

# PROFESSIONAL NOTES

FOR MENTAL HEALTH PROFESSIONALS

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## **PRACTICE WITH A CHILD OR YOUTH IN THE CARE OF THEIR FAMILIES**

These practice guidelines attempt to inform practitioners about special issues and practices arising when the primary client is a child or youth in the care of their family. These guidelines do not address special populations requiring specialized practice guidelines, and the clinician is referred to the practice standards and the Colorado Children's Code for guidance when physical or sexual abuse exists, or divorce and custody disputes arise, or delinquency and relinquishment of parental rights occur. It is intended that professional judgment be the foundation for these guidelines.

In working with children or youths in the care of their families conflicts between the rights of the child or youth client and the rights of the parent may arise and require informed professional judgment. Balancing must occur between the rights of children to nurturance, care, protection, guidance and control and the rights of parents to privacy, self-determination, and support in parental functioning.

Clarity about who is the identified client, and knowledge of the legal definition of minority status help clinical clinician to manage issues of confidentiality, dependency, contracting, informed consent, and access to treatment. The child client's dependent status necessitates protection. However, custodial parents have that primary responsibility. and it is in the best interest of the child client to reinforce that parental responsibility and to not interfere but encourage it. However, when the parent is inadequate or failing in their protection of the child, the social worker must assume responsibility for protecting the child. While it is preferable to develop a cooperative relationship with parents, there may be instances in which cooperation may not be possible. In those instances the clinician responsibility is to the primary client, which may be the child.

### **Initial contracting for psychotherapy with a child:**

1. It is preferable when clinically appropriate to obtain parental sanction and approval by including parents in an initial session. For children under age 15 approval of parents is necessary, unless the therapy is court mandated. Although it is preferable to include both parents in an agreement for therapy, it is acceptable to obtain only the agreement and cooperation of the custodial parent.
2. There should be at least one joint meeting to include both parents, if possible, and the child with the purpose of discussing and agreeing on the contract for proceeding. The role of the therapist,

child and parent should be discussed.

3. Agreed upon problems to be addressed in the therapy should be established during the joint contracting meeting. The child needs to hear from the parent what their concerns are and their reasons for bringing him/her to therapy, and he/she must have an opportunity to identify his/her own concerns. An agreement should be reached identifying problems of concern to both the parents and the child.

4. The child's assent to be involved in therapy should be sought in all cases unless otherwise legally mandated. However, initial reluctance may indicate anxiety about the unfamiliar. If refusal to cooperate persists over a period of time, it may be an indication that the treatment contract be renegotiated or treatment be discontinued.

5. The role and responsibility of the therapist and the parents should be clearly defined, including location for the work, and procedures for making appointments, and transportation of the child to appointments, as well as means for continuing communication with the parents, and handling of any emergencies.

6. Any conditions for treatment should be discussed, and with whom collaborations will occur. Permission from parents and child must be obtained to collaborate and coordinate with other involved agencies and institutions, such as the schools and the Department of Social Services. The child should understand the limits imposed on his confidentiality including the kinds of information to be shared with other authorities.

7. Confidentiality should be discussed in the initial meeting with the parents, and therapy should only be under taken if the parents agree to respect the confidentiality of their child. Breaking of confidentiality should only occur if the child is in danger to himself or others, or if the child needs to be protected through a report of abuse and/or neglect. The child should be apprised of any reports or sharing of information with others.

8. The initial meeting with the parents should include an agreement about the process for termination, and therapy should not be begun without such an agreement. Premature termination and the negative implications of this for the child's progress should be discussed. This will serve to protect the child's relationship with the therapist.

9. Evaluations conducted for custody determinations or other reasons should be clearly stated for the child during the initial meeting or in a joint meeting at the time of the procedure, and the limits of confidentiality and report writing should be specified.

10. The disclosure statement should be given to the custodial parent for children and youths less than 15 years of age by statute.

11. Existing statute requires that the fee and method of payment should be discussed and established during the initial meeting with the parents.

## **Age of Consent**

1. Consent is formal permission to treat, which may be governed by statute. It varies from state to state, and the practitioner is well advised to consult the appropriate state statute (In Colorado The Children's Code). Assent is distinguished from consent, and is the voluntary agreement to participate in treatment.
2. In the case of a child or youth below the age of 15, by law, the custodial parent must consent to psychotherapy for the child. In addition, assent from the child is desirable for proceeding with psychotherapy, that is voluntary agreement to participate should be sought from the child.
3. When a child requests and seeks psychotherapy and the parent refuses to consent, a child or youth having reached the age of 15 years may consent to out-patient therapy or may voluntarily sign themselves into a hospital for care.
4. Hospitalization, either voluntary or involuntary, does not necessarily require the consent of parents. By law [27-10-103(2) C.R.S.] "The professional person rendering mental health services to a minor may, with or without the consent of the minor, advise the parent or legal guardian of the minor of the services given or needed."
5. When possible or required by statute, parental involvement is to be invited, unless according to the social worker's judgment it is not in the best interest of the client or has the potential to cause harm to the client. In the event of involuntary as well as voluntary treatment, the custodial parent may benefit from being informed of the treatment, as determined by sound clinical judgment.
6. Even though the child's consent to inform the parents is not required, it is sound practice to inform the child that the therapist is telling the parents of the provision of mental health services and to explain the reasons for doing so.
7. If a minor is certified for treatment in Colorado, the hospital will do an independent review to determine if hospitalization is necessary and the least restrictive form of treatment. This serves as protection of the child's civil rights. Clinician in other states should consult state statute.
8. In determining the form of consent to treatment, the social worker should decide the level of personal liability to take. Although a verbal agreement reached with the parent and child can serve as consent, it involves a greater level of liability than a formal written consent. Signing of the mandatory disclosure is an example of documenting evidence of consent, as would be referencing consent and assent in the written record.

## **Confidentiality**

1. A balance of rights between the parent and the child ideally is to be maintained. Parents should be kept reasonably informed, except if there is a compelling reason not to do so. A compelling reason is if the child protests, or if imminent harm or danger would exist for the child, or if the release of information would pose potential harm or threat to the child or the therapeutic process.

2. The parents have a right to information about the location and general treatment plan of their minor child providing that compelling reasons do not exist for not divulging this information. However, certain information from sessions is confidential, and confidentiality is important in preserving the therapeutic relationship with the child. The child's request to keep information from sessions private from parents should be honored unless harm or danger is present.
3. When it is determined that serious harm or danger is present or that a compelling reason exists, the social work therapist should inform the child or youth that he/she must take action by discussing the harm or danger with others as appropriate. While assent by the child is preferable it is not required. For example, when suicide risks are present according to the professional assessment of the therapist, the social worker's actions may include a discussion with the parents when the parent is not a perpetrator of harm. However, when the parent is an alleged perpetrator, the social worker's action need not include informing the parent. It is preferable to seek assent from the client when the social worker determines that information needs to be shared outside of the therapeutic relationship.
4. In the event of conjoint modalities (couple, family and group) confidentiality of each individual should be protected.

### **Record Keeping**

1. Record keeping in all cases should include an initial assessment and a statement of the presenting problem. Additional information to be kept includes: documentation of consent, releases to collaborate, referrals made, dates of service, supervision, and any formal documents. Termination date and status should be recorded. Personal notes or information received from non-professionals should not be kept in the client record.
2. Records should be kept until the child reaches age 25. Releases for sharing of confidential information must be obtained from the parent or guardian of a child under age 15, and from the client after age 15 unless abuse is suspected or has occurred or the child is a threat to others or himself.
3. When a client or custodian of an underage child or youth requests access to the record or information contained in the record, the social worker should discuss the reasons and information sought before deciding what information to convey and the manner in which it is conveyed. While the record is in the custody of the therapist, the client or custodian has a right to reasonable access to information in the record. Access to information contained in the record is limited to the child who has reached the age of 15 or to the parent of a child under age 15.
4. Because records need interpretation and explanation, they should be reviewed with the therapist present.
5. Parents may have access to the information contained in the record of their child under the age of 15 unless restrictions otherwise exist or compelling reasons exist for not divulging.

### **Consultation or Supervision**

Consultation or supervision should be used to manage complicated reactions to the child's situation. Feelings that the therapist could be a better parent, or over identification with the child, or villainizing of the parents, for example, need to be managed through consultation or supervision.

## **Termination**

The therapeutic relationship with the child or youth client should be managed sensitively acknowledging the loss to the child or youth of the therapeutic relationship by termination. It is essential that the child or youth participate in decisions to terminate. The termination process should include a review of accomplishments and any referrals for additional assistance.

See *Termination Guidelines* for a youth 15 years old or older.