

---

## Child Psychiatry and Child Welfare: A Collaboration for Change

Michael W. Naylor, MD  
Tanya R. Anderson, MD  
Alan Morris, PsyD

**ABSTRACT.** This article describes an innovative program, the Comprehensive Assessment and Response Training System (CARTS), designed to address the clinical needs of a selected population of adolescents with severe emotional disturbances who were made wards of Illinois Department of Children and Family Services (DCFS) for severe abuse and neglect. A collaborative effort between DCFS and the University of Illinois at Chicago, Department of Psychiatry, the CARTS Program provides crisis intervention, intensive evaluation and treatment planning services, technical assistance and consultation to residential facilities, and consultation to DCFS. *[Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <<http://www.HaworthPress.com>> © 2003 by The Haworth Press, Inc. All rights reserved.]*

**KEYWORDS.** Residential treatment, child welfare, adolescence, severe emotional disturbance, technical assistance

### *INTRODUCTION*

The Illinois Department of Children and Family Services (DCFS) is the single largest purchaser of mental health services for youth in Illi-

---

Michael W. Naylor, MD, may be written at The University of Illinois at Chicago, Department of Psychiatry, 1601 W. Taylor Street, M/C 912, Chicago, IL 60612.

Residential Treatment for Children & Youth, Vol. 21(1) 2003  
<http://www.haworthpress.com/store/product.asp?sku=J007>  
© 2003 by The Haworth Press, Inc. All rights reserved.

10.1300/J007v21n01\_03

33

---

nois. Unfortunately, the care purchased has often been ineffective. Furthermore, there has historically been an overutilization of high-end services. According to DCFS figures, the number of children in group home and residential treatment facilities increased from 1,811 to 4,114 between 1990 and 1995, an increase of 127% (ILDCFS<sup>a</sup>, Figure 1). Complicating the explosive growth in utilization of residential treatment services, most residential treatment facilities in Illinois during the early 1990s operated on a child welfare model and were ill prepared to care for adolescent wards with severe emotional disturbances (SED). This had two implications. First, the most severely disturbed and difficult to manage adolescents were generally referred to locked, out-of-state residential facilities. In 1995, the number of adolescents referred for out-of-state residential treatment peaked at 792 (ILDCFS<sup>b</sup>, Figure 2). Second, when adolescents with SED cared for in in-state residential treatment facilities or group homes proved to be difficult to manage, residential treatment facilities often terminated the placement, generally with no more than the required 14-day notice resulting in multiple placement disruptions. Such frequent changes in placement interfered with the adolescent's ability to make appropriate interpersonal attachments and to be engaged in developmentally appropriate social, educational, leisure, vocational, and community roles.

For these reasons, DCFS embarked on a mission to decrease the number of youth placed in residential treatment facilities, to increase placement stability, to return adolescents who had been referred for out-of-state placement back to Illinois, and to set up a comprehensive evaluation procedure for adolescents referred for care in out-of-state facilities. This initiative has been remarkably successful. Since its inception, the number of wards placed in residential settings decreased from 4,114 in 1995 to an estimated 2,338 in FY 2001, a decline of 43.2% (ILDCFS<sup>a</sup>, Figure 1), while the number of adolescents treated in out-of-state residential treatment facilities decreased from 792 in 1995 to 48 in 2001, a decrease of 93.9% (ILDCFS<sup>a&b</sup>, Figure 2). As anticipated, these striking changes had a major impact on the clinical characteristics of wards placed in residential treatment facilities. The severity of psychopathology increased dramatically with a concomitant increase in aggressive, self-harmful, and other difficult to manage behaviors. Additionally, wards in institutional care settings in Illinois had more severe cognitive deficits than was the case in the past. The dramatic changes in the clinical characteristics of youth referred for institutional care in Illinois has presented a daunting clinical challenge to care providers.

FIGURE 1. Number of DCFS Wards in Residential Care from 1989-2001

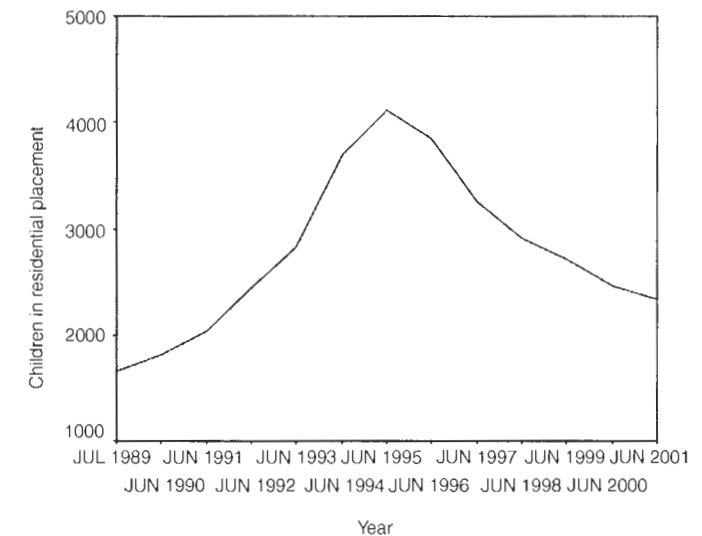
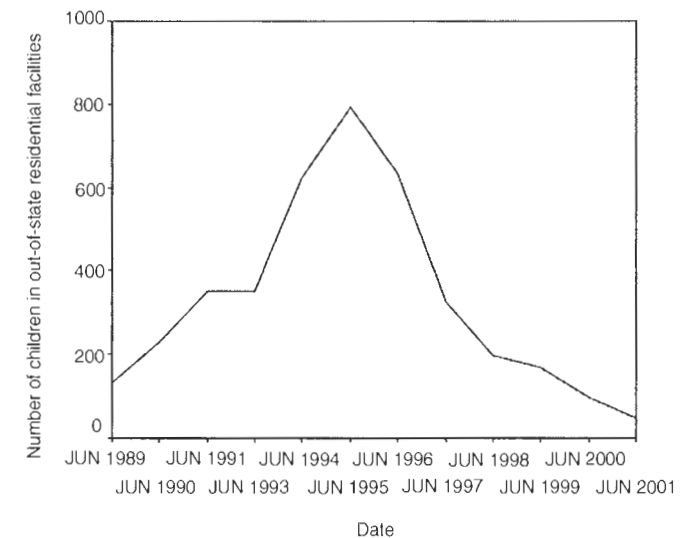


FIGURE 2. Number of Children in Out-of-State Residential Facilities



In an effort to improve the quality of care provided to DCFS wards in residential and group home placements and to enhance placement permanence, DCFS contracted with the University of Illinois at Chicago in 1998 to develop a program that would:

1. provide input into Departmental policies governing the psychiatric care of DCFS wards with severe emotional disturbances,
2. provide consultation to DCFS regarding clinical management and placement recommendations for difficult to manage adolescents with severe emotional disturbances,
3. provide acute inpatient services, including crisis intervention and stabilization, evaluation, and extensive treatment planning services to the most difficult to manage adolescents,
4. provide technical assistance and consultation to residential and group home treatment providers,
5. advocate for DCFS wards with severe emotional disturbances, and
6. act as a liaison between care providers and DCFS to obtain services and resources necessary to enhance the youth's chances of success in his placement.

The Comprehensive Assessment and Response Training System (CARTS) was established as a result of this contract.

### ***THE COMPREHENSIVE ASSESSMENT AND RESPONSE TRAINING SYSTEM (CARTS)***

The CARTS Program is a multidisciplinary program consisting of an acute psychiatric inpatient unit—the Comprehensive Assessment and Treatment Unit (CATU), a mobile consultation team—the Response Training System (RTS), and a psychiatric consultation program for difficult to manage youth who have been referred for out-of-state residential placement. The CARTS Program was designed to improve the quality of mental health services provided for DCFS wards with severe emotional disturbances. This objective is accomplished in two ways: (1) by helping develop, implement, and export a new model of clinical care for severely disturbed adolescents, and (2) by participating in the composition and revision of policies designed to enhance the quality of psychiatric care provided to DCFS wards. In designing the CARTS Program, the Director of the Illinois Department of Children and Family

Services envisioned a network of care designed to meet the needs of “high-end” DCFS wards with severe emotional disturbances who utilize an inordinately large proportion of mental health services. According to this model, there would be a network of satellite CARTS-like programs consisting of an inpatient unit and a mobile consultation team that work with affiliated residential treatment facilities. Conceptualized as the hub of this network, the UIC CARTS Program would serve as the primary site of intake into the system. The CARTS Program would conduct an in-depth assessment on and design a comprehensive treatment plan for the patient. This plan would be transferred by the RTS consultant to the regional satellite program where the adolescent is placed. The consultant would provide technical assistance and consultation to the satellite program.

### ***Treatment Philosophy***

Adolescents treated in the CARTS Program, by definition, have experienced severe neglect; physical, emotional, and/or sexual abuse; have been removed from their family of origin; have behavioral and emotional disturbances severe enough to warrant psychiatric hospitalization and/or incarceration; and have a history of multiple placements and placement disruptions. In addition, they often have a genetic and/or biological predisposition towards mental illness. The confluence of these adverse biological, psychological, and social forces have had a profoundly negative impact on their psychosocial adaptation. The history of abuse and neglect speaks to severely impaired attachments with their primary caregivers. A secure attachment is critical to the development of trust, a basic sense of self-worth and self-love, frustration tolerance, impulse control, and regulation of mood and arousal states (Cicchetti & Toth, 1995). These very basic self-regulatory skills form the basis of one's social interactions, and accordingly, the youth served in the CARTS Program generally have extremely impaired social interactional skills. The history of multiple placement disruptions further affects their ability to form satisfactory interpersonal attachments and interferes with their academic achievement. Raised in placements, many have not developed even basic independent living skills required to function effectively in more normative social settings. In short, virtually all aspects of their development have been adversely affected.

We believe that the adolescent's desire for self-mastery and autonomy represents a potent force for health. Thus, one of the major goals of our program is to help adolescents have as normative a developmental

experience as possible through a stable educational placement and age-appropriate activities in the community. Adolescents served in the CARTS Program have strengths that often go unrecognized. We believe that we can build on the adolescent's competencies, helping him or her develop a more positive self-regard and to develop compensatory skills for their deficits.

The treatment philosophy is based on the understanding that adolescents have several roles in a variety of social and community systems, including his or her family, the schools, the church, and his or her placement. We believe that in order to be successful, all of the systems involved in the adolescent's care must coordinate their efforts and resources. The CARTS Program works to improve the quality of the collaboration between the various systems with which the adolescent finds himself or herself involved. We believe that his or her care must be developed in the context of a nurturing, empathic, and supportive relationship with the caregiver. As most of clients are African-American or Hispanic, we recognize that it is important that the care delivered is both culturally sensitive and relevant. (See Treatment Philosophy, Appendix 1.)

### *The Comprehensive Assessment and Treatment Unit (CATU)*

The CATU is the acute inpatient psychiatric unit of the CARTS program. It is a 9-bed unit for DCFS wards between the ages of 11 and 17 who meet criteria for admission to the CARTS program. As with admission criteria for other acute inpatient psychiatric units, the adolescent must have a severe disorder of mood, thought, or behavior; must present an acute danger to self or others; and must be able to benefit from inpatient psychiatric hospitalization. In addition, adolescents admitted to the CATU must meet two other criteria designed to screen for the most difficult to manage and severely impaired wards of the state. First, the adolescent's emotional disturbance and behavioral problems have not been successfully managed in less restrictive settings, has caused multiple placement disruptions, and endangers the adolescent's current placement. Typically, eligible adolescents have failed in several foster home placements, group homes, and residential treatment facilities and have had 3 or more inpatient psychiatric hospitalizations in the preceding 18 months. Second, the adolescent must have a history of severe, repetitive aggression. The aggression may be directed toward others, property or self. Some adolescents also present with sexual aggression.

Referrals for admissions to the CATU are made by the DCFS Psychiatric Hospital Program, the gatekeeper to the CARTS program. The gatekeeper monitors the psychiatric hospitalizations of wards all over the state of Illinois, identifying those wards who have been repetitively hospitalized and who have had multiple placement disruptions. After identifying an eligible ward, the gatekeeper reviews potential clients' cases with the Medical Director of CATU and they jointly make a final decision about appropriateness for admission. All wards are screened prior to admission by a community-based crisis intervention agency—the Screening, Assessment, and Support Services or SASS—to insure that the adolescent is acutely ill and in need of treatment in an inpatient psychiatric setting. Upon arrival to the hospital, the psychiatrist assigned to the patient conducts an assessment to determine if the patient indeed requires inpatient hospitalization.

The initial phase of treatment on the CATU is aimed at crisis stabilization. During the initial 48 hours the adolescent is oriented to the rules and structure of the CATU and the multidisciplinary evaluation is initiated. In this orientation phase the adolescent's contact with peers are highly structured. Stabilization, assessment, and treatment planning form the bulk of the remainder of the psychiatric hospitalization. The CATU assessment is designed not only to identify the adolescent's deficits but also his or her strengths. The multidisciplinary assessment includes psychiatric, medical, neurological, psychological, social, milieu, functional and educational evaluations. Neuropsychological assessments and speech pathology evaluations are obtained when indicated.

The most unique portion of the CATU multidisciplinary assessment is the Response Training System (RTS) evaluation. The RTS consultant assigned to the adolescent begins the consultative process with an in-depth evaluation of the adolescent's current placement within the first week of hospitalization. This includes an assessment of the physical layout of the facility, the treatment model employed, staffing patterns utilized, the education and training of staff, the administrative structure, the program's milieu treatment approach, the type and frequency of activities and formal therapies and the on-site school. Additionally, the consultant learns more about the residential staff's experience of working with the client in their program. Here, issues such as program resources and characteristics, milieu management strategies (both successful and unsuccessful), the client's functioning in various programs and activities, staff-client relationships and attachments, and staff reactions to the client are discussed with those staff members who have day-to-day familiarity with the youth. Particular at-

tention is paid to how the safety of the adolescent and those around him or her is impacted by the features examined. The RTS evaluation is integrated with the other components of the multidisciplinary assessment during the weekly treatment planning meetings that are held throughout the adolescent's CATU admission. Based on the results of the multidisciplinary assessment and the RTS evaluation, the RTS consultant and the nursing/milieu staff develop treatment interventions uniquely designed to stabilize and meet the needs of the adolescent in the environment of the current placement. These treatment interventions are piloted on the CATU to assess their efficacy and feasibility before they are exported to the placement.

One of the keys to an adolescent's successful adaptation in his or her placement is the transition back to the community from the hospital. Consequently, we begin planning for transition early in the hospitalization. When indicated we prescribe a series of transitional passes back to the placement. In addition to the work with the adolescent, milieu staff from the placement are encouraged to collaborate with CATU milieu staff in preparing the adolescent for return to the placement. They are invited to follow their client through a typical hospital day to see how our staff works with him or her. This is often a vital part of the discharge planning process. Finally, as described in more detail below, the RTS consultant begins on-site consultations with the placement staff prior to discharge to export and to begin the implementation of the treatment recommendations prior to discharge. The goal is to make the transition from the hospital to the placement as smooth and as seamless as possible.

Given the severity of illness of the typical CARTS patient and the selection criteria by which they are identified for the program, psychiatric rehospitalizations are not uncommon. CARTS adolescents are preferentially readmitted to the CATU if inpatient beds are available. This allows our multidisciplinary team to establish continuity of care and to fine tune our previous treatment plan and recommendations to reflect any changes in the status of the adolescent or the placement. The subsequent CATU admissions are shorter than the initial hospitalization and focused on addressing specific stressors if known.

### *The Response Training System (RTS)*

The Response Training System (RTS) functions as the consultation arm of the CARTS Program. The primary goals of the RTS are to enhance the continuity of treatment between the hospital and residential or group home, to assist the residential staff in implementing discharge

recommendations, to provide technical assistance, and to act as client advocates with respect to DCFS and other involved agencies. The RTS is a multidisciplinary team comprised of nine professional staff, including:

- three licensed clinical psychologists (one of whom functions as the team director),
- two licensed clinical social workers,
- one registered occupational therapist,
- one licensed psychiatric nurse,
- one special educator, and
- one child psychiatrist who acts as consultant to the RTS.

All consultants have considerable inpatient and residential experience. Several have held managerial/administrative positions in those settings.

RTS consultants follow a protocol, developed over the course of the first year of experience consulting with residential and group home providers, that outlines consultant responsibilities both during and following a youth's hospitalization on the CATU. During the hospitalization, the RTS consultants function as part of the inpatient treatment team. The consultant's specific focus pertains to factors relevant to the client's post-discharge adaptation. Toward that end, the consultant meets with the patient on a regular basis in order to gain an understanding of his or her experience of life in the residential program. The RTS consultant's role in the inpatient assessment was described in detail in an earlier section.

Based on the assessment and observations of the youth during his or her stay, the RTS consultant compiles a set of highly specific discharge recommendations prior to the patient's discharge (RTS Discharge Recommendations, Appendix 2). The recommendations incorporate information from the hospital assessments, milieu approaches found to be effective on the inpatient unit, information obtained from the site visit(s), and RTS consultant observations. These recommendations are written specifically for use by childcare staff and emphasize milieu interventions. In this manner, RTS consultants provide "user friendly," "hands-on" recommendations that address the everyday issues and struggles that so often result in placement failure. These recommendations are reviewed with provider staff at the time of discharge from the hospital.

Following discharge, the RTS consultant maintains weekly telephone contact with provider staff and provides weekly on-site consultation. These consultations and telephone contacts are designed to assist program staff in implementing the recommendations, to provide opportunities to incorporate additional observations/data in order to modify the recommendations as appropriate, to support the program staff as they continue to work with highly challenging youth, to head off potential problems in a timely fashion, and to identify critical resource needs. The on-site consultations may be incorporated into existing planning meetings such as staffings, daily rounds, and team meetings, or they may be more informally structured with a few key staff. In addition to the identified primary RTS consultant, the RTS special education consultant is available to meet on-site with teachers and other school staff to address issues ranging from classroom management to accessing appropriate educational services and resources. The frequency and nature of the RTS consultations are reviewed with the RTS Director and/or the entire consulting team on a monthly basis and are modified as necessary. Cases are "deactivated" when the youth demonstrates greater stability within the residential setting and both agency staff and the RTS consultant concur that the provider staff have incorporated the issues addressed during the consultations into their treatment approach. Typically, cases remain active for three to four months, although the range has been as short as six weeks and as long as eighteen months. Any case can be reactivated again on request of the provider, DCFS, or other involved agency in the event that further contact/consultation is desired. Frequently, RTS consultants become involved again at times of transition; for example, when the youth is "stepped down" from a residential program to foster care or independent living.

During the initial implementation of the RTS program several problems emerged. As we knew of no comparable model to serve as an experience base for RTS consultants, some confusion emerged regarding the role of the RTS consultant. Contributing to this was the common experience of residential staff members who often have to interact with a multitude of individuals regarding each ward, including caseworkers, DCFS clinical staff personnel, and legal advocates to note a few. Thus, many residential staff members were unclear about the RTS role. Frequently, caseworkers and other DCFS staff were also unfamiliar with the RTS concept. As a result, RTS consultants were variously viewed as having responsibilities consistent with those of a DCFS caseworker or of an investigator or monitor of the agency. In some cases RTS consultants were even characterized as overinvolved hospital staff! Even in situ-

ations where the consultative role of the RTS staff member was recognized, the structure of the consultations were often conceptualized by providers as limited to meetings with their professional clinical personnel (i.e., therapists and case managers) rather than involving the whole treatment team, especially child care workers who staff the milieu. As the RTS consultants are initially involved in the treatment planning process at the request of DCFS (rather than the residential agency), to be effective, residential staff members had to understand the nature of the relationship and become comfortable with the consultation process itself.

It became clear that a much more comprehensive orientation to the program was necessary. The CARTS program in general, and the RTS component in particular, was presented to a wide range of DCFS personnel and discussed in meetings with a wide variety of stakeholders. A focus group, which included a large number of residential and group home agencies, was held to facilitate communication between DCFS, the CARTS Program, and the provider community and to elicit initial feedback on provider experience with CARTS. In those cases where the CARTS Program had no prior experience with a residential program, consultants reviewed the role and nature of RTS involvement with an administrator at the provider agency in order to facilitate the process and to avoid any confusion. The role of the RTS was also specifically addressed early on during initial CATU staffings while the youth was hospitalized. Through these discussions, questions and concerns could be identified and addressed quickly, and the RTS approach—which heavily emphasizes the role of the therapeutic milieu and the importance of including child care staff in the consultations—could be effectively communicated.

### *Placement Consultation*

Some adolescent wards with severe emotional disturbances do not meet the criteria for acute hospitalization but present such difficulties in their management that a placement review team recommends a change in placement. The change recommended is typically to a more restrictive level of care (such as from a group home to a residential treatment facility) or for out-of-state residential placement. Requests for out-of-state placement automatically trigger a consultation referral to the CARTS Program. The CARTS consultant, a 0.5 FTE child psychiatrist, reviews the available records, interviews the youth in his or her placement, interviews the caregivers in the placement, and obtains information from other informants involved in the youth's care. Based on the

assessment, a report is generated which includes a thorough biopsychosocial formulation and in-depth treatment recommendations. The treatment recommendations generated from the assessment are prescriptive and address the adolescent's unique psychotherapeutic, academic, milieu, and psychopharmacologic needs. Flowing logically from the biopsychosocial formulation and from the problems identified in the assessment, the treatment recommendations are aimed at maintaining the adolescent in his current setting. When this is not possible, the plan generally recommends transfer to another in-state facility. Adolescents are rarely approved for out-of-state placement as a result of this consultation. In all instances, the treatment plan is forward seeking, projecting the treatment needs into the future and addressing issues of transition to the next level of care, whether that is step-down to a group home or a foster home from the residential treatment center or transition to independent living.

### *Program Efficacy*

Despite the initial confusion and "start up" complications noted above, available evidence indicates that the CARTS Program has impacted positively on both the lives of those challenging youth treated within the CARTS program as well as on the placements that care and treat these youth. CARTS staff have assisted many residential and group home providers in redesigning their programs to treat a more behaviorally and psychiatrically impaired population, and have informed DCFS policy with respect to the needs of seriously emotionally disturbed youth.

For many providers, CARTS involvement over time has allowed for the development of a strong working collaboration, with enhanced levels of comfort and trust. Increasingly, RTS consultants note that many of the recommendations initially designed for a specific youth have been generalized to the treatment of others, or incorporated into the provider's overall treatment program. In some cases, providers have directly requested that RTS consultants broaden their targeted consultation to include issues related to overall program development. Agencies have sought RTS consultation regarding youth who had not been previously identified as eligible for CARTS services and, on several occasions, agencies have made their acceptance of a particularly challenging youth conditional on having RTS consultation available to them. Similarly, over time, providers have expressed growing interest in sending

their staff to the CATU in order to observe and consult with inpatient staff.

Over the past year, DCFS and the UIC have conducted a continuous quality improvement initiative regarding residential and group home assessments of the RTS consultation process. This project involved ten agencies, representing a range of programs. Questionnaires were sent to several staff members who were actively involved in the RTS consultation process at each of the provider agencies. Following the return of the questionnaires, a DCFS administrator and the RTS Director visited each agency to discuss their experience working with the RTS consultants in the treatment of their most challenging residents.

Overall, the findings were very positive, especially considering the fact that the consultations frequently began with at least some of the residential program staff opining that their program was not suitable for the treatment of that particular youth. The discussions with agency leadership were very helpful in identifying several areas where the RTS could further enhance their consultative efforts. Results from the questionnaires revealed that respondents:

- overwhelmingly found the RTS Discharge Recommendations to be highly user friendly and highly valuable,
- believed that the RTS consultants were highly effective and highly knowledgeable, and
- described the consults as a highly useful and valuable experience and would welcome RTS consultation in the future.

Finally, to directly assess the efficacy of the CARTS Program we analyzed data regarding psychiatric hospitalization for comparable pre- and post-periods of time relative to the index CATU admission. For over 100 youth, results revealed that the number of psychiatric hospital admissions, the total number of psychiatric hospital days and the average length of stay of subsequent hospitalizations were significantly reduced. These data and data regarding placement stability are currently being analyzed and will be discussed in a future publication.

### *CARTS/DCFS COLLABORATION*

The CARTS Program is also involved in others DCFS initiatives to improve the quality of mental health care services provided to wards. These initiatives focus on best practice models, training, and prevention efforts.

### ***Behavioral Health Care Services***

The CARTS Program is collaborating in a DCFS initiative to develop a screening protocol for youth upon entry into the child welfare system. The purpose of this initiative is the early identification of wards with behavioral, emotional, developmental, and psychiatric disturbances. Once identified, wards determined to be in need of mental health services will be referred to mental health professionals participating in a statewide network of providers. The goal of the screening program will be to prevent development of severe emotional disturbances in young wards and to decrease the sequelae and morbidity in those with early onset psychiatric, emotional, or behavioral disturbances.

### ***Policy Development***

The CARTS Program is working with DCFS to revise Illinois Department of Children and Family Services policies governing the provision of mental health services to DCFS wards. To date, CARTS input has been provided for policy revisions on the utilization of psychiatric hospitalization, the behavioral management of wards with severe emotional disturbances (including the use of restraints), and procedures directing the prescription of psychotropic medications for DCFS wards.

### ***Training***

Based on recommendations of a consortium of residential care providers in Illinois, DCFS and the UIC Department of Psychiatry are jointly developing an educational program to teach child care workers statewide the basic skills necessary to work with adolescents with severe emotional disturbances. The curriculum will include instruction in behavioral management techniques, normal adolescent development, milieu management, psychopharmacology and medication administration, psychopathology, cognitive delays, risk assessment, and sexuality and gender issues.

### ***Provider Profiling***

Recently DCFS undertook an ambitious plan to help placements definitively describe their treatment philosophy, identify the clinical pop-

ulation they treat, and describe their treatment program. The CARTS Program has provided significant input into the "Provider Profiling" process. The purpose of the profiling is twofold. First, establishing provider profiles will help DCFS find appropriate placements for youth with severe emotional disturbances. Second, the profiling will help placements write their program plans for their upcoming contract renewals. The goal is for placements to be reimbursed on the basis of the population they serve and the intensity of the care they provide.

## ***CONCLUSIONS***

Children involved in the child welfare system have high rates of emotional disturbance and are often heavy utilizers of high-end mental health care services. In addition, these youth often present with significant cognitive deficits, severe behavioral problems, and aggression directed towards themselves or others. This combination of clinical characteristics makes these youth extremely difficult to manage, even in residential treatment facilities. As a result of their emotional and behavioral problems, these children and adolescents often have a history of repeated psychiatric hospitalizations and multiple placement disruptions.

The CARTS Program, an innovative, collaborative program between the Illinois Department of Children and Family Services and the University of Illinois at Chicago Department of Psychiatry, was designed to meet the needs of this challenging patient population and the programs that serve them. The CARTS Program is charged with the task of improving the quality of mental health care for abused and neglected youth with severe emotional disturbances. To meet this demand clinically the CARTS Program develops, implements, and exports effective treatment plans into the community from the hospital via a mobile consultation team. The CARTS Program also works to meet this goal systemically and is currently involved in developing policies and procedures governing mental health delivery to DCFS wards, providing educational opportunities to clinicians and caseworkers, and developing preventive programs for new wards. The CARTS Program has been well received by care providers and has proven to be effective at decreasing the utilization of psychiatric hospital resources.



## REFERENCES

- Cicchetti, D. & Toth, S.L. (1995). A developmental psychopathology perspective on child abuse and neglect. *Journal of Child and Adolescent Psychiatry*, 34 (5) 541-565.
- Illinois Department of Children and Family Services<sup>a</sup>: Signs of Progress in Child Welfare Reform. Independent living vs. residential placements. IL Department of Children and Family Services Website (<http://www.state.il.us/dcf/signsil.htm>).
- Illinois Department of Children and Family Services<sup>b</sup>: Governor's Children and Family Services. Budget Continues Improvement in Services to Abused and Neglected Children. DCFS Newsletter, February 21, 2001. IL Department of Children and Family Services Website (<http://state.il.us/dcf/com-communications-pr-feb022001.shtml>).
- Illinois Department of Children and Family Services<sup>c</sup>: Children placed out of the state. IL Department of Children and Family Services Website (<http://www.state.il.us/dcf/liv2.pdf>).

SUBMITTED: 12/10/01

ACCEPTED: 01/23/02

## BIOGRAPHICAL NOTES

Michael W. Naylor, MD, is Clinical Associate Professor of Psychiatry at the University of Illinois at Chicago and Director of the Comprehensive Assessment and Response Training System.

Tanya R. Anderson, MD, is Assistant Professor of Psychiatry at the University of Illinois at Chicago and Medical Director of the Comprehensive Assessment and Treatment Unit.

Alan Morris, PsyD, is Assistant Clinical Professor of Psychology in the Department of Psychiatry at the University of Illinois at Chicago and Director of the Response Training System.

## APPENDIX 1

## The CARTS Program Treatment Philosophy

1. We believe that adolescents treated in the CARTS Program, like all adolescents, strive to master the skills required to care for themselves, to work, to play, to relate successfully to others, and to live independently. Their quest for mastery, however, is hampered by underlying psychiatric and emotional disorders, cognitive deficits, physical and medical limitations, a history of impaired relationships with caregivers, and limitations in their ecological systems.
2. We believe that in order to help our patients develop competency, self-mastery, and autonomy we must help them recognize and utilize their inherent abilities and develop effective compensatory skills for their deficits. We believe that a comprehensive diagnostic evaluation that addresses both the adolescent's deficits and his or her strengths forms the foundation of our work.
3. We believe that the adolescent's ultimate success depends largely upon the design and successful implementation of a definitive treatment plan based upon our understanding of his or her strengths and weaknesses. This treatment plan is developed and executed in conjunction with all systems involved in the adolescent's life, including the family, the school, the church, the criminal justice system, recreational programs, and the adolescent's placement and spans the gap between the hospital and community.
4. We believe that normal adolescent development, characterized by the desire for self-mastery and autonomy, represents a potent force for health. The long-term goal for adolescents treated in the CARTS program, therefore, is to help them have as normative an adolescent experience as possible. We do this by offering technical assistance to the adolescent's care provider following discharge from the hospital to help them establish a stable placement, a consistent educational setting, involvement in age-appropriate community activities, and opportunities for the adolescent to learn the skills necessary to live independently.
5. We believe that in order for adolescents to gain the competencies needed for self-mastery and autonomy, they first need to feel that they are valued and that caregivers can be nurturing, empathic, trustworthy, and supportive. We believe that successful treatment occurs within the context of the relationship between the adolescent and the caregiver.
6. We believe that all adolescents strive to create meaning in their lives, to develop a system of spiritual beliefs, and to develop a sense of community and belonging.
7. We believe that the care we provide must be delivered in a culturally sensitive and culturally competent manner.

APPENDIX 2

RTS Discharge Treatment Recommendations

Name: \_\_\_\_\_

D.O.B.: \_\_\_\_\_

MR#: \_\_\_\_\_

DCFS ID#: \_\_\_\_\_

PLACEMENT/ENVIRONMENTAL

PSYCHIATRIC/MEDICAL

SAFETY

PSYCHOTHERAPEUTIC

MILIEU/INTERPERSONAL APPROACH

BEHAVIORAL APPROACH

EDUCATIONAL/VOCATIONAL

LEISURE/COMMUNITY INTEGRATION

COMPETENCE DEVELOPMENT/ENHANCEMENT

RESPONSE TRAINING SYSTEM INVOLVEMENT

FUTURE CONSIDERATIONS

\_\_\_\_\_      Response Training System      \_\_\_\_\_      Director, CARTS