the foster care caseworker's responsibilities but works alongside the foster care caseworker. Sometimes the foster parent will adopt the child, sometimes a family member adopts the child, and sometimes parents from the community will adopt the child. Each state has different methods to recruit potential adoptive parents. Younger children often obtain adoptive placement more readily than do adolescents.

### **Residential Treatment**

If a foster care child cannot successfully live in a foster home, the child might be placed in a residential treatment facility for short-term treatment. Treatment centers range in the level of restriction placed on the child. Some treatment centers provide 24-hour staff, but children go to a community school and live in a house-like setting, whereas other centers appear more like institutions, with locked doors, 24-hour staff, and mental

health professionals on-site. A child might stay in one of these homes for a short time or for years. A standard requirement for placement involves the term “least restrictive community-based placement.” Foster care or a family-type home is considered the least restrictive, whereas locked residential treatment is the most restrictive. A child in residential treatment will have a caseworker on-site as well as the foster care caseworker and will interact with different staff throughout the day.

### **Supervised/Independent Living**

The final stage of the child welfare agency service is supervised independent living (SIL) or independent living (IL). When a foster care child reaches age 16 and reunification or adoption appears unlikely, the caseworker will often refer the child to SIL or IL. Designed to help youth in foster care transition to adulthood, these programs involve allowing a child to rent a room from a home provider or placing a child in an apartment setting with other youth in foster care. Each child receives meals, a monthly stipend to pay rent and utilities, and has a curfew; many obtain and maintain employment and attend school. The Fostering Connections to Success and Increasing Adoptions Act extended eligibility for Title IV-E payments for youth in foster care to age 21 (U.S. Department of Health and Human Services, 2013), so youth in foster care may now choose to stay a dependent ward until age 21. Some universities and colleges have instituted support programs for youth in foster care, and some tuition funds exist to support youth in foster care through either community college or a traditional 4-year college.

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