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A Crisis of Credibility: Professionals' Concerns about the Psychiatric Care Provided to Clients of the Child Welfare System

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Abstract

Objectives—This study examined child welfare and mental health professionals' views of the quality of psychiatric services received by consumers of the child welfare system and explored root causes of perceived quality problems.

Methods—One hundred and thirty child welfare, mental health and court professionals participated in qualitative interviews individually or in groups. Data analyses identified perceived problems in quality and perceived causes of quality problems. Participants in member checking groups were then asked to comment on and further clarify the results.

Results—The participants reported concerns related to overuse of psychotropic medication, overmedicated children, short inpatient stays, and continuity of psychiatric care. Overuse of psychotropic medications and overmedication were perceived to be driven by short evaluations, liability concerns, short inpatient stays and a lack of clinical feedback to psychiatrists from child welfare partners. Medicaid reimbursement policies were at the heart of several quality concerns. These problems contributed to a distrust of psychiatric practices among child welfare professionals.

Conclusions—These findings underscore the adverse effects of modern marketplace medicine coupled with low Medicaid reimbursement rates on quality of care for vulnerable groups. Child welfare and mental health professionals and their associated stakeholders may together possess substantial clout to advocate for a reimbursement system and structure that promotes quality service. The findings also point to a crisis of credibility toward psychiatric practice among social service and other non-psychiatrist mental health professionals. Efforts are needed to increase the

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capacity for psychiatrists and child welfare professionals to communicate effectively with each other and for psychiatrists to receive the information that they need from their child welfare partners to ensure accurate diagnosis and effective treatment.

Introduction

Researchers have designated the child welfare system as a defacto mental health service system (Lyons & Rogers, 2004), a gateway to mental health services (Leslie et al., 2005) and have referred to the foster care system as an open-air mental hospital (Rosenfeld et al., 1997). This is due to (1) the high rates of mental health service use among child welfare system consumers (Burns et al., 2004; dos Reis, Zito, Safer, & Soeken, 2001; Harman, Childs, & Kelleher, 2000; McMillen et al., 2004; Zima, Bussing, Yang, & Belin, 2000) and (2) the immediate and drastic increase in service use once a child comes into contact with the child welfare system (Leslie et al., 2005). Although, as a group, children involved in the child welfare system receive a lot of mental health services, we know little about the nature and quality of these services. This article focuses on one segment of mental health services for child welfare consumers, psychiatric care. It explores the views of child welfare and mental health professionals involved with child welfare consumers on the nature and quality of the psychiatric services child welfare clients receive.

We started the study with two assumptions based on prior research. The first was that child welfare consumers come into frequent contact with psychiatrists. Children in the foster care system account for 28% of all Medicaid spending on inpatient psychiatric services (Geen, Sommers, & Cohen, 2005), for example. In addition, prior studies demonstrated relatively high rates of psychotropic medication use (dos Reis et al., 2001; McMillen et al., 2004, Raghavan et al., 2005) and inpatient psychiatric services (e.g., McMillen et al., 2004) in child welfare populations.

The second assumption was that some problems in the quality of psychiatric services provided to child welfare consumers may be present. This was based on: (a) a documented national shortage of child and adolescent psychiatrists (e.g, Thomas & Holzer, 1999) that may affect service delivery to vulnerable populations, (b) recent research that suggested that children served by Medicaid and in publicly funded clinics regularly received psychiatric treatment outside established practice guidelines (Richardson, DiGuiseppe, Christakis, McCauley, & Katon, 2004; Zima et al., 2005), (c) studies that indicated substantial racial and ethnic disparities in mental health service use among child welfare populations (e.g., Hurlburt et al., 2004; McMillen et al., 2004), and (d) concerns from older youth in foster care documented in qualitative research about medication management issues (Lee et al., 2006). Some youth reported being overmedicated. “They try to drug you up. You can’t function” (p. 490). Other youth reported that medications were prescribed too quickly. “Dr. B slapped meds on me the first day I met her. She didn’t even take the time to listen” (p. 490). The press and state government officials have also begun questioning medication practices with children from the child welfare system, accusing child welfare agencies of overuse of medication and dangerous overmedication of some children (AP, 2005a; AP, 2005b; Chapman, 2003; Strayhorn, 2004; Weber, 1998). Researchers, however, have rarely examined met and unmet need for psychotropic medication in child welfare populations and only in limited subgroups (e.g., Zima, Bussing, Crecelius, Kaufman, & Belin, 1999).

Recent research also suggested that quality of mental health care for child welfare consumers can be improved. Hurlburt et al. (2004) found that where stronger structural linkages existed between child welfare and mental health service agencies, systems were better at targeting specialized mental health services to those with the most need and reducing racial disparities (Hurlburt et al., 2004). Given this background, the study reported

here was developed to identify potential quality improvement targets related to psychiatric care in child welfare in one geographic region. To accomplish this, we examined child welfare and mental health professionals' perspectives on the psychiatric services received by child welfare consumers. The study focused on professionals' views regarding the most common psychiatric services provided to child welfare populations: psychiatric evaluations, psychotropic medication management and inpatient psychiatric treatment. Where problems were identified, we attempted to identify potential causes.

Methods

Participants

This qualitative study involved key informant individual and group interviews with professionals from the child welfare, mental health and court systems from St. Louis City and St. Louis County, Missouri. In total, 130 professionals were interviewed from December 2004 until August 2005. We interviewed 88 child welfare professionals. We purposefully recruited more public child welfare workers than other professionals because we wanted to hear from child welfare professionals across the child welfare continuum of services. Therefore, we conducted group interviews with child welfare professionals who investigated abuse and neglect allegations, provided in-home services to maltreating families, served children in out-of-home care and their families, and provided adoption services. We also conducted a group interview of supervisors from across these services. In this region, most child welfare services were provided by a public agency, but some private providers that had contracts with the public agency also provided foster care case management services. We therefore also conducted group interviews at three private child welfare agencies. A total of 69 public child welfare employees and 19 private agency child welfare professionals were interviewed.

Child welfare professionals providing direct services in this region typically have a bachelor's degree, often not in a social science or social work. Supervisors in this system typically have a master's degree and child welfare practice experience. Child welfare professionals were informed of the group interviews by their supervisors. Interviewed participants were volunteers who chose to attend a group interview. Group interviews were conducted during regular work hours. These methods did not allow us to know how many child welfare professionals were invited to attend the group interviews and chose to not do so.

Mental health professionals were purposefully recruited as key informants, seeking those that provided services to child welfare consumers, usually as nominated by child welfare professionals. We interviewed five Ph.D. level psychologists, five psychiatrists, four masters level mental health professionals from residential and inpatient programs, and 19 masters level agency-based mental health practitioners (14 of these in three group interviews). We also interviewed six agency administrators (child welfare and mental health), three court officials (sitting or retired family court judges that heard child welfare cases), and four professional child advocates. Of the 130 participants, 97 (75%) were female, 72 were Caucasian (55%), 53 were African American (41%) and five (4%) were of other races.

Interview Methods

Individual and group interviews were conducted at the participants' place of employment, with the exception of two group and three individual interviews that took place nearby and four individual interviews that were conducted by phone. Group interviews were the most efficient way to talk with child welfare professionals and agency affiliated mental health professionals that shared the same jobs and allowed opportunities to inquire about

agreements and disagreements among participants. Initial interview guides were created in consultation with experts in qualitative methods, mental health and child welfare. The interview guides evolved over the course of the study to confirm findings from earlier interviews and to explore new questions raised by analyzing data from earlier interviews. A total of ten iterations of interview guides were used. Interviews were conducted by three of the authors (a medical anthropologist, a public health researcher, and a social worker with experience in the child welfare and mental health systems). Participants who were not state employees were paid $30 for participating. State rules did not allow us to pay public employees. Washington University's institutional review board approved all procedures in advance.

Data Management and Analysis

Interviews were audio recorded, professionally transcribed, cleaned, purged of identifying information and imported into NVIVO, a qualitative data management software package. Because we knew we would explore perceived root causes of identified quality problems, we followed a modified grounded theory approach (Glaser & Straus, 1967; Straus, 1987; Straus & Corbin, 1998). Data analyses occurred concurrently and interactively with data collection. Early transcripts were read by the team to identify major issues being discussed and code names were developed by consensus for these issues. These early analyses provided the focus for subsequent interviews and allowed us to explore participants' views of the reasons behind phenomena identified earlier. Additional codes were added as subsequent interviews raised new topics of interest. Early transcripts were coded by two researchers who compared codes to improve agreement. One researcher coded the rest of the transcripts. NVIVO was used primarily to generate reports on specific topics. These reports were then read multiple times by multiple readers seeking regularities in the data (themes), differences in perspectives across professional categories and exemplary quotes.

We took several steps to increase confidence in the validity of the data, including the use of multiple interviewers to see if they yielded the same story, multiple readers (to see if they discovered the same story) and the use of member checking groups (Lincoln & Yuba, 1985), a qualitative method of sharing findings with participants as part of the analytic process to see if the findings represented the story as participants perceived it. A total of 125 child welfare professionals, court professionals and agency administrators, most of whom were interview participants, attended one of four member-checking groups. Preliminary findings were presented and group members were asked to elaborate on any feature of the story not adequately represented and queries were made about any findings for which we had additional questions. Findings altered through the member checking process are noted in the text. These groups were also audio-taped and transcribed.

Results

The professionals interviewed in this study identified several major quality concerns about the psychiatric care received by child welfare clients. This first part of the results section describes these concerns. A second section explores potential causes of these quality problems.

Descriptions of Quality Problems

The professionals expressed concerns about overmedicated children, overuse of psychotropic medications, short inpatient stays and discontinuities in psychiatric treatment. We begin with the related concerns about prescribing practices.

Concerns about Psychotropic Medications—Child welfare, court and non-psychiatrist mental health professionals all complained about children that were receiving too many medications or medications at doses perceived to be too high.

> "These kids are walking zombies." (Child welfare professional)
>
> "You can say, 'Whoa. Where did my kid go?' There is this little zombie walking around." (Child welfare professional)
>
> "I had an 11-year old once who was on 14 meds. That was totally ridiculous." (Child welfare professional)
>
> "I have had kids [in my office] that I couldn't wake up. They had to leave… They are overmedicated. I believe that some of these kids are overmedicated. I believe that." (Psychologist)
>
> "We have [child welfare] kids who…come into the detention center with toxic levels of medication in their system. How does that happen when they are being supervised by professionals?" (Court official).

Child welfare professionals also complained about overuse and over-reliance on medications. In short, they thought too many children were receiving psychotropic medications. Child welfare professionals complained bitterly on many occasions about psychiatrists moving quickly to prescribe medications without exploring other treatment options.

> "Some of the psychiatrists don't even try to find out what is going on. They just say, 'They need Ritalin. Give them Adderall.' They are like, 'How was your day today? Are you sick? OK. Give them some Adderall."' (Child welfare professional)

Child welfare professionals saw this as tied to very short psychiatric evaluations.

> "There is one psychiatrist in particular that I am not very fond of and we go into the office and he is giving my kid a kind of trial and error kind of thing. 'Well, how's is it going? Maybe we'll try you on this. Maybe we'll try you on that. OK. See you later.' I was like, 'What?' We were out of there in five minutes or less." (Child welfare professional).

R1: "I just run into psychiatrists, one in particular, who does not know the child but is ready to write fifteen prescriptions for a child they barely know."

R2: "I have had that situation also. He talked to him for five minutes and then wrote him four prescriptions. I did not get them filled. I got another evaluation. It disturbed me." (Child welfare professionals)

Mental health professionals, including psychiatrists, confirmed that short evaluations leading to multiple prescriptions were often a problem.

> "They have like 15 minutes to see the psychiatrist. They ask 'How are you doing?' and tell you to make an appointment in three months or whatever. I had a Mom tell me that this doctor is writing a prescription as they walk in the door." (Masters level mental health professional)
>
> "To just say, 'Oh, they're acting up, you need this drug and this drug' and that's often what I see coming from other clinicians. 'Oh, you're acting up, you need Risperdal and Depakote."' (Psychiatrist)

Hearing us describe these complaints, a psychiatrist gave this phenomenon a name. "Ah," he observed, "The problem of shotgun medications."

In general, child welfare professionals said very little that was favorable about psychotropic medications. When we asked child welfare professionals to respond to the words "psychotropic medications," the response was pervasively negative, as exemplified by this interaction from a group interview.

> Respondent 1: Too much.
>
> Respondent 2: Too many.
>
> Respondent 3: Too often.
>
> Respondent 2: Side effects.
>
> Respondent 4: Too easy.
>
> Respondent 1: Zombie children.

In contrast, although non-psychiatrist mental health professionals expressed concerns about the ways that medications were prescribed, in general they expressed positive views about the enefits of psychotropic medications.

> "Thank God we have it. It's made a huge difference for us." (Mental health professional at a residential treatment program)
>
> "We need to remove the hysteria about it and we need to recognize that psychotropic medication for some children is needed and necessary." (Psychologist)

Too-short In-patient Stays—In general, child welfare and mental health professionals reported a role and a need for in-patient psychiatric treatment for child welfare consumers. But, they felt that in-patient stays were typically too short to be helpful.

> "It's too short term. They kick them out within seven to ten days. Mostly seven." (Child welfare professional)
>
> "You can have a child try to commit suicide and be out in two or three days. It's the insurance that's kicking them out." (Child welfare professional)

The briefness of the treatment may be too short to meet its primary objective, which is usually stabilization.

> "You can get into a whole philosophy of, 'Can you really stabilize a kid that's either acting out or psychotic or really depressed in five days?' (Mental health professional)

We asked a psychiatrist how long it takes to stabilize child patients in an in-patient setting.

> "If it's really bi-polar disease, you can probably get them stable in a week to two weeks as long as they respond to the first medication you give them… If they don't respond and you've got to do a couple of different meds, it may be a couple weeks or three weeks. If a kid is really depressed, it takes longer because medications take longer to start working." (Psychiatrist)

Continuity of Care—Child welfare and mental health professionals noted that well-known discontinuities in the foster care system (placement changes and turnover among child welfare case managers) affected the quality of psychiatric treatment. Most notably, the child's psychiatrist usually changed whenever the child changed placements and a change in psychiatrist often meant a change in treatment strategy.

> "They'll end up in a hospital and they can't keep them very long. They will be there for three days to stabilize their medication and then they'll be discharged and they'll go to a residential where there will be a new psychiatrist who will evaluate their medications and then it will be all different." (Advocate)

> "We have had situations where a child's home medication regime was changed within a day, totally, and just totally destroyed the stability in this child's life and it just results in more and more outbursts and more and more dysfunction." (Mental health professional)

Exploring Root Causes of Quality Problems

The qualitative methods used in this study allowed us to explore potential root causes of some of these quality problems. We did this for the described perceived problems of overuse of psychotropic medications, overmedicated children and short inpatient stays. We have already mentioned one antecedent to the perceived overuse of psychotropic medications, short psychiatric evaluations and consultations. With new iterations of interviews, we probed about potential causes of short psychiatric evaluations and consultations.

The Productivity Model and Its Limitations—One psychiatrist pointed out that psychiatrists practice within a "productivity model," in which payment is based on the number of individuals seen, rather than quality of services or the amount of time spent with patients. This was seen as the primary cause of the short amount of time spent with psychiatrists that the child welfare professionals reported.

> "The productivity model means that as a psychiatrist, you only generate revenue during face to face sessions. So, you maximize the number of face to face sessions." (Psychiatrist)

Some agencies that employ child psychiatrists were reported to accent this productivity over other considerations.

> "They [administrators at mental health agencies] were very clear that you are here to see patients and you see them for ten or fifteen minutes because we need you to see five or six patients an hour to generate adequate revenue." (Psychiatrist)

Brief Inpatient Stays—In addition to being too brief to stabilize children and youth in acute psychiatric crises, brief in-patient stays may also contribute to the overmedication of some youth. Forced to release a child or youth back to the community in such a short time period, overmedication may serve as a proxy for stabilization. Child welfare professionals reported that children were often discharged from inpatient treatment in what they perceived to be overmedicated states.

> "When I go and pick them up and discharge them they are walking zombies. I mean they do not even know who I am. They can barely talk, but they [the hospitals] are saying that they are ready to go back in the community." (Child welfare professional).

> "I think they put them in there and they overmedicate them or just put them in there and change their meds and then let them out when they seem like they're drowsy." (Child welfare professional).

Medicaid Reimbursement Policies—Both the accent on seeing lots of patients quickly and the short inpatient stays were thought to be driven by Medicaid reimbursement policies. State Medicaid rules limited the number of days reimbursed in inpatient care and paid for office visits at rates that psychiatrists found inadequate. Child welfare professionals reported

that Medicaid reimbursement rates made it difficult to find good psychiatrists to serve their clients.

R1: It's frustrating to get a good psychiatrist because everywhere you call, 'We're not taking Medicaid.'

R2: So then we have to go to the bad one just to be seen because we're court ordered to have him seen by a psychiatrist. So it's a lose-lose situation for that child.

Stakeholders Push for Medication—Psychiatrists noted that there is an implicit plea for medication in many of the referrals they get from the child welfare system.

> "Part of it, I think, is that there are caseworkers who are pushing you to do things. 'You have to do something. This kid is out of control. He's hitting people.' What are you going to do?" (Psychiatrist)

We asked child welfare professionals to identify who was pushing for medications and received a variety of responses from participants in one interview group.

> R1: Teachers. Parents also think that if you can just give little Johnny some Ritalin, he will sit his behind down and not bother me.
>
> R2: Facilities.
>
> R3: Right.
>
> R4: Foster parents.
>
> R3: Right. Residential facilities.

Other participants also commented on the motives of residential treatment providers' use of psychotropic medications.

> "Sometimes they are just short staffed. It ends up being crowd control." (Child welfare professional)
>
> "It almost becomes a safety question. You know, that the kid who beat the hell out of some worker or something. I've had that twice. And they are medicated because they beat the shit out of some worker. So it's almost like for their protection and for (pause) it's easier for them to manage the kid." (Court official)

Lack of Clinical Feedback—The data suggested that psychiatrists may not be receiving the clinical feedback that they need about a child's functioning and side effects from the child welfare system in order for the proper treatments to be determined. In the member checking groups, child welfare professionals expressed a hesitation to provide clinical feedback that disagreed with a psychiatrist's opinion.

> "We are relying on the expertise of that psychiatrist to prescribe what is needed for that child. There is not a whole lot that is said [when the worker thinks a child is on too much medication]. You know, staff may comment that it is too many medications but, you know, what do you do about it?" (Child welfare professional in member checking group)
>
> "The [child welfare] workers get intimidated when a psychiatrist says, 'Where did you get your medical license?"' (Child welfare professional in member checking group)

Participants initially indicated two sources of this hesitation to provide clinical feedback to psychiatrists: their lack of knowledge about psychiatric issues and fears of offending

psychiatrists that agreed to work with their clients. Foster care professionals in the study area, like many nationwide, had the legal responsibility of authorizing treatment for the children they served, including medications and medication changes. Child welfare professionals thought that they did not know enough about psychotropic medications to be effective treatment partners with psychiatrists in this process.

> "We are not nurses or anything like that. So there are a lot of kids that are on a lot of different meds and I don't have the time to do the research and even if I did I am not qualified to say very much about that." (Child welfare professional)

> "We are under-qualified when it comes to that [psychotropic medications]. When I have a kid at residential, they call me and say that they are about to change and are going to put them on such and such meds. What do I know? I'll give them an approval, but I don't know if it is any good." (Child welfare professional)

Some child welfare professionals felt that staff members at residential treatment facilities were reluctant to offer opinions contrary to those of a psychiatrist lest it be considered criticism. In an age when there are not enough psychiatrists to meet demand, these facilities have a difficult time finding consulting psychiatrists and don't want to risk losing one.

> "The psychiatrist's recommendations or prescriptions are not challenged routinely by residential staff. If they have a psychiatrist on staff or someone who they've contracted to provide services exclusively for them, that's a pretty coveted asset for the residential facility… So if they have that set up with the psychiatrist, you're not going to challenge, on a regular basis, multiple meds or diagnoses." (Child welfare professional in member checking group)

Administrators, court and child welfare professionals reported having a difficult time accessing psychiatrists. In this environment, child welfare professionals may find it difficult to disagree or challenge a psychiatrists' opinion.

Liability Concerns—Psychiatrists also identified concerns about professional liability as a possible cause of the overuse of psychotropic medications.

> "We have liability issues to think about. If I send a kid out on no medication who knifes somebody because they have a history of being violent, and that goes to court. 'Well doctor, why didn't you put him on something?"' (Psychiatrist)

Hearing this, child welfare professionals in member checking groups said they had similar concerns about liability.

> "I think our workers are the same as the psychiatrists about the liability. What if we say, 'I am uncomfortable with the child being on this many medications' and the next day he committed suicide or attacked another child because he has had no medications?" (Child welfare professional in a member checking group)

Discussion

Results identified a number of quality concerns regarding the psychiatric care received by children and youth in the child welfare system. These included overuse of medication, overmedication, and discontinuities in psychiatric treatment. The one psychiatric intervention that participants agreed was needed, inpatient treatment for psychiatric stabilization, was deemed of insufficient duration to help.

One central story that emerged from the findings was a complicated tale of the interrelated causes behind the perceived overuse and overmedication of some children in the child welfare system. Overuse, as reported by our participants, has four identified direct causes:

external pressures by stakeholders to control youths' behaviors, short psychiatric evaluations, a shortage of psychiatrists that will accept Medicaid and psychiatrists' liability concerns. Overmedication shares most of these same direct causes, but also may be due to short inpatient stays and limited communication across disciplines about target symptoms, the context of a child's behavior problems, and medication side effects. External pressures to control youth behavior within the context of either short evaluations or short inpatient stays can create potent scenarios for both overmedication and overuse of medications.

Short psychiatric evaluations and consultations are driven primarily by pressures on psychiatrists from their employers to maximize the income produced. The Medicaid payment structure plays a substantial role in this pressure. In such an environment, services to patients that are reimbursed from Medicaid will likely be brief. Psychiatrists may be unwilling to conduct longer evaluations at Medicaid rates when other patients that pay better could be seen. Other psychiatrists may choose not to serve Medicaid patients at all, contributing to the dearth of psychiatrists willing to serve child welfare clients. Medicaid policies are also behind short inpatient stays. Hospitals will naturally be reluctant to keep patients for periods longer than Medicaid will reimburse.

The reluctance of child welfare and residential employees to provide relevant clinical feedback to prescribing psychiatrists has three identified root causes: a desire to not offend psychiatrists willing to work with their clients, child welfare professionals' lack of knowledge about psychiatric issues and psychotropic medications leaving them often unwilling to voice their opinions, and their concerns about liability if they choose not to follow the psychiatrists' prescribed medication plan. In short, some child welfare professional do not feel empowered to share their views. In addition, there is no venue, such as a team-planning meeting, where psychiatrists and other professionals come together, in which to share information.

Children in the child welfare system usually do not have an involved parent driving psychiatric care. An involved parent may disagree with a psychiatrist's diagnosis of a child she knows well. Or, an involved parent may provide feedback to a psychiatrist when a child exhibits side effects such as drowsiness, allowing a change in dosing or medication. The stakeholders in the child welfare system (residential care employees, child welfare case managers, foster parents) may not be adequately filling this role usually fulfilled by the parent seeking services.

We chose not to fully explore with our participants the causes behind discontinuities in psychiatric treatment. This concern arose fairly late in our field work and we felt the causes were fairly circumscribed, limited to employment and contractual practices. Residential programs and some private contractor agencies (like those providing treatment foster care) have service contracts with individual psychiatrists. Inpatient programs are also often affiliated with certain psychiatrists. When a child enters these programs, they are assigned to the psychiatrists affiliated with these programs no matter what psychiatrist was seeing them previously. When children leave these specific programs to live in the community, they are served by whatever psychiatrist the case manager can find that will accept Medicaid. In short, psychiatrists don't follow children from placement to placement.

The second story to emerge from these data is a deep underlying skepticism toward psychiatrists by many of the professionals we interviewed, especially the child welfare workers. Their tone in interviews was often derogatory and dismissive of psychiatrists' professional opinions. While in the presence of psychiatrists, child welfare professionals may be quiet and reluctant to voice their opinions; among their own, however, psychiatrists received little respect. Recently, American Psychiatric Association President Steven

Sharfstein referred to a crisis of credibility for American psychiatry among the general public, based largely on problems with quality and access (Sharfstein, 2005). This research suggests that the crisis of credibility extends beyond the general public to professionals that deal regularly with psychiatrists.

This crisis of credibility may result, at least partially, from psychiatrists struggling to practice within the structural constraints of modern marketplace medicine. While the government attempts to keep Medicaid growth in check with low reimbursement rates and managed limits on services, psychiatrists are expected to maximize income for either their private practices or the community agencies that employ them. Meanwhile, psychiatric consumers want thoughtfully delivered care. Additional stakeholders desire quick help for acute problems. This creates an intra-role conflict for psychiatrists who cannot maximize income in such a reimbursement system *and* provide quick fix solutions that satisfy demanding stakeholders *and* provide high quality care. Ethnographic observers have described the mandate for industrial efficiency in modern psychiatric practice (Donald, 2001; Luhrmann, 2000), and how modern mental health professionals are judged not by the quality of their clinical work, but by the quantity of the hours billed (Robins, 2001).

American Academy of Child and Adolescent Psychiatry guidelines (2003) call for thorough psychiatric evaluations for children that require several hours to complete. Knowing this and feeling forced to evaluate children in much shorter time periods likely causes some psychiatrists professional distress that is hard to reconcile. Psychiatrists in this practice context may risk suffering from what Ware, Lachicotte, Kirschner, Cortes, and Good (2000) called a loss of moral vision of good mental health treatment. In order to reduce the tension caused by the feeling that they may be forced to provide what they consider inadequate care, psychiatrists may re-define in their own minds what adequate care looks like.

Research Implications

This study identified additional opportunities for research. These include research that (a) provides rich description of the professional lives of practicing psychiatrists, to explore how they manage the conflicts between a desire to provide high quality care and the external constraints placed on them, (b) explores administrators and psychiatrists viewpoints of needed structural changes to enhance practice processes and outcomes (c) examines psychotropic medication use in relation to clinical need for child welfare and other child consumers, (d) explores how to better implement guideline concordant prescribing practices, (e) quantifies the amount of time psychiatrists spend with young patients and explores the relationship between time spent and patient outcome, and (f) examines the impacts of inpatient stays of differing durations.

Limitations

The study was designed to examine issues of psychiatric treatment in two counties of one state. Although child welfare and mental health systems have similarities across jurisdictions, unknown variations in psychiatric and child welfare practices, Medicaid and child welfare policies, and court systems make it unknown how tied the findings are to geographic location. In addition, different researchers may have pursued different paths of inquiry as the project unfolded.

We used two different interview types: group and individual. It is possible that this decision affected results in unknown ways. Child welfare professionals' comments about psychiatric care might not have been as pointedly negative without the group context. And psychiatrists, who were generally polite in their descriptions of child welfare practices and professionals in individual interviews, may have been more derogatory in their comments in a group

context. Although we sought a variety of viewpoints, it is possible that child welfare professionals with negative views of the child welfare system, the child mental health sector or both were more motivated to participate in the study.

Clinical, Administrative and Policy Implications

The results, coupled with the results from Hurlburt et al. (2004) point to a need for increased capacity for the coordination of psychiatric care for child welfare consumers, particularly for mechanisms to support a team approach that increases communication across disciplines. The reimbursement system, again, serves as a key impediment, as it typically does not reimburse mental health professionals for time spent attending case planning meetings or phone consultations with referring professionals. No matter the barriers, child welfare professionals and psychiatrists need to find mechanisms to communicate. When they do, child-serving psychiatrists may need to alter their partnering strategies with child welfare professionals to address the reticence of these collaborators to voice their concerns and to ensure that psychiatrists receive the clinical feedback that serves as a corrective force in treatment. Some professionals may need more education and assurances about the medications being prescribed than other professionals. The study also identifies a need for training for child welfare professionals to help them partner better with psychiatrists. This could include background information on psychiatric disorders, psychotropic medications, and the kinds of information psychiatrists need from their clinical partners. We believe that with proper coaching, child welfare professionals are capable of being effective treatment partners in psychiatric care.

Administrators in mental health agencies and psychiatrists need to begin dialogue that addresses the causes and repercussions of services delivered in 15 min increments. With the ongoing shortage of child-serving psychiatrists, agencies that can provide a practice environment conducive to quality service will have a recruitment and retention advantage.

The interplay between well-known system structure issues often voiced by psychiatrists and consumer advocates and complaints about the quality of current psychiatric practice for a vulnerable population voiced by non-psychiatrists was striking in these findings. A national shortage of child-serving psychiatrists, malpractice concerns, Medicaid reimbursement rates that psychiatrists and mental health agencies view as too low, and a productivity based incentive system that has led to 15 minute appointments all serve as enormous barriers to improved psychiatric care. Each of these barriers has its own complicated socio-political history that has contributed to the entrenchment of these problems. The problems in quality attributable to these problems and how they affect psychiatric consumers have not yet been well described. A number of key players (psychiatrists, consumers, other mental health and social service professionals) are aware of these problems. Some of these groups, such as child welfare consumers, have little to no voice in the making of policy and no single group likely has sufficient pull to affect change in entrenched social policy. Together, these groups may have substantial clout to advocate for a reimbursement and system structure that promotes quality service.

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