



CALIFORNIA INSTITUTE FOR MENTAL HEALTH

Promoting Excellence in Mental Health Services

**CIMH Board of
Directors:**

Larry Pooster, PhD,
Central Counties
Member, President

Ten Mullins,
At-large Member,
President Elect

Gale Bataille, MSW,
At-large Member,
Past President

Michael Cassetta,
LCSW, Superior
Counties Member,
Secretary, Treasurer

J.R. Eppers, MD,
At-large Member,
Executive Committee

Darlene Prettyman,
RNC, Family Advocate
Member, Executive
Committee

John Hatakeyama,
MS, Los Angeles
County Member

Diane Koditek, MFCC,
Southern Counties
Member

Jay Mahier,
Consumer Advocate
Member

James Kelly, PhD,
At-large Member

Kathleen Burne, LCSW,
Small Counties
Member

Karen Hart, Parent
Advocate and Mental
Health Board Member

Marye L. Thomas, MD,
Bay Area
Counties Member

Areta Crowell, PhD,
At-large Member

Rudy Lopez, MSW,
At-large Member

Sandra Naylor Goodwin,
PhD, MSW,
Executive Director

April 24, 2002

Thank you for downloading this copy of "Evidence-Based Practices in Mental Health Services for Foster Youth." This report is a component of the *CIMH Caring for Foster Youth* initiative that has been funded and supported by the *Zellerbach Family Fund*. This project has focused upon the promotion of mental health assessments and services for foster children throughout California. Two screening tools, designed to support child and family service systems in these efforts, have been created through this project as well. [The Mental Health Screening Tool (MHST) 5-adult and (MHST) 0-5 are available for download or to order at this website as well].

The "Evidence-Based Practices in Mental Health Services for Foster Youth" report has been presented throughout the state, and is now available in written form, to inform those who plan, implement and participate in services for foster youth. This report and the training series that will follow into Winter 2002, encourage the use of research information in the development and delivery of mental health services for this vulnerable population.

CIMH acknowledges the state and county mental health and social services staff, foster parents, California Youth Connection, and the Zellerbach Family Fund whose efforts and resources, through this project, work to improve the lives of foster youth.

Sincerely,

Bill Carter, LCSW
Deputy Director

**Evidence-Based Practices
In
Mental Health Services
For
Foster Youth**

**By
Lynne Marsenich, LCSW**

March, 2002

For more information about the California Institute for Mental Health
products and documents contact:
Bill Carter, LCSW, Deputy Director, CWTAC/CIMH
Sandra Naylor Goodwin, PhD, Director, CIMH

CIMH
2030 J Street
Sacramento, CA 95814
(916) 556-3480

Table of Contents

Executive Summary	11
<i>Part I: Review of Literature</i>	11
<i>Profile of California Foster Youth</i>	11
<i>Evidence-Based Mental Health Practices for Foster Children</i>	12
• Table I - Evidence-Based Strategies for Working with Foster Children	14
• Table II - Evidence-Based Treatments for Childhood Mental Disorder	15
 <i>Part II: The Views of Participants in the Foster Care Paradigm</i>	16
 <i>Part III: Conclusions</i>	17
Introduction	23
Part 1: Review of the Literature	24
<i>Profile of California Foster Youth</i>	24
<i>Incidence of Mental Health Problems Among Children in Foster Care</i>	25
<i>Posttraumatic Stress and Attachment Disorders</i>	26
<i>Posttraumatic Stress Disorder</i>	26
<i>Reactive Attachment Disorder</i>	27
<i>Common Problems Experienced by Children in Foster Care</i>	28
<i>Placement Instability and Permanency Outcomes</i>	28
<i>Disruptive Behaviors, Peer Relationships and School Problems</i>	29
<i>Mental Health Service Use by Children in Foster Care</i>	30
 <i>Evidence-Based Treatment for Foster Children</i>	32
<i>Intervention Models for Foster Children</i>	33
<i>Wraparound</i>	33
• Table I - Evidence-Based Strategies for Working with Foster Children	34
<i>Treatment Foster Care</i>	35
<i>Promising Interventions for Infant and Preschool Foster Children</i>	37
<i>Oregon Social Learning Center-Early Intervention</i>	37
<i>Attachment Theory Research</i>	38

Table of Contents

<i>Evidence-Based Treatment for Childhood Mental Disorders</i>	39
<i>Disorders with Evidence-Based Outpatient Treatment</i>	39
<i>Depression</i>	39
<i>Attention-Deficit/Hyperactivity Disorder (ADHD)</i>	39
<i>Anxiety</i>	40
<i>Disruptive Behavior</i>	40
• Table II - Evidence-Based Treatments for Childhood Mental Disorders	41
<i>Psychopharmacology Evidence for Childhood Disorders</i>	42
<i>The Surgeon General's Report</i>	42
<i>NIMH Research Units of the Pediatric Psychopharmacology Network</i>	43
<i>FDA-Approved Psychoactive Medications for Children Under 12</i>	43
 <i>Abuse-Specific Interventions</i>	43
• Table III - Stimulants Approved by the FDA for Children	44
• Table IV - Mood Stabilizing Medications Approved by the FDA for Children	44
• Table V - Antidepressant and Antianxiety Medications Approved for Children	45
Antidepressant and Antianxiety Medications Not Approved for Children under 18	45
• Table VI - Antipsychotic Medications Approved by the FDA for Children .	46
Antipsychotic Medications Not Approved for Children under 18	46
<i>Treatment for Physically Abused Children</i>	47
<i>Treatment for Sexually Abused Children</i>	47
<i>Treatment for Neglected Children</i>	48
 <i>Evidence for Institutional and Comprehensive Community-Based Interventions</i>	49
<i>Strong Evidence</i>	49
<i>Moderate Evidence</i>	50
<i>Weak Evidence</i>	50
• Table VII - Institutional and Community-Based Interventions by Relative Level of Supporting Evidence	51

<i>Additional Resources</i>	51
<i>Practice Guidelines</i>	51
<i>Guidelines for Seeking Psychiatric Consultation</i>	52
<i>References</i>	54
<i>Part II: The Views of Participants in the Foster Care Paradigm</i>	60
<i>Child Welfare Staff</i>	60
<i>Staff Providing Health and Mental Health Services to Foster Children</i>	61
<i>Foster Parents</i>	64
<i>Foster Youth</i>	64
Part III: Conclusions	66
<i>Implications for Planning & Practice</i>	66
<i>Recommendations</i>	69

Acknowledgements

I had a great deal of help in the writing of this report every step of the way. My thanks first to all of the people who gave so generously of their time and knowledge while I was researching the project: John Landsverk, PhD, William Arroyo, MD, Jacquelyn McCroskey, DSW, Todd Sosna, PhD, Devon Brooks, PhD, Linda Lewis, BA and Mary Hargrave, PhD.

My interest in improving mental health practice has been shaped and supported by Donna Dahl, LCSW. In the two decades that I have known her she has been a tireless advocate for quality mental health care for children and youth. Her wisdom, trust and friendship helped see this project to fruition.

I am deeply indebted to Penny Knapp, MD, for reading the paper with great care and intelligence. Her thoughtful and clear-sighted advice regarding the research on psychotropic medication made for a much better final paper.

Finally, I am grateful to the many people who agreed to be interviewed for this project despite, in many cases, overburdened professional and personal lives: foster parents, child welfare professionals, private sector mental health providers, county and state mental health staff and finally, the children's coordinators from various county mental health departments. Everyone I talked with supported and encouraged the project by sharing their insights and suggestions for better services for a vulnerable population of children.

- *Lynne Marsenich, LCSW*

Foreword

Evidence-Based Practices in Mental Health Services for Foster Youth, reflects the California Institute for Mental Health's (CIMH) goal to promote evidence-based mental health services. While it has always been the Institute's practice to utilize scientific information, CIMH is increasing its commitment to disseminate information regarding research and mental health services, explore the manner in which evidence-based practice can be effectively integrated into system planning and service delivery, and better understand what type of training and technical assistance assures the transport of research supported practice to California counties.

This report is an example of the constructive manner in which research information can be presented to inform the decision making of those planning and providing mental health services. In addition to reviewing evidence regarding mental health services for foster children, the author systematically analyzes other mental health research to identify that most relevant to foster youth. Lastly, she integrates feedback provided by those working in the California foster care system to highlight practices that may best meet the needs of our communities.

However, the effort to use evidence-based practice information is not without complication. This project, as it consulted stakeholders and presented findings, struggled with determining the criteria that qualifies practice as "evidence-based" for this report, and balancing the promotion of evidence-based practices with some of the limitations inherent to research.

The project selected a fairly narrow and rigorous standard for evidence-based practice. However, choosing the standard was challenging for a number of reasons. Colleagues frequently directed us to research and other materials that do not meet the criteria determining inclusion in the report. And the relatively small amount of research meeting the report's standards supported the stance that practices demonstrating positive results within less exhaustive research should be considered in service system development. Perhaps most interestingly, we recognized that there are important practices that should not necessarily be limited by research. These practices reflect our values, priorities, and/or common sense and will be implemented prior to availability of supportive research.

We also discussed the degree to which the report focuses upon scientific research, as a variable determining the worth of a mental health service. There are a number of limitations associated with research. Studies in carefully controlled settings may not have much relevance to the "real world." Outcomes selected by researchers sometimes bear little resemblance to those sought by children, families and those working in local child and family services. And practices outlined in research can require resources that are not available in our service systems and communities.

There is merit in all of the alternative stances suggested regarding the standard of evidence and the value of research in mental health service delivery. The discussion regarding evidence-based practice is only complete when the complexity of these and other considerations are fully investigated. Nonetheless, this report rests upon several firm assertions.

Research into mental health practice is one of the most valuable resources available to those who plan and implement child and family services. Prioritizing practices proven to be effective assures more efficient use of funds and human resources, and protects children and families from participation in potentially useless or detrimental treatment. It seems clear that administrators and providers should use research information throughout their decision making processes. When there is evidence supporting a practice, use that practice, unless there are compelling reasons not to do so. In the absence of strong evidence, look to respected practice guidelines and developing evidence to inform decisions. Avoid using those practices for which there is no supporting research.

These assertions do not suggest that implementing evidence-based practices is as simple as utilizing information to guide decisions. Administrators designing child and family service systems must respond to multiple obstacles. Funding sources do not always support new, innovative or nontraditional services. Politics and policy exert influence that can work against practices that have scientific support. Human resource shortages, and the need to retrain an existing work force, hamper the implementation of system reform. And, the process that effectively moves a practice from a research environment to communities is complicated.

Each of these realities requires a unique set of responses in our ongoing efforts to improve outcomes for children and families with mental health needs. However, understanding information regarding evidence-based practice, and committing to its use in system planning and service delivery, are two important first steps. CIMH adds this report to the growing body of materials designed to fill this need.

Bill Carter, LCSW
Deputy Director
California Institute for Mental Health

Executive Summary

As one component of the California Institute for Mental Health (CIMH) project, Meeting the Needs of Foster Youth, Evidence-Based Practices in Mental Health Services for Foster Youth reports and examines the relevant literature, and considers this information in the context of the California foster care environment as described through key informant interviews. The report is designed to initiate and inform interdisciplinary dialogue between mental health and child welfare administrators and practitioners, researchers, the judiciary, families and foster youth.

The goals of the report are: (1) to highlight the available social science evidence on mental health services for foster children, from which service systems models can be developed; (2) to encourage the integration of known research into the planning, development and delivery of mental health services to children in foster care; (3) to dispel some of the prevailing myths and misperceptions about the mental health needs and best treatment options for children in foster care; and (4) outline some of the implications of this information and offer recommendations designed to improve the delivery of mental health services to foster children.

The report includes a literature review of available information on the specific mental health needs of foster children, their current mental health service use and what is currently known about effective treatments specifically tailored for foster children. Since the scientific literature on evidence-based mental health treatment for foster children is sparse, this report also incorporates the broader research on mental health interventions with abused children, and children generally, to produce a more useful and comprehensive review. The perceptions and experiences, expressed through interviews of mental health and child welfare practitioners, foster parents and foster youth are included to draw a picture of the foster care environment in

California, and offer guidance as to how available research may best be used to address current needs and opportunities. Finally, based on the literature review and the perspectives of participants in the foster care system, the report makes recommendations for training, research and program improvements to improve the delivery of mental health services to foster youth.

Part 1: Review of Literature

Profile of California Foster Youth

California's current foster care population is younger, and its individuals are more likely to be members of an ethnic minority group and are more frequently removed from their homes because of child neglect than the foster care populations of the past.

Growing Numbers of Children in Foster Care- Consistent with national trends, the number of children in foster care in California has dramatically increased in recent decades. The emerging research suggests that the increase is due to the growing number of neglect cases resulting from parental drug and alcohol abuse and to the impact of poverty, homelessness, AIDS, and domestic violence on at-risk families.

Average Age of Children in Foster Care Has Declined- In 1983, the average age of children in foster care was 10 years, 2 months. By 1990, the average age decreased to 8 years, 3 months and has remained relatively constant at that level. By 1997, 33 percent of the children in out-of-home care in California were aged 0 to 5 years.

Ethnicity of Foster Children is Changing- Over the last two decades, the ethnicity of foster children has shifted so that in 2000, children of color accounted for 70 percent of California's foster care caseload, up from 54 percent in 1983.

Executive Summary (continued)

Children in Foster Care Have Greater Mental Health Needs than Children in the Community-

Research reveals that the range of children entering foster care with significant mental health problems is anywhere from 35 to 85 percent. The incidence of emotional, behavioral and developmental problems, among children in foster care is *three to six times greater* than in children in the community. Externalizing disorders—such as disruptive behaviors, delinquency, hyperactivity and aggression—are more common in foster children than internalizing disorders—such as anxiety, fear, low self-esteem, sadness and depression.

Foster Children Have Higher Mental Health Service Use-

Research reveals that mental health service utilization by children in foster care is high relative to other children, and varies among foster care children depending on factors such as age, gender, ethnicity and type of placement. Predictors of higher mental health service use among foster children include age (being older); gender (being male); placement in non-relative foster care; and being removed from the home because of physical or sexual abuse. The evidence also reveals disparate access to mental health services, and to specific treatments, according to gender and ethnicity. For example, among children in foster care clinically diagnosed with a severe psychiatric disorder, for which medication is a standard component of care, boys were more likely than girls to receive medication. In addition, Latino, African American, Asian and other ethnic groups have lower service utilization than Caucasian youth, with African Americans receiving fewer services for low to moderate level problems and Latinos receiving fewer services across all problem severity categories.

Mental Health Problems Affect Placement Stability and Permanency Outcomes- Children with emotional and behavioral problems have a reduced likelihood of reunification and/or

adoption, and children with externalizing disorders have the lowest probability of exiting foster care. In addition, children with developmental delays, children 12 and over, and non-white children are the least likely to move out of the foster care system.

Foster Children Exhibit the Same Disruptive Behaviors as Abused Children Generally-

Foster children have a relatively high incidence of behavior problems, academic delays and problems in peer relationships which negatively affect their placements, options for permanency, and their long-term social adjustment. Posttraumatic stress disorder may be more common in foster children than generally acknowledged, and appears to affect children who have experienced diverse forms of abuse, not just those who were sexually abused. However, the literature fails to support the conventional wisdom that foster children have higher levels of reactive attachment disorder (RAD) or that RAD offers a good explanatory framework for understanding disruptive behaviors in foster children.

Evidence-Based Mental Health Practices for Foster Children

The project reviewed the literature to identify treatment programs and strategies that have been shown to be *efficacious* (beneficial when delivered under carefully controlled experimental conditions) and *effective* (beneficial when delivered to heterogeneous samples of clinically referred individuals in clinical settings).

The Evidence Supports “Wraparound” and Treatment Foster Care-

Only two intervention models have demonstrated effectiveness in the treatment of foster children—the wraparound service strategy and therapeutic foster care. Wraparound is a family-focused, strengths-based program where intensive and comprehensive social,

Executive Summary (continued)

mental health and health services are “wrapped around” children and their families (biological, adoptive and/or foster families) to reinforce natural family supports. Therapeutic Foster Care involves having the foster parents assume the role of primary interventionists and providing foster parent training, clinician support and consultation, case management, and family therapy. The report highlights the results and information from successful projects in these two areas.

Promising Research in Treating Infants and Preschool Foster Children- The project identified and reported on two promising interventions—currently in the early stages of development—for infants and preschool foster children—the Oregon Social Learning Center Early Intervention Program and a University of Delaware project investigating foster care adjustment for infants and preschoolers from a developmental/attachment perspective.

(See Table I for more information regarding Evidence-Based Strategies for Working with Foster Children)

Evidence on Effective Treatments for Childhood Mental Disorders May Help in Working with Foster Children- Since there is so little research specifically focused on mental health treatment of foster youth, the project reviewed the broader literature on mental health treatment for children. The review found that there are four disorders of childhood for which there are evidence-based treatments: 1) depression, 2) attention deficit hyperactivity disorder (ADHD), 3) anxiety, and 4) disruptive behavior (including the following diagnoses: oppositional defiant disorder, conduct disorder, and the aggression and anti-social behavior often associated with ADHD). The effective treatments for each are listed in Table II.

Research Information on Psychopharmacology is Rapidly Changing- The report includes an overview of current drug therapies recommended for treatment of the mental health problems and disorders affecting youth, with a strong caveat that psychopharmacology is a fast-moving and changing field where recommendations regarding medications and treatment regimens quickly become outdated. The report urges professionals, caregivers and practitioners to continually review the changing status of research and best practices, specifically ensuring that individual medications have been evaluated and approved for the treatment of children (and at what ages).

There is Limited Evidence on Abuse Specific Interventions- Limited empirical evidence is available to guide practitioners in the treatment of abused and neglected children, but a few studies offer some direction. Therapeutic day care programs were shown to result in developmental gains for physically abused and neglected children. Families participating in family-centered casework, cognitive behavior therapy or family therapy also had improved outcomes. These types of interventions made little difference, however, in the incidence of overall aggression or hostility in children studied. Research on interventions with sexually abused children has shown that abuse-specific cognitive behavioral therapy (CBT) results in better outcomes than standard community treatments.

Executive Summary (continued)

Table I

Evidence – Based Strategies for Working with Foster Children			
Program or Treatment	Program Description	Target Population	Research Status
Wraparound	A family-focused, strengths-based program where intensive and comprehensive social, mental health and health services are “wrapped” around children and their families (biological, adoptive and/or foster families) to reinforce natural family supports.	Foster children with emotional and behavioral problems	EFFECTIVE Fostering Individualized Assistance Program Developers: Hewitt Clark and colleagues University of South Florida
Treatment Foster Care	Parent Management Training based on social learning theory. Foster parents are the primary interventionists. Foster parents are provided with training, consultation, and clinician support.	1) Children and adolescents with chronic delinquency and conduct problems 2) Adolescents with severe emotional disturbance; and 3) Latency age children with behavior problems	EFFECTIVE Multimodal Treatment Foster Care Developers: Patricia Chamberlain and colleagues Oregon Social Learning Center
Early Intervention Program	Multidisciplinary team approach which includes foster parents. Includes behavior management foster parent training, screening for developmental delays, activity-based curriculum and long term placement planning.	Maltreated preschoolers	PROMISING Early Intervention Foster Care Developers: Phil Fisher and colleagues Oregon Social Learning Center
Foster Parent Training: An Attachment Theory Prospective	Foster parents are taught to recognize and respond sensitively to infants problematic attachment strategies	Foster parents caring for infants	PROMISING Developers: Mary Dozier and colleagues University of Delaware

Executive Summary (continued)

Table II

Evidence-Based Treatments for Childhood Mental Disorder		
Target Diagnosis or Disorder	Treatment	Research Status
Depression - Children and adolescents who exhibit symptoms of depression (not necessarily clinically diagnosed)	Cognitive Behavior Therapy Self-control therapy	EFFICACIOUS
Attention-Deficit Hyperactivity Disorder (ADHD)	Behavioral parent and teacher training Systematic programs of contingency management in specialized classrooms	EFFICIACIOUS
Anxiety	Systematic desensitization and reinforced practice reduce phobic symptoms Cognitive behavior therapy reduces anxiety symptoms and fears Coping Cat – cognitive behavioral intervention reduces anxiety symptoms and fears	EFFECTIVE
Disruptive Behavior	Parent Training Program – Living with Children Videotaped parent modeling program	EFFECTIVE
Conduct Problems	Anger control therapy, anger coping therapy, assertiveness training, delinquency prevention program, multi-systemic therapy, parent-child interaction therapy, parent training program, problem solving skills training, rational-emotive therapy, and time-out plus signal seat treatment.	EFFICIACIOUS

Executive Summary [continued]

Part II: The Views of Participants in the Foster Care Paradigm

Part II of the report contains a synthesis of information gathered from key informant interviews with professionals working with foster children, a focus group of foster parents, and the perspectives of foster youth as reported to the California Youth Connection. Key informants included representatives from public sector child welfare and mental health; drug and alcohol services; health; education; academia; private children's agencies and the State and County Departments of Mental Health and Social Services.

Child Welfare Staff Uniformly Identifies Key Issues

Child welfare managers interviewed agreed that there is high need for services for foster children often referred to as the "revolving door" children, who have chronically unstable placements. They also reported that foster parents need additional training and support services, and more foster parents are needed. In addition, they felt there are benefits to collaboration among disciplines but the high staff turnover in child welfare results in a reduced ability of the system to effectively serve children and their families. One of the areas of greatest need identified in the survey is for strategies and resources for working with aggressive and oppositional youth. A 1997 national survey of child welfare professionals by the National Technical Assistance Center for Children's Mental Health mirrored the findings of the interviews in this project. According to informants, collaboration among departments improves communication, increases knowledge and makes referrals more efficient than where there is no collaboration.

Service Delivery Staff Identify Barriers to Collaboration and Effective Services

The views of service professionals fell into three general categories – system barriers to treatment, mental health practice issues and training.

Among health and mental health professionals providing services to foster children, while collaboration is desirable, they see the need for increased training and understanding among and between child welfare and service delivery staff. Most of those interviewed felt that staff roles and responsibilities are often unclear when mental health staff and child welfare staff are working with the same children. Informants reported significant challenges in maintaining continuity of care for foster children, including children missing many appointments, moving from one placement to another without consultation or notification to the mental health provider, and children not continuing treatment after they are reunified with parents. Providers expressed a need for practice or evidence-based treatment guidelines and overwhelmingly agreed that foster youth should be treated as a specialized treatment group. Informants felt that juvenile court judges, mental health practitioners (both public and private sector), child welfare workers, administrators in child welfare and mental health, and foster parents could benefit from improved training opportunities.

Foster Parents Want More Involvement and Support

A focus group of foster parents conducted for this project found that foster parents want to be considered part of a team approach to meeting the needs of foster youth. Focus group participants felt that decisions are now often made on behalf of the children in their care, without their input or knowledge. They are

Executive Summary (continued)

seldom included in the mental health treatment plan for the child and have infrequent contact with the child's social service worker. In addition, they confirmed the need for more effective services, training and support in dealing with the more difficult children – those who are aggressive, destructive or hostile. Foster parents also felt that there are just not enough mental health resources for foster children – particularly child psychiatrists – and that requests for services or treatment were often delayed significantly.

Foster Youth Seek Better Information, Involvement and Creative Service Delivery

This report highlights the findings from multiple focus groups of foster youth for the June 2000 California Youth Connection report, entitled “Foster Youth Proposals to Improve Mental Health Services.” According to the youth participants, young people in foster care suffer from a lack of knowledge about mental health issues and services and feel that professionals in the mental health system do not solicit their input on treatment or services provided. Many youth reported that no one ever asked for their opinions regarding their own treatment preferences. In addition, youth reported that they often hide the fact that they are receiving mental health services or fail to request services because of negative perceptions of mental health within their peer groups. When asked to rank a variety of mental health services in order of importance, the top five choices included: individual counseling, mentor programs, family counseling, group counseling and mental health education programs.



Part III: Conclusions

Implications for Planning & Practice

Social Service and Mental Health Systems Coordination is Necessary to Support Service Improvement- At the system level, in local communities and at the state and federal level, policy makers, program administrators, practitioners and families need to more explicitly acknowledge the practice implications of disparate goals for mental health and child welfare; implement improved lines of communication and ongoing inter-disciplinary dialogue; and work toward agreement on compatible, complementary and realistic strategies to meet the total needs of foster youth. This report is in part intended to initiate, inform and encourage that dialogue.

Evidence Regarding Services and Foster Youth is Available That Can Help to Improve the Foster Care System- The evidence reviewed for this project revealed that the children least likely to exit the foster care system, either through reunification or adoption, are those with externalizing disorders and very young children with developmental delays. In addition, children who are aggressive, defiant and disruptive are more likely to experience placement instability than children without these problems. The empirical evidence is confirmed by the perceptions of staff working in child welfare, and foster parents, because they find children with externalizing disorders the most difficult to place and support. The treatment foster care model and the wraparound service model are the mental health treatment interventions that research reveals may prove beneficial with foster children who are disruptive, aggressive, and defiant and who experience unstable placements. This evidence should influence the foster care system design and the service and treatment choices being implemented by service professionals and families working with foster youth.

Executive Summary (continued)

Effective Practices from General Mental Health Research, for Those Conditions That Most Negatively Impact Foster Youth, are Valuable Resources- In addition to the therapeutic foster care and wraparound interventions mentioned above, the evidence supports outpatient mental health services targeted to the problems most frequently experienced by foster youth. The empirical literature describing the problems of foster children consistently characterizes them as having poor peer relationships, poor social competencies, and as being aggressive and disruptive. This is consistent with the experience of those working in the foster care system. These problems not only contribute to poor permanency outcomes but also lead to peer rejection and school failure, which in turn predict maladaptive outcomes in adolescence and adulthood. In treating these “conduct” problems, mental health practitioners have several options: two interventions proven to be effective and ten judged to be efficacious. In addition, the research is promising on foster care interventions for infants and preschoolers.

Recommendations

The information contained in this report strongly suggests that improvements in the quality and effectiveness of services to foster children will most likely result from providing treatment informed by evidence rather than by traditional, popular or familiar practices. In addition, the evidence overwhelmingly speaks to the need to recognize foster children as a specialized population with unique and distinctive problems and needs. The following guidelines are offered as first steps to improving outcomes for this vulnerable population of children and youth.

Treatment Should Have an Evidence Base- Generally speaking, most studies on the effectiveness of outpatient interventions support behavioral and cognitive behavioral therapy over non-behavioral therapies.

Additionally, research on the effectiveness of specific community based services supports the use of intensive case management including wraparound, therapeutic foster care and home-based interventions such as multisystemic therapy. Finally, while hospitalization, residential treatment and group homes are common treatments for children and youth with complex emotional and behavioral disorders, the evidence on these treatments consistently fail to show long term positive effects.

Focus on Common Problems- Foster children should be provided services to address the problems of aggression, peer rejection, defiance and poor school behavior. Not only does the literature indicate that these are the most common mental health problems of foster children, but they are also the same problems that, if left untreated, will diminish the likelihood of children achieving a stable home setting.

Use Caution in Diagnosing and Treating Foster Children- A primary goal of this report is to emphasize the evidence and the research as a way to refine current methods of treating foster children with behavioral and mental health problems. In two areas in particular – attachment disorders and posttraumatic stress disorder – the research strongly suggests that conventional wisdom and common practice may be in conflict with the evidence.

Specialized Training

There are three key groups for whom training should be provided in order to improve the quality of services provided to children in foster care: juvenile court judges; direct service and administrative staff in child welfare, health and mental health agencies; and foster parents.

Executive Summary [continued]

• **Judges Must Have Access to Information About Children’s Mental Health Problems and Appropriate Treatments for Foster Children-** Mental health service providers interviewed for this report consistently expressed concerns with the juvenile court orders regarding medications, psychosocial interventions or placements. Examples given included: judges requiring individual therapy when group interventions might be just as successful; and judges reducing medication dosage, eliminating medication or prohibiting physicians from initiating medications, particularly in younger children. In addition, judges may order costly and higher levels of services when less intrusive interventions might be effective, including moving a child to residential placement before treatment foster care or outpatient treatment is attempted. Judges should be presented with training opportunities on effective interventions for the problems most commonly seen in foster children through existing peer and educational forums.

• **Administrators and Direct Service Staff Need Training to Understand Systems and Services-** Training for direct service staff and administrators should include information to help in assessing problems and information on the resources available. Particular attention needs to be paid to the assessment of young children, children of color, children who are victims of child neglect, children who have been exposed to community and domestic violence and children whose placements are disrupted. Professionals involved in serving foster children need better information on the mental health and child welfare service systems. Mental health professionals working with children in foster care should understand the goals of the child welfare system, the role of the juvenile court, the time frames for court review and the criteria for various kinds of child welfare services, including family reunification, family maintenance and permanency planning. Child welfare professionals should have knowledge about

Wraparound and Therapeutic Foster Care: Evidence, Advantages & Opportunities

- § First and foremost, both programs meet the criteria for effective intervention, and the evidence suggests that, if implemented as intended, foster youth will benefit.
- § The programs promote the child welfare system goals of permanency and placement stability, helping to ensure that mental health and child welfare professionals share the same outcome goals for children in foster care.
- § They are consistent with system of care principles (e.g., establishing parents as partners, being sensitive to a child’s culture and providing treatment in the least restrictive environment possible).
- § In addition to increasing placement stability and improving child behavior, the parent-mediated foster care intervention has the potential to increase foster parent retention. Past research with the model has demonstrated increases in foster parent competencies and decreases in foster parent stress, which may lead to greater satisfaction with their role and fewer dropouts from the foster parent ranks.
- § Neither intervention is heavily dependent upon professional staff, which is important given the critical staffing shortages in child welfare and (increasingly) in the mental health service system.
- § Legislation passed in 1997 authorized the use of foster care group home funds to support pilot projects in wraparound services, creating the opportunity to implement the wraparound service as a proven method of treatment.
- § These interventions are amenable to transfer to a variety of service systems, because they provide both tools and training to help ensure effective implementation.

Executive Summary [continued]

mental health system of care values, and policies and practices employed in mental health services. Training should include information on the respective roles and responsibilities of staff providing intervention services to foster children in each service system. Staff providing interventions to foster children, and the caretakers of foster children, need extensive training in evidence-based models so that they can deliver the most effective services available.

- **Foster Parents Need Training Too-** Finally, foster parents should be provided training that helps them to manage the aggressive and disruptive behaviors that often lead to placement breakdown.

Conduct More Focused Research- This report highlights the general lack of evidence and research to support and explain the mental health problems and the appropriate interventions for foster children. Moreover, there is no information on either effective preventive interventions or ameliorative interventions. Clearly, this entire field requires at the very least, descriptive and exploratory research. Specifically, there is a pressing need for research that acknowledges foster children as a distinct and specialized population requiring individualized management and treatment.

Evaluate Evidence-Based Interventions in Community Context- The information collected for this report suggests that evidence-based treatments are not always selected in the everyday practice of working with children. One approach to solving this problem is to “transport” evidence-based treatments into community service delivery systems. Treatment manuals and practice guidelines may help to ensure effective implementation of evidence-based treatments. In addition, local mental health agencies could partner with social work and psychology departments in universities to help evaluate the effectiveness of evidence-based, manualized

treatments, more directly within the context of community service delivery systems.

Provide Services to Children in Need Regardless of the Form of Abuse- There is no research evidence to suggest that any one type of child maltreatment has more negative effects than any other. Children should be referred based upon the frequency, duration and chronicity of symptoms. It may be just as likely that a child who witnesses domestic violence will experience untoward consequences as it is for a child who experiences sexual abuse.

Address Cultural, Ethnic and Gender Disparities- While the evidence regarding racial, ethnic and gender variation in mental health service use by children in foster care is equivocal, it does raise concerns about equal access to and utilization of services by all foster children with mental health problems. All parties to the foster care system must work to ensure that there is no systematic bias in the referral process. In addition, child welfare and mental health staff will likely need to increase their outreach efforts to this population, and actively address cultural differences among families regarding their willingness to accept external help and support for “family problems.” As always, treatment must be designed to fit the needs of the clients, rather than clients having to fit the needs of treatment providers.

Involve Foster Parents, and Family When Appropriate, as Active Partners- Treatments for foster children must include foster parents, and when appropriate families, as partners. Foster care remains the primary resource for children in need of out-of-home care. If it is to be an effective intervention for children, foster parents need support and training to ensure that they are able to provide quality care to the children placed with them. They need to be seen as primary interventionists rather than custodial caretakers. In addition, when foster parents are

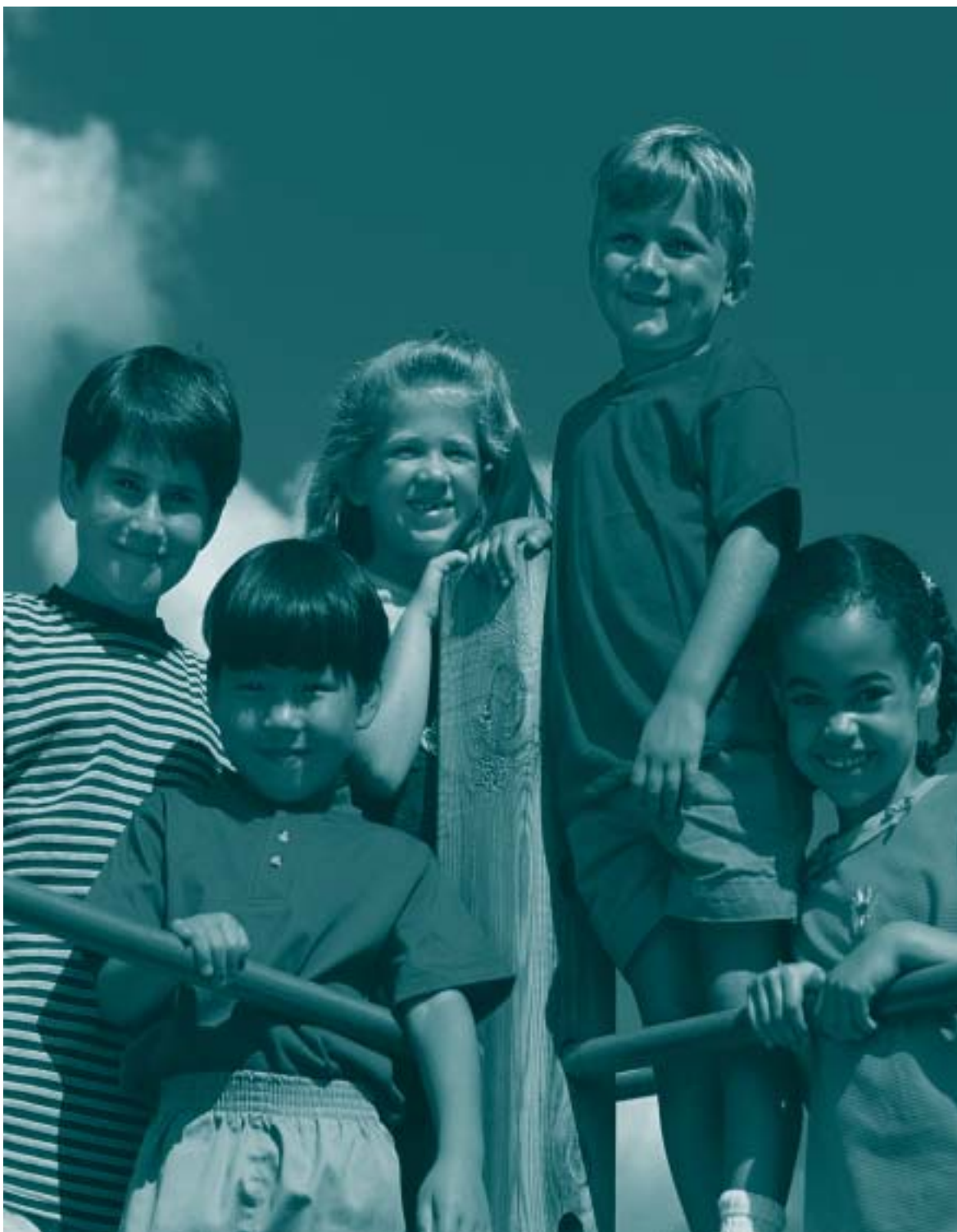
Executive Summary [continued]

provided with the skills and support to manage the difficult behaviors of the children in care, not only do children improve, but also foster parent stress is lower and satisfaction is higher. Lastly, many effective interventions used by foster parents should be provided through families that are involved with their children who are in foster care as well.

Involve Foster Youth in Their Own Treatment-

Professionals and practitioners providing services and direction to youth in foster care must increasingly empower youth to participate in and help to influence the services and treatments they receive. Youth in foster care whose opinions are highlighted in this report clearly feel that mental health professionals do not solicit their input on treatment or services provided and many reported that no one ever asked for their opinions regarding treatment preferences. Current and former foster youths participating in the focus groups had good and clear ideas on services and treatments that will make the greatest impact in their lives and recovery. Systems serving youth should rely on and build on their innate good sense and experience with services in developing effective models to improve the lives, health and mental health of children in the foster youth system.

Foster children are clearly a vulnerable population of children who demonstrate higher rates of psychopathology than do children in the general population. They are disproportionately poor, lag behind in school, and have suffered the pernicious effects of having lived in chaotic, often violent, family and community environments. Intervention should be provided to alleviate their suffering, restore their hope, and prevent maladaptive outcomes in adulthood. These goals are best accomplished by ensuring that foster children receive interventions and treatments with demonstrated effectiveness.



Introduction

As one component of the California Institute for Mental Health (CIMH) project, Meeting the Needs of Foster Youth, Evidence-Based Practices in Mental Health Services for Foster Youth reports and examines the relevant literature, and considers this information in the context of the California foster care environment as described through key informant interviews. The report is designed to initiate and inform interdisciplinary dialogue between mental health and child welfare administrators and practitioners, researchers, the judiciary, families and foster youth.

The goals of the report are: (1) to highlight the available social science evidence on mental health services for foster children, from which service systems models can be developed; (2) to encourage the integration of known research into the planning, development and delivery of mental health services to children in foster care; (3) to dispel some of the prevailing myths and misperceptions about the mental health needs and best treatment options for children in foster care; and (4) outline some of the implications of this information and offer recommendations designed to improve the delivery of mental health services to foster children.

Part I begins with a review of the literature related to the mental health needs of foster children and their current mental health service use. The last three sections of the literature describe what is currently known about effective treatments specifically tailored for foster children, treatments designed to treat the consequences of child abuse and neglect *and* treatments for specific childhood mental disorders most common in foster youth. Since the most common mental health problems experienced by children in foster care are also experienced by children not in foster care settings, and since there is limited research on interventions specifically designed for foster children, the report incorporates the broader research on mental

health interventions with abused children and children generally.

Part II focuses on interviews with key informants responsible for ensuring quality services for foster children. The purpose of these interviews was to determine how information from the mental health services and intervention literatures could be beneficial in helping administrators, policy makers, practitioners and advocates plan and implement effective services for foster children. The format of the interviews was informal and allowed participants wide latitude in identifying the mental health needs of foster children and the gaps in services they confront.

Part III outlines the practice implications that can be drawn from the first two sections of the report. This section focuses on targeting the common problems experienced by foster children, through utilization of evidence-based treatments to promote permanence for children in care. This approach was chosen not only because it has the potential to improve outcomes for children, but also because it is consistent with the goals of both the child welfare and mental health service systems. Part III also includes specific recommendations intended to maximize service effectiveness in an environment characterized by increasing need and decreasing resources.

Part I: Review of the Literature

Methodology

Since the scientific literature on evidence-based mental health treatment for foster children is sparse, this project explored related topics in order to produce a more comprehensive overview. The first section highlights evidence on the prevalence of emotional, behavioral, and developmental problems of foster children and information on their current use of mental health services. The last four sections describe what is currently known about effective treatments specifically tailored for foster children, treatments designed to treat the consequences of child abuse and neglect *and* treatments for specific childhood mental disorders.

The following databases were searched for the years 1980 through 2000: psychinfo, sociofile, medline and social work abstracts. In addition, the following web sites were reviewed: Center for Effective Collaboration and Practice, Georgetown University Child Development Center, and the Research and Training Center for Children's Mental Health at the University of South Florida. Finally, the author consulted with John Landsverk at the Child and Adolescent Services Research Center in San Diego and with Devon Brooks and Jacquelyn McCroskey, both of whom are faculty in the School of Social Work at the University of Southern California.

Definitions- For the purposes of this review, **foster care** includes: *kinship care, non-relative foster care, group home, residential treatment and (in some cases) placement in a psychiatric hospital.* The term **children**, is used to refer to the *age period from early childhood through adolescence*, except where there is need to draw a distinction between children and adolescents.

Profile of California Foster Youth

Over the last two decades, there has been a 60 percent increase in the number of children entering the foster care system nationally (Barbell, 1997). The emerging research suggests that the increase is due to the growing number of neglect cases resulting from parental drug and alcohol abuse and to the impact of poverty, homelessness, AIDS, and domestic violence on at-risk families (Barbell, 1997). California has the largest child welfare system in the country. Of the nearly one-half million children estimated to be in out-of-home care nationwide, one in five is a dependent of the California child welfare system (Administration for Children and Families, 1996). In California, the number of children in out-of-home placement increased from 56,957 in 1994 to 87,387 in 1998, a 30 percent increase (Needell, Webster, Barth, Monks, and Armijo, 1995). According to the Office of the Legislative Analyst (LAO), 2000-2001 Analysis of the Budget, from 1989 to 1999 the foster care caseload increased 70 percent. The LAO reported that a portion of the increase resulted from an increase in the number of children entering foster care, but the majority of the increase was because children are remaining in foster care longer.

In addition, a growing number of children entering the child welfare system do so because of general or severe neglect, much of which is related to parental substance abuse (Needell, Webster, Cuccaro-Alamin, Lee and Brookhart, 2000). In 1997, about 75 percent of children entering foster care in California were removed from their homes due to neglect.

The age profile of children in foster care has also changed. The increase in the prevalence of substance abuse in society in general, and child welfare populations in particular, accounts for growing numbers of children aged 0 to 5 entering foster care (Needell, et al., 1998). According to

Part I: Review of the Literature (continued)

the Department of Social Services Foster Care Information System, in 1983, the average age of children in foster care was 10 years 2 months. By 1990, the average age decreased to 8 years, 3 months and has remained relatively constant at that level. By 1997, 33 percent of the children in out-of-home care in California were aged 0 to 5.

Over the last two decades, the ethnicity of foster care children has shifted so that, in 2000, children of color accounted for 70 percent of California's foster care caseload, up from 54 percent in 1983. In 2000, African American children accounted for 36 percent and Hispanic children for 31 percent of children in care.

Thus, California's current foster care population is predominantly young (33 percent infants and toddlers and 41 percent 6-12 years), predominantly members of an ethnic minority group and more likely to be a victim of child neglect.

Incidence of Mental Health Problems Among Children in Foster Care

Children entering the foster care system are at risk for significant emotional and behavioral problems for several reasons. First, entry into the child welfare system is occasioned by family breakdown resulting from abuse, neglect or both. Second, children suffer disruptions in their relationships when they are separated from family, friends and teachers to enter foster care. Third, children who suffer the chronic stresses of living in poverty are over-represented in child welfare populations (Franck, 1996).

In addition, since multiple foster placements are common and the length of placement is often indeterminate, the foster care experience itself may actually exacerbate emotional and behavioral problems (McIntyre and Kessler, 1986). Finally, the federal Adoption Assistance and Child Welfare

Act of 1980 mandated increased efforts to maintain children in their own homes. Consequently, many children entering foster care do so only after the failure of other services, and hence suffer more physical, developmental and psychological problems than their non-maltreated peers (Chernoff, Combs-Orme, Risley-Curtis, and Heisler, 1994).

The literature reveals that anywhere from 35 to 85 percent of children entering foster care have significant mental health problems, depending on the sample type and the instrument used to measure emotional and behavioral problems. Significantly, the incidence of emotional, behavioral and developmental problems, (including depression, conduct disorders, difficulties in school and impaired social relationships) among children in foster care is *three to six times greater* than children in the community. This finding holds true even when foster children are compared to children in the community who have known similar kinds of deprivation.¹

Pilowsky (1995) found that externalizing disorders were more common than internalizing disorders. *Externalizing disorders* create difficulty for the child's external world. They are characterized by children's failure to control their behavior to meet the expectations of adults, peers, teachers and/or legal authorities. These disorders are characterized by noncompliance, aggression, destructiveness, attention problems, impulsivity, hyperactivity and delinquent behaviors. *Internalizing disorders* are psychological problems that have a greater impact on the child's internal world. In childhood and adolescence, these disorders manifest as anxiety, fear, low self-esteem, sadness and depression.

Developmental assessments of young children ages 2 to 5 years entering foster care find prevalence rates for developmental delay between 49 percent

¹ *This finding holds true in multiple studies. See Clausen, Landsverk, Ganger, Chadwick, and Litrownik, 1998; Halfon, Mendoca, and Berkowitz, 1995; Pilowsky, 1995; Simms, 1989, and Urquiza, Wirz, Peterson and Singer, 1994.*

Part I: Review of the Literature (continued)

and 61 percent.² The results of developmental evaluations showed that delays in language were the most frequent problem, followed by delays in cognitive and gross motor domains. The relatively high rate of developmental delays in young children entering foster care is striking when compared to prevalence figures of 3 percent to 18 percent found among children in the general population (Klee, Kronstadt, and Zlotnick, 1997).

Posttraumatic Stress and Attachment Disorders

Discussions with mental health professionals, review of the practice literature, and the numerous advertisements practitioners receive for continuing education classes suggest that both posttraumatic stress and attachment disorder are considered to be increasingly common disorders in the foster care population. The research literature for these disorders for children in foster care is very limited and the findings suggest caution be used in both diagnosis and treatment. Each diagnosis is considered separately below.

Posttraumatic Stress Disorder- Studies examining the prevalence of posttraumatic stress disorder (PTSD) among sexually abused children report contradictory findings, with figures ranging from 0 prevalence to 90 percent (Dubner and Motta, 1999). Some studies suggest that more than 50 percent of sexually abused children meet partial or full criteria for PTSD.³ The variability in the findings may be a function of different samples, characteristics of the service system, characteristics of the children, the lack of standardized measures or varying accuracy of abuse reports.

Dubner and Motta examined the relationship between sexual abuse and PTSD for a group of

children placed in foster care. The researchers compared physically abused and non-abused foster children to sexually abused children. They found that PTSD was diagnosed in 60 percent of the sexually abused children and 42 percent of the physically abused children. In addition, 18 percent of children who had not been abused were diagnosed with PTSD. One possible explanation of this finding of PTSD in foster care children who had not been abused, is that children in foster care generally may have experienced multiple traumas, including witnessing both domestic violence and community violence, prior to foster placement.

The study found both gender and age differences in the prevalence of PTSD. Girls and preadolescents (8-12 year olds) were more likely to be diagnosed with PTSD than were boys and all youth from 13 to 19. Finally, there appeared to be no relationship between intensity of PTSD symptoms and the severity and duration of the abuse.

Although this is the only study available specifically examining PTSD in foster children, the findings suggest that PTSD may be more common in some foster children — beyond those who have been sexually abused — than previous research indicated. The study findings also challenge typical notions that PTSD is common in sexually abused children, but not necessarily among children who have been victims of others forms of maltreatment. Finally, the findings also indicate that children who have suffered any forms of child maltreatment, including exposure to domestic or community violence, should be assessed for PTSD. Given the relatively small sample size in this carefully designed study, and the potential significance of the findings, more research is needed to better understand PTSD among subgroups of foster children.

² *For sampling of works with this finding, see Halfon, Mendonca, and Berkowitz, 1995; Horowitz, Simms, and Farrington, 1994; Klee, Krinstadt, and Zlotnick, 1997; Silver, DiLorenzo, Zukoski, Ross, Amster, and Schlegel, 1999, and Simms, 1989.*

³ *See McLeer, Deblinger, Atkins, Foa, and Raphe, 1998; and McLeer, Deblinger, Henry, Orvashel, 1992.*

Part I: Review of the Literature (continued)

Reactive Attachment Disorder- In recent years there has been an increase in the use of Reactive Attachment Disorder (RAD) diagnosis to describe a variety of emotional and behavioral problems exhibited by infants and young children. Attachment theories, and the RAD diagnosis, are based upon the assumption that early development is experience-dependent. The theory holds that subsequent behavior grows out of the child's earliest experiences with parents. If a child's parents were neglectful, abusive, and/or inconsistent in responding to a child's needs, the child develops a "survival strategy" for dealing with his environment. Depending upon particular early life experiences, according to this theory, infants with "attachment problems" adapt to their environments by becoming withdrawn, hostile, mistrustful and/or nonresponsive to the adults in their world. These behavioral adaptations tend to become stable over time and persistent in new interpersonal situations (for example, with the foster mother). Basically, children continue the behavior patterns they developed as a response to their earliest interactions with parents.

Children with a history of maltreatment are the most likely to receive the RAD diagnosis, because their behavior problems are presumed to be the result of maladaptive relationships with caretakers. It is very important that clinicians learn to recognize, accurately diagnose and treat attachment problems. The research shows that negative attachment styles (how children relate to adults), typically referred to as "insecure" or "disorganized" attachment, appear to be risk factors for the development of relationship psychopathology in later childhood (Boris and Zeanah, 1998). Further, there is evidence suggesting insecure and disorganized attachments are commonly found among infants and toddlers with a history of maltreatment (Trickett and McBride-Chang, 1995).

There are, however, major barriers to the accurate diagnosis and treatment of RAD. We currently know little about the epidemiology or the etiology of the disorder.⁴ Diagnosis and treatment are complicated by the presence of the frequently occurring co-morbid conditions, such as health, mental health and developmental problems requiring assessment and treatment. In addition, psychopathology and/or substance abuse in the parent may worsen the attachment difficulties in the child, and little is known about how to effectively address these problems.

However, the Reactive Attachment Disorder diagnosis has been seized upon by a particular therapeutic industry, often referred to as the "rage reduction," "holding" or "rebirthing" practitioners. These practitioners have used the RAD diagnosis with older children — those with a variety of problems in interpersonal relationships and of self-regulation (mood, anxiety, attention, behavioral impulses), as well as children who have been exposed to poor parenting for prolonged periods of time. Further, practitioners of these treatments assume that RAD as a diagnosable mental disorder survives infancy. While it may be true that relationship problems persist into later childhood and adolescence, the diagnosis does not. It is more likely that Reactive Attachment Disorder in infancy is implicated in the development of mood and conduct disorders in later childhood.

None of the treatments currently being prescribed for older children with attachment problems have been subjected to rigorous scientific testing for either safety or effectiveness. Moreover, some of these treatments are costly and potentially dangerous to the child. For example, treatments that advocate physical containment of children for prolonged periods of time may have disastrous results for children ("Seeking"). On the other

⁴ For more thorough review of the evidence related to Reactive Attachment Disorder and the findings discussed here, see Hanson and Spratt, 2000.

Part I: Review of the Literature (continued)

hand, there are safe and effective treatments for children with mood and conduct disorders where difficulty in interpersonal relationships is often predominant symptom.

There is very early research on the relationship between child maltreatment, quality of attachment, and later adjustment. One such study examined the potentially curative effects of foster care for a group of school-aged children placed because of parental neglect and/or abuse. Milan and Pinderhughes (2000) were interested in the influence of children's internal images, self-image and maternal images, on subsequent relationships with foster mothers and on their behavioral adjustment in foster care. Investigators found that representations of self, biological mother and foster mother were correlated. In general, children who had more positive images of themselves and their biological mothers tended to view their relationships with their foster mothers as affectively positive. In fact, the majority of children in this study had positive representations of self and biological mother.

In addition, the severity of maltreatment experienced by the child was significantly related to the child's emotional relationship with the biological parent. Children with severe maltreatment histories reported feeling less positive affect in the company of their mothers. In turn, the children's emotional relationships with their biological mothers essentially determined their relationship with the foster mother.

Finally, different underlying mechanisms were found to account for internalizing and externalizing problems. Both the severity of maltreatment *and* perceptions of self contributed to the extent of internalizing behavior exhibited by the children in this sample. In contrast, maltreatment severity and perceptions of self and biological mother at entry into care were not related significantly to externalizing behavior. This

study suggests that while attachment theory may help explain the underlying mechanisms sustaining some internalizing problems, the same cannot be said for externalizing problems. Attachment theory does not seem to offer a good explanatory framework for understanding disruptive behaviors in children.

Common Problems Experienced by Children in Foster Care

There is relatively little research directly focused on the mental health needs and mental health treatment of children in foster care. To further build toward an analysis of the mental health needs of foster children, this section examines the literature on common problems children experience while in foster care.

Placement Instability and Permanency Outcomes

Placement instability and poor permanency outcomes appear, in large part, to be the consequence of a related constellation of problems common among foster children who are the victims of child maltreatment. There is a small, but consistent body of evidence suggesting that children in foster care who have emotional and behavioral problems have a reduced likelihood of reunification and/or adoption. Other factors associated with reduced likelihood of exiting the child welfare system are: being older, being a victim of sexual abuse, living in a rural area, and being non-white (Horowitz, et al., 1994, and Glisson, et al., 2000).

Foster children with problems in psychosocial functioning (as measured by the CBCL) were significantly less likely than foster children without these problems to be reunified with family and/or adopted (Landsverk, Davis, Ganger, Newton, and Johnson, 1996). These children are typically also in the child welfare system longer (Glisson, et al., 2000).

Part I: Review of the Literature (continued)

Children with externalizing disorders have the lowest probability of exiting care either through adoption or reunification (Landsverk, et al., 1996, and Glisson, et al., 2000). The research also shows that these children experience greater placement instability. One study examining the relationship between problem behaviors and number of placements found that baseline externalizing behaviors (as measured by the CBCL upon entry to the foster care system), proved to be the strongest predictor of placement changes for all children in the sample (Newton, Litrownik, and Landsverk, 2000). Children who are disruptive, aggressive and defiant are more likely than children without these behaviors to be moved to another placement.

However, the findings also suggest a relationship between placement moves and *later* internalizing and externalizing problems. For children rated as *not* evidencing behavioral and emotional problems upon entry into foster care, *and* who experienced more than four placements (which was the median for this particular sample), number of placements consistently predicted subsequent internalizing *and* externalizing problems. The evidence may suggest that placement disruption actually increases the likelihood that some children will experience behavioral and emotional problems as a direct consequence. Further research is needed to determine the causal or predictive relationship between placement disruption and subsequent problems.

The literature reveals that specific types of children are the least likely to exit foster care, including:

- § Young children with developmental delays (Horowitz, Simms, and Farrington, 1994);
- § Children with emotional and behavioral problems – especially children with

externalizing disorders (Landsverk, et al., 1996 and Glisson, et al, 2000);

- § Older children, 12 years old and above (Horowitz, et al., 1994); and
- § Non-white children (Glisson et al, 2000).

Disruptive Behaviors, Peer Relationships and School Problems- Peer problems, aggression, disruptive behavior, academic skill delays and school failure are among the most consistent research findings on the relationship between child maltreatment and psychopathology. Children who have been abused and/or neglected evidence poor peer relationships, disruptive behavior, and aggression. In addition, maltreated children evidence more school problems, including maladaptive behavior, poor standardized test scores, and frequent grade retention. In terms of school outcomes, neglected children appear to fare the worst. Research has also shown high levels of Attention Deficit Hyperactivity Disorder among sexually abused and physically abused children and among children who have experienced multiple forms of abuse (Trickett and McBride-Chang, 1995). Recent research confirms that children in foster care experience many of the same disruptive and behavioral problems as abused and maltreated children generally.

As one example, Zima and her colleagues (2000) in Los Angeles found evidence of behavior problems, academic skill delays and school failure among foster children. Overall, 69 percent of school age foster children in their sample evidenced a behavior problem, academic skill delay or school failure; 34 percent were rated by teachers as having at least one behavior problem in the classroom; 23 percent had a severe delay in either math or reading; 13 percent had repeated a grade; and 14 percent had either been suspended or expelled.

Part I: Review of the Literature (continued)

The study found that 27 percent of the foster children in the sample scored within the clinical range of the CBCL. Foster children who scored in the clinical range of the CBCL for internalizing, externalizing and total behavior problems were significantly more likely to have been suspended or expelled than children who did not score in the clinical range.

Type of foster care placement was also shown to be predictive of the incidence of behavioral and school problems. Children living in therapeutic foster care were three times more likely to be rated by their foster parent as having a clinical behavior problem than children living in either kinship or family foster care. Children living in group homes were three times more likely to repeat at least one grade than children living in kinship or family foster care. Children living in foster care for longer periods of time were also significantly more likely to have been suspended or expelled from school. Further, foster care placement instability was significantly related to academic skill delays.

Kinard (1999) explored the relationship between child maltreatment and children's perceptions of their own social skills and social competencies. The study explored three issues: a) the effect child maltreatment has on children's social skills and social competence, b) whether social support from peers affects these skills and competencies, and c) to what extent these effects change over time. Kinard concluded that children's perceptions of their social skills and competencies were not affected by having been maltreated, nor did their perceptions change over time. However, peer support was most predictive of children's views of their own social skills and social competencies. In addition, maltreated children had more impoverished social networks than children who had not been maltreated. In fact, maltreated children in this study were three times more likely than non-maltreated children to have no close friends. Maltreated children were also

more likely to score within the clinical range of the CBCL. Children who were reported to have no friends scored within the clinical ranges of measures on both internalizing and externalizing disorders. Price and Brew (1998) reviewed the research literature on foster children's peer relationships and concluded findings from the literature suggest that foster children display behavioral patterns that have been previously found to undermine children's relationships with peers, that foster children differ from other children in the quality of their peer relationships and that poor peer relationships are sometimes correlated with poor psychosocial and mental health outcomes (Price, J.M., & Brew, B. 1998).

Findings from the studies reviewed in this section are consistent with the research on the developmental consequences of child maltreatment. Findings related to the importance of peer support are consistent with the child development literature, showing that peer rejection in childhood is a powerful predictor of maladaptive outcomes in adolescence and adulthood (Parker, Rubin, Price and DeRosier, 1995).

Mental Health Service Use by Children in Foster Care

Research reveals that mental health service utilization by children in foster care is high relative to other children, and varies among foster care children depending on factors such as age, gender, ethnicity and type of placement. Predictors of higher mental health service use among foster children include age (being older); gender (being male); placement in non-relative foster care; being removed from the home for physical or sexual abuse; and race/ethnicity (Caucasians).

One of the few studies specifically focusing on mental health service utilization by foster children in California analyzed 1988 claims data

Part I: Review of the Literature (continued)

from the Medi-Cal fee-for-service program (Halfon, Berkowitz, and Klee, 1992). The authors found that while foster children represented only 4 percent of children on Medi-Cal, they represented 41 percent of mental health service users. In addition, foster children were twenty times more likely to use outpatient services and nine times more likely to be hospitalized for mental health problems than Medi-Cal children not in foster care.

A team of researchers affiliated with the Child and Adolescent Services Research Center in San Diego found that mental health service use by children in foster care increases with age. In this study, the data revealed that 70 percent of foster care children aged 7 through adolescence were utilizing mental health services. In addition, they found that children with multiple episodes of mental health service usage tend to be older and in more restrictive placements than those with only single episode use. Moreover, older children in foster care tended to utilize services at all levels of care and disruptive behavior disorders were the most commonly occurring diagnoses (Blumberg, Landsverk, Ellis-MacLeod, Ganger, and Culver, 1996).

Three additional studies examined data from the same large sample of San Diego foster children and identified possible predictors of mental health service use in foster care children. These studies found that children with higher levels of behavioral problems, as measured by the Child Behavior Checklist (CBCL),⁵ had higher mental health services use.⁶ Children removed from their homes for sexual and physical abuse were more likely to receive mental health services than

children who had not experienced sexual or physical abuse (Garland, et al., 1996). In addition, children who experienced caretaker absence (as a reason for entry into the child welfare system) received fewer services than those with different presenting issues (Leslie, et al., 2000).

Researchers have consistently found differences in mental health service use by race/ethnicity. San Diego researchers found that mental health service utilization by foster children is high overall and varies significantly by race/ethnicity (Garland, Hough, Landsverk, McCabe, Yeh, Ganger and Reynolds, 2000). Garland and colleagues examined a sample of foster care children, controlling for age, severity of behavior problems, and type of maltreatment (all factors correlated to higher service use in previous research). The study revealed that Caucasian youth were significantly more likely to receive mental health services than African American and Latino youth. In addition, the study highlighted ethnic differences, depending on problem severity. Researchers divided problem severity into high, moderate and low based on CBCL total scores. They found that when problem severity was high, Caucasians and African Americans were equally likely to receive services. However, Caucasians had the greatest likelihood of receiving services even when problem severity was low. Latino service use was low across all problem severity categories — low, medium, or high.

Cantos, Gries and Silas (1996) found significant differences in the profile of foster children who had been referred for mental health treatment when compared to those who were not referred for treatment while in foster care. Referred

⁵ *The CBCL includes a 118-item behavior problem scale. Children's symptoms are assessed on a continuum, producing a total problem score, two broadband syndrome scores (internalizing and externalizing), and eight narrow-band syndrome scores (withdrawn, somatic complaints, anxious/depressed, social problems, thought problems, attention problems, aggressive problems, delinquent problems). Scores are generated based on the total in each category - the higher the score the more severe a child's problems. Scores above 70 are in the clinical range, which means a child's problems are severe enough to warrant therapeutic intervention.*

⁶ *See Garland, Landsverk, Hough, and Ellis-MacLeod, 1996 and Leslie, Landverk, Ezzet-Lofstrom, Tschann, Slymen, and Garland, 2000.*

Part I: Review of the Literature (continued)

children had more internalizing and externalizing problems, had been placed in foster care at older ages and were typically in non-relative foster care.

Medication Use- The only study to report psychotropic medication treatment patterns for children in foster care was carried out by Zima and her colleagues at UCLA (Zima, Bussing, Crelius, Kaufman, and Berlin, 1999). Their study reviewed psychotropic medication use among a sample of 6 to 12 year old children in foster care in Los Angeles County. The analysis revealed that 16 percent of the sample had taken medication during their lifetime, with stimulants the most common class of medication used in the previous year. The highest predictors of medication use in the previous year were being older, being Caucasian or biracial, and having lived in a group home. In addition, the study found that neither severity of the psychiatric disorder, nor placement instability, were predictive of psychotropic medication use.

Among children in foster care clinically diagnosed with a severe psychiatric disorder, for which medication is a standard component of care, boys were more likely than girls to receive medication. In other words, boys in the sample received more adequate care than girls, at least with regard to utilization of medication. Researchers suggested that one explanation for the difference could be that Attention Deficit Disorder with Hyperactivity was the most commonly occurring diagnosis in this sample and there is a greater prevalence rate of the disorder in boys.

In summary, these studies demonstrate high rates of mental health service use across all age groups of foster children, with the highest rate reported at 70 percent for children over seven in one San Diego sample. Additionally, children who are older, male, more disturbed and have been placed in non-relative foster care are the most likely to receive mental health services.

Further, ethnic minority foster children receive mental health services less frequently than do Caucasian foster children.

Evidence-Based Treatment for Foster Children

The field of psychosocial treatment for children and adolescents is still in its early development. However, in the last two decades research has been growing, methodologies have improved and public awareness concerning children's mental health issues has increased. The next section of the paper will deal with psychosocial treatments that have strong empirical support, referred to as "evidence-based" treatments. In order for treatments to be included in this section of the report, they must be consistent with the characteristics for the evidence-based, guidelines developed by the National Institute of Mental Health, highlighted in the Surgeon General's report on Mental Health (U.S. Department of Health and Human Services, Surgeon General's Report, 1999) and outlined by Burns (2000):

- § At least two control group design studies or a large series of single-case design studies;
- § Minimum of two investigators;
- § Use of a treatment manual;
- § Uniform therapist training and adherence;
- § True clinical samples of youth;
- § Tests of clinical significance of outcomes applied;
- § Both functioning and symptom outcomes reviewed; and
- § Long-term outcomes beyond termination.

Part I: Review of the Literature (continued)

Efficacious treatments are those that have beneficial effects when delivered under carefully controlled conditions designed for experimentation. The investigators exert considerable control of selection of study participants, delivery of the intervention, and the setting in which the intervention takes place.

Effective (or well-established) treatments are those that have beneficial effects when delivered to heterogeneous samples of clinically referred individuals treated in clinical settings by clinicians other than researchers.

Table I highlights the treatments for foster youth that meet the criteria outlined here.

Intervention Models for Foster Children

To date, there are only two intervention models that have demonstrated effectiveness for the treatment of foster children. One is a service strategy — “Wraparound”— and the other is therapeutic foster care intervention. Both are described in detail below.

Wraparound- Hewitt Clark and his associates (1995 and 1996) at the University of South Florida developed the Fostering Individualized Assistance Program (FIAP) to provide individualized wraparound supports and services to foster children with emotional/behavioral disturbance (EBD) and their families (biological, adoptive, and foster). The primary program goal was to improve permanency outcomes for foster children. The children served in the FIAP were the most challenging 10 percent of children within the foster care system. The children in this study were between 7 and 12 years old, had been in out-of-home placement an average of 2.6 years and had an average of four placement changes prior to entering the FIAP study.

There are four clinical components to the FIAP intervention: 1) strength-based child and family

assessment to address individualized needs; 2) life domain area service planning to support and enhance permanency plans; 3) clinical case management of individualized, wraparound service plans, and 4) follow-along supports and services to maintain permanency and improve overall adjustment.⁷

The clinical components of the program are administered by the FIAP case management group, consisting of four family specialists (FS) and a clinical supervisor. The FSs serve as family-centered clinical case managers and in-home counselors, collaborating with parents and other service providers. The FSs follow and serve children across all service settings – “wrapping” services around them as needed.

FIAP researchers recommend specific strength-based intervention and assessment strategies. Strength-based assessment is based on reviewing all available child and family reports *and* on direct observations. The first phase of the intervention is life domain service planning, including a review of the child’s permanency plan. Life domain service planning considers any and all participants in a child’s life (e.g., teachers, ministers, service providers, extended family, biological parents, foster parents). After completing the life domain service plan, the wraparound team meets to develop an integrated, collaborative service plan. Some of the specific services employed in the project include family systems therapy, tutors, behavior specialists, vocational training for parents, child abuse counseling, grief counseling and the use of flexible funds to secure other needed services or supports (Burns and Goldman, 1999).

The entire team meets, reaches a consensus and makes a commitment to any goals that are set, working toward an appropriate permanency placement plan. After the permanency goal is determined, the remainder of the meeting is spent

⁷ For a detailed description of this model see McDonald, Boyd, Clark, and Stewart, 1995.

Part I: Review of the Literature (continued)

Table I

Evidence – Based Strategies for Working with Foster Children			
Program or Treatment	Program Description	Target Population	Research Status
Wraparound	A family-focused, strengths-based program where intensive and comprehensive social, mental health and health services are “wrapped” around children and their families (biological, adoptive and/or foster families) to reinforce natural family supports.	Foster children with emotional and behavioral problems	EFFECTIVE Fostering Individualized Assistance Program Developers: Hewitt Clark and colleagues University of South Florida
Treatment Foster Care	Parent Management Training based on social learning theory. Foster parents are the primary interventionists. Foster parents are provided with training, consultation, and clinician support.	<ol style="list-style-type: none"> 1) Children and adolescents with chronic delinquency and conduct problems 2) Adolescents with severe emotional disturbance; and 3) Latency age children with behavior problems 	EFFECTIVE Multimodal Treatment Foster Care Developers: Patricia Chamberlain and colleagues Oregon Social Learning Center
Early Intervention Program	Multidisciplinary team approach which includes foster parents. Includes behavior management foster parent training, screening for developmental delays, activity-based curriculum and long term placement planning.	Maltreated preschoolers	PROMISING Early Intervention Foster Care Developers: Phil Fisher and colleagues Oregon Social Learning Center
Foster Parent Training: An Attachment Theory Prospective	Foster parents are taught to recognize and respond sensitively to infants problematic attachment strategies	Foster parents caring for infants	PROMISING Developers: Mary Dozier and colleagues University of Delaware

Part I: Review of the Literature (continued)

outlining the tasks and strategies necessary to achieve the permanency plan. The case plan is implemented through clinical case management. The most critical role of the FS is to be accountable as the clinical monitor and communication link among all of the players while the service plan is implemented. McDonald and colleagues note that implementation of the plan should always include incorporation and use of any naturally available resources accessible to the child and family.

Once the permanency plan has been achieved, it is important that the family continue to receive support and clinically relevant services, beyond the 30-90 days typically offered in most post-placement service plans. Follow-up services are provided based on decisions made by the wraparound team. Finally, as the wraparound teams succeed in achieving permanency goals, children and families are moved to maintenance follow-up versus active case status. Actively tracking and monitoring the families has been shown to reduce new or recurring serious problems.

A random assignment study was designed to evaluate the effectiveness of the FIAP (Clark, Lee, Prange, and McDonald, 1996). The research design compared children receiving services, which were standard practice (SP), with those who received FIAP. The outcome variables evaluated in this study were: placement settings and change rates, runaway status and incarceration. The summarized results are as follows:

- § FIAP children were significantly less likely to change placements than were those in the SP group during the intervention
- § Both groups showed significant improvement in their emotional and behavioral adjustment over time

- § FIAP boys had significantly lower rates of delinquency and fewer externalizing behaviors than their SP counterparts
- § Older FIAP youths were significantly more likely than their SP peers to be in permanency settings with their parents, relatives, adoptive parents, or living on their own
- § The subset of children who had histories of incarceration and running away, spent fewer days per year, on average, on runaway or incarceration status during the post intervention period than did the SP children

Treatment Foster Care- Patricia Chamberlain and her colleagues at the Oregon Social Learning Center have developed a treatment foster care program targeted toward three populations of children and adolescents: those with chronic delinquency and conduct problems (referred by the juvenile justice system), adolescents with severe emotional disturbance (referred by the mental health department as a step-down from state hospital) and latency age and preschool children with behavior problems (referred by the child welfare system).⁸

Chamberlain reports that the Oregon treatment model was heavily influenced by the parent management training intervention program developed by Gerald Patterson. Over the past three decades, a series of intervention studies have been conducted on the efficacy of parent management training. The results of these studies made it increasingly clear that working with parents was a powerful means of changing children's behavior.

Parent management training interventions, although implemented for youngsters of various ages and with different symptoms, had several key elements in common: the interventions had parents track both their children's prosocial *and*

⁸ For a detailed description of this foster care model for adolescents with delinquency, see *Family Connections* (Chamberlain, 1998).

Part I: Review of the Literature (continued)

problem behaviors, provide daily encouragement, and utilize consistent, rational limits and nonviolent discipline. Outcome studies showed that by using these strategies, rates of child problem behaviors dropped to normal levels in 75 percent of cases and that the effects of the intervention persisted long term (Patterson, 1982, 1985).

Chamberlain and her colleagues applied this parent-mediated intervention model to foster parents caring for emotionally disturbed and conduct disordered children and adolescents. In this model, foster parents, rather than clinicians, are seen as the primary interventionists. Clinicians are responsible for ongoing training, support and consultation for foster parents and for providing case management and family therapy for children and their biological parents.

The program's effectiveness has been evaluated in three studies. One of those studies was a National Institute of Mental Health (NIMH) random assignment study comparing outcomes for delinquent boys ages 14 through 17 in therapeutic foster care (TFC) with those in group care (GC) (Chamberlain and Reid, 1998). Outcomes were examined at one year following exit from placement, using a strategy that involved collecting data from a variety of sources, including youth, parents, or other adult caretakers, probation officers, and official records. The data indicated that TFC was significantly more effective than GC in reducing rates of criminal activity. Forty one percent of the TFC youth had no criminal referrals in the year following exit from placement while only 7 percent of the GC youth had no referrals.

Investigators followed the subjects in both intervention conditions for two years after discharge from care. When compared to the GC intervention, significantly more TFC boys worked in legal jobs, reported that they had not used drugs (including marijuana), reported a positive

relationship with parents and had refrained from unprotected sex.

The project recently received additional funding to permit collection of follow-up data for the next five years.

Research on the parent-mediated intervention model for foster children is currently being extended to include additional groups of children. The research team at the Oregon Social Learning Center has also developed an early intervention foster care model for maltreated preschoolers and is currently testing its efficacy. The results are reported in the next section of this paper.

Patricia Chamberlain is currently conducting an NIMH-funded random assignment study in the child welfare system in San Diego. Children are randomly assigned either to foster care as usual or to the treatment program, where foster parents will receive 16-week parent management training. As this research has just begun, there are no results yet reported.

While both the therapeutic foster care and wraparound interventions have proven effective with foster children, the research to date has focused on different children for each intervention, making it difficult to determine which approach works best for which children. Chamberlain focused on adolescent criminal offenders and mentally ill adolescents with the goals being return to family and age appropriate role functioning. The University of South Florida studies focused on younger children and the goal of permanent placement. There is, therefore, no solid evidence that one approach is overall better than the other. Ultimately, the answer to what works best may depend on the outcome goals and the treatment resources available in a particular community.

Part I: Review of the Literature (continued)

Promising Interventions for Infant and Preschool Foster Children

There are two promising interventions for infant and preschool foster children in the early stages of research and development. The primary focus of this research is on a treatment foster care approach.

Oregon Social Learning Center–Early Intervention- The treatment foster care program at the Oregon Social Learning Center includes an early intervention program targeted to the needs of maltreated preschoolers (Fisher, Ellis, and Chamberlain, 1999). The program elements are based on the risk factors for maltreated preschoolers identified in the empirical literature, and address behavior problems, difficulty managing emotions and developmental delays.

Foster parents are provided ongoing support and training to help them cope with the challenging behaviors presented by these young children. In order to improve the disruptive behaviors of the preschoolers, foster parents ensure that expectations are clear, there is a high rate of reinforcement for pro-social behaviors and effective consequences for problem behaviors are imposed. Overall, there is emphasis on consistency in the foster home, with foster parents using distraction and time-out as the primary behavior management techniques.

The program employs an early interventionist who screens all children for possible developmental delays at the time of placement. Using a system developed by Bricker and colleagues (Bricker, Bailey, and Bruder, 1984; Bricker and Cripe, 1992, cited in Fisher, Ellis and Chamberlain, 1999), an activity-based curriculum is developed that facilitates remediation of delays. The early interventionist works closely with preschool staff and foster parents to implement the curriculum.

Young children with difficulties in emotion regulation engage in frequent and prolonged tantrums, property destruction and even suicidal ideation. In addition, they manifest great emotional lability. These problems respond to the same clear limits and behavioral contingencies used to address other problem behavior.

The program utilizes a multidisciplinary team including foster parents, the clinical supervisor, the foster parent consultant, the early interventionist and a family therapist. Weekly team meetings assess progress on identified goals and ensure that the treatment remains focused. As behavior and emotion stabilize, the focus shifts to remediating the developmental delays in motor skills, language and self-care.

Long term placement planning is an integral part of the program. In order to ensure that skills are transferred to the long-term placement, intensive work is also done with that placement resource. In most cases, children are reunified with biological parents, so biological parents are taught the same skills as foster parents.

Research evaluating the effectiveness of the early intervention program model is in the early stages. Fisher and colleagues (in press) conducted a pilot study in order to examine the following: parenting strategies employed by the program's foster parents; the impact of the intervention on children's initial adjustment to foster care (i.e. 3 to 4 months following placement); and children's functioning in terms of biological indicators. Children in the early intervention program foster care (EIFC) were compared to children in regular foster care (RFC) and to a community comparison group of non-maltreated preschoolers living with their biological parents.

The results of the Fischer study revealed that EIFC foster parents adopted and maintained positive parenting strategies (i.e., those taught by the

Part I: Review of the Literature (continued)

program staff) throughout the study period. In addition, foster parents in the EIFC reported less stress over time, whereas RFC foster parents reported more stress. Further, child behavior in the EIFC showed improvement over time. The behavior of children in RFC actually became worse over time. Finally, (while not statistically significant) children in EIFC also showed changes in several salivary cortisol measures. Cortisol, a hormone, rises rapidly when an individual is stressed, which can be measured by taking a saliva sample. This process allows measuring cortisol levels over time to learn how an individual's stress level changes or remains static. The changes in cortisol levels identified for these children in the EIFC suggest that this intervention may reduce stress over time.

Attachment Theory Research- Mary Dozier and her colleagues at the University of Delaware have been investigating foster care adjustment for infants and preschoolers from a very different theoretical perspective (Stovall and Dozier, 1998). They hypothesize that, consistent with the developmental research on attachment theory, forming an attachment with a new caretaker later in the first year of life (i.e. 6-8 months) will be an especially difficult task for infants and their caretakers. They further postulate that a foster parent's ability to accurately interpret a child's need for nurturance, despite difficult and demanding behavior, is critical to developing a secure relationship with a foster infant. In their view, this necessitates foster parents providing therapeutic intervention rather than just temporary caretaking only.

There have been two recent preliminary studies published from the large scale NIMH sponsored research undertaken by Dozier and her colleagues. The primary purpose of the first study was to investigate foster parents' understanding of children's problematic attachment strategies (Tyrrell and Dozier, 1999). In the study, foster

children evidenced more attachment problems than did biological children in the sample and children placed after 6 to 8 months of age had more attachment problems than did children placed before six months. The study found that foster parent sensitivity and responsiveness was correlated with foster parent knowledge about attachment strategies.

The second study sought to understand infant attachment behavior in the context of a new caregiver relationship (Stovall and Dozier, 2000). Ten infant (6 to 20 months) and foster mother dyads were studied as their relationship developed in the first two months of placement. Foster parents kept a diary to help researchers assess the quality of attachment over time. Foster parents were asked to describe and categorize the infant's behavior in response to being physically hurt, scared and separated from the parent. These situations were chosen because they are prototypical conditions under which attachment behavior is activated.

Research on adult attachment has shown that a parent's ability to read their child's cues and respond appropriately is, in part, explained by the parent's own attachment representation or state of mind. Researchers in this study hypothesized that a foster parent's sensitivity and responsiveness would be influenced by their own attachment state of mind. The Adult Attachment Interview was used to assess the foster parents' state of mind as either autonomous or free to evaluate attachment, dismissing, preoccupied or unresolved (AAI; George, et al., 1985, cited in Stovall and Dozier, 2000).

Researchers also hypothesized that two factors were equally important to establishing a secure relationship with the foster parent: early placement (prior to 6 to 8 months of age) and an autonomous foster parent state of mind. The study findings supported the hypotheses. Foster parent

Part I: Review of the Literature (continued)

autonomy was associated with security of attachment, but only for those infants placed early.

While the theoretical approaches and treatment strategies differ in the two emerging foster care interventions for infants and preschoolers, they share the perspective that foster parents can and must be therapeutic agents, not just surrogate caregivers. Both programs provide intensive training and support for foster parents so that they are better able to meet the needs of these vulnerable young children. The number of infants and toddlers entering the foster care system has increased dramatically over the past few years, and they have found a foster care system ill-prepared to meet their needs. The programs described above offer some cause for optimism.

Evidence-Based Treatment for Childhood Mental Disorders

As stated earlier, there is little research specifically focused on the mental health problems and treatment needs of foster care children. To gain insight into treatments for foster children experiencing mental health problems, this section highlights the available evidence on treatment of mental disorders in children generally. The information presented in this section is drawn from two sources — the 1999 Surgeon General's report entitled, *Children and Mental Health*, Chapter 3, and a recently published review of effective treatment for mental disorders in children and adolescents authored by Burns, Hoagwood and Mrazek (1999).

Disorders with Evidence-Based Outpatient Treatment

There are four disorders of childhood for which there are evidence-based treatments: 1) depression, 2) attention-deficit hyperactivity disorder (ADHD), 3) anxiety and 4) disruptive

behavior (which generally includes the following diagnoses: oppositional defiant disorder, conduct disorder and the aggression and anti-social behavior often associated with ADHD). Table II highlights the findings related to treatments for specific mental health disorders.

Depression- Despite the frequency of depression in children and adolescents, there are few studies on this disorder. There are currently no effective treatments for childhood depression. However, both cognitive behavior therapy and self-control therapy have been shown to be efficacious treatments for children with symptoms of depression. With few exceptions, the literature reveals most children are treated based on depressive symptoms rather than based on an actual diagnosis of depression.

Stark and colleagues developed a twelve-session group intervention involving both self-control and behavioral problem-solving therapy (Burns et al, 1999). The intervention is delivered in school settings to children from grades three through eight. Clarke has developed a school-based intervention for adolescents known as Coping with Depression, similar to the intervention for elementary children (Burns et al, 1999). The treatment is delivered in a group format and is 12 to 16 weeks in duration. Follow-up data on both of these interventions indicate that treatment gains were maintained.

Attention-Deficit/Hyperactivity Disorder (ADHD)- The two psychological treatments for ADHD shown to be efficacious are: (1) behavioral parent and teacher training and (2) systematic programs of *contingency management* implemented in specialized classrooms. Individual psychosocial treatments, including cognitive behavior therapy, cognitive training, and social skills training have been less efficacious. Psychosocial treatments do not result in the same improvements as those found with psycho-stimulants.

Part I: Review of the Literature (continued)

Behavioral interventions tend to improve targeted behaviors or skills, but are not as helpful at reducing the core symptoms of inattention, hyperactivity or impulsivity.

Anxiety- Although anxiety disorders are the most common disorders of youth, there is relatively little research on the efficacy of treatments. Most of the anxiety treatment literature has focused on the symptoms - childhood fears, phobias, or anxiety - rather than clearly defined anxiety disorders. Systematic desensitization and reinforced practice (in vivo exposure and rewards) have been shown to be effective in reducing phobic symptoms and fears. Cognitive behavioral therapy has also been shown to reduce anxiety symptoms and fears. Kendall (1996) developed a manual-driven cognitive behavioral intervention for latency aged children, known as Coping Cat. Coping Cat has four major components: recognizing anxious feelings, clarifying thoughts in anxiety provoking situations, developing a plan for coping and evaluating the success of the coping strategies.

Disruptive Behavior- Two interventions for disruptive behaviors meet the criteria for effective treatments: a parent training program based on the manual Living with Children and a videotaped modeling training program for parents.

Parent training programs based on Patterson and Guillion's manual, Living with Children, are based on operant principles of behavior change. The programs are designed to teach parents to monitor targeted deviant behaviors, monitor and reward incompatible behaviors and ignore or punish deviant behaviors.

Webster-Stratton's (1996) parent-training program includes a series of videotaped parent training sessions, including modeling of effective techniques. The videotape is administered to parents in groups, with follow-up discussions led by a therapist. The

treatment has been tested in several studies, where it was compared to wait-list control groups and alternative parent training formats. The studies have typically included both boys and girls in the 4-8 year old range, selected for treatment based on either a parent referral for behavior problems or diagnostic criteria for Oppositional Defiant Disorder or Conduct Disorder.

There are ten treatments for children or adolescents with conduct problems that have been judged to be efficacious.⁹ The treatments discussed below are for children with conduct problems - not specifically for ADHD. Where the symptoms are similar, as is the case with impulsivity, which can occur with ADHD, these treatments may be helpful. Conduct problems generally refer to behaviors including aggression, destructiveness, and impulsivity, lying, and cheating. Efficacious treatments, are:

- 1) Anger Control Training designed for children 11 through 18 - Feindler and Iwata, (1984).
- 2) Anger Coping Therapy - designed for children from 8 through 12 - Lochman, and Lampron (1984) and Lochman, et al (1989).
- 3) Assertiveness Training - used with both latency aged children and adolescents. Huey and Rank (1984).
- 4) Delinquency Prevention Program - developed for young children - lower grade elementary children (K-2). Tremblay and Vitaro (1995). Vitaro and Tremblay, (1994).
- 5) Multisystemic Therapy - developed for adolescents, 12 to 18. Bourdin, et al (1995). Henggeler, et al (1998).
- 6) Parent-Child Interaction Therapy - developed for young children (preschool through about 8) and their parents. Eyberg,

⁹ For a complete review see Brestan and Eyberg, 1998.

Part I: Review of the Literature (continued)

Table II

Evidence-Based Treatments for Childhood Mental Disorders		
Target Diagnosis or Disorder	Treatment	Research Status
Depression - Children and adolescents who exhibit symptoms of depression (not necessarily clinically diagnosed)	Cognitive Behavior Therapy Self-control therapy	EFFICACIOUS
Attention-Deficit Hyperactivity Disorder (ADHD)	Behavioral parent and teacher training Systematic programs of contingency management in specialized classrooms	EFFICACIOUS
Anxiety	Systematic desensitization and reinforced practice reduce phobic symptoms Cognitive behavior therapy reduces anxiety symptoms and fears Coping Cat – cognitive behavioral intervention reduces anxiety symptoms and fears	EFFECTIVE
Disruptive Behavior	Parent Training Program – Living with Children Videotaped parent modeling program	EFFECTIVE
Conduct Problems	Anger control therapy, Anger Coping therapy, Assertiveness training, Delinquency prevention program, Multi-systemic therapy, Parent-child interaction therapy, Parent training program, Problem Solving skills training, Rational-emotive therapy, and Time-out plus signal seat treatment.	EFFICACIOUS

Part I: Review of the Literature (continued)

- and Algina, (1995). McNeil, C.B., Eyberg, et al (1991).
- 7) Parent Training Program - primarily used with latency-aged children. Peed, Roberts, and Forehand, (1977).
 - 8) Problem Solving Skills Training - primarily used with adolescents - Two articles: Kazdin, et al (1987).
 - 9) Rational-Emotive Therapy - used with high school students. Block (1978).
 - 10) Time-Out Plus Signal Seat Treatment - developed primarily for latency aged children and their parents. Hamilton and MacQuiddy (1984).

Psychopharmacology Evidence for Childhood Disorders

In developing this paper, the decision to include or exclude an overview of psychoactive medications - and how to discuss medications if included - was a source of some debate. This is because information on the safety and efficacy of medications for children and adolescents with mental disorders quickly becomes outdated in an area with such rapidly developing knowledge and research. Including information about the status of these medications at any one point in time can be potentially misleading to parents and non-medical practitioners. However, the ultimate decision was to include this section on medication (with several caveats) because some problems are so severe and persistent that there can be serious negative consequences for a child if untreated, and because psychosocial interventions alone may not always be effective.

The first part of this section on psychopharmacology is taken from the Surgeon General's report on Mental Health. The second part out-

lines the most recent findings from the clinical trials conducted by the National Institute of Mental Health (NIMH). The third part details the classes of FDA-approved medications for children and adolescents. A set of recommended guidelines for use by social workers, clinicians, foster parents and others when working with physicians to make decisions regarding the use of psychoactive medications in the treatment of a foster child, is included in the "Additional Resources: Practice Guidelines" section at the end of this part of the report.

The Surgeon General's Report

ADHD- The effectiveness of pharmacological treatments for ADHD has been well documented. Psycho-stimulant medications, including methylphenidate (Ritalin), dextroamphetamine (Dexedrine and Aderal) and pemoline (Cylert) have been found to be quite effective short-term treatments for the symptoms of ADHD. These medications have been shown to have their greatest effect on the core symptoms: hyperactivity, impulsivity, inattention, and associated features (e.g. defiance, aggression and oppositional behavior). Small treatment effects have been reported in learning, school achievement and cognitive tasks (U.S Department of Health and Human Services, Surgeon General's Report, 1999).

Depression- Evidence regarding the effectiveness of psychopharmacology for depression is moderate. Research addressing the efficacy of tricyclic antidepressants for the treatment of childhood depression failed to find superiority for their use over a placebo. Thus, there is no evidence to suggest that tricyclic antidepressants should be used in the treatment of children with depression.

However, research investigating the effectiveness of selective serotonin reuptake inhibitors (SSRIs) is promising. One recent double blind, placebo controlled study of fluoxetine (Prozac) for child-

Part I: Review of the Literature (continued)

hood depression reported significant treatment effects relative to a placebo. A second new generation antidepressant, venlafaxine, has, however, not been found beneficial for this population.

Before strong statements can be made about the effectiveness of antidepressant medication with children and youth, there needs to be far more evidence from well-designed studies (U.S. Department of Health and Human Services, Surgeon General's Report, 1999).

Obsessive Compulsive Disorder (OCD)- The evidence base for medications to treat OCD focuses on two types of drugs — the tricyclic antidepressants and the SSRIs. However, side effects are not inconsequential and include dry mouth, drowsiness, dizziness, fatigue, tremors and constipation, which occur at fairly high rates (Burns, et al, 1999). The evidence base is not yet strong enough to warrant wholesale endorsement of these medications for obsessive-compulsive disorder.

Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD)- No drugs have been demonstrated to be consistently effective in treating disruptive behavior. In one study, lithium and methylphenidate (Ritalin) effectively reduced aggression, but two subsequent studies with the same design failed to find similar effects for lithium. There is one study that found clonidine was effective in decreasing aggressive behaviors, but there were also significant side effects necessitating monitoring of cardiovascular and blood pressure parameters (U.S. Department of Health and Human Services, Surgeon General's Report, 1999).

Disorders with Weak Psychopharmacology Evidence- At this point in time the evidence base is weak for the following disorders and medications: bipolar treated with lithium, anxiety treated with SSRIs and Tourette's treated with antipsychotics (U.S. Department of Health and Human Services, Surgeon General's Report, 1999).

NIMH Research Units of the Pediatric Psychopharmacology Network

The NIMH reported the results of a multi-site study, (including the University of California, Los Angeles), to evaluate treatments for anxiety disorders in children and adolescents, which found that fluvoxamine (Luvox) was more than twice as effective as the placebo (sugar pill). Luvox is an SSRI generally used to treat depression and anxiety in adults and has also been approved for use with children 8 and older that are diagnosed with Obsessive Compulsive Disorder.

Children diagnosed with generalized anxiety disorder, separation anxiety disorder, and social phobia were randomly assigned to treatment and placebo conditions. No severe side effects from the medication occurred in the study, although 49 percent of the study participants had stomachaches compared to 28 percent on placebo. The medication was also associated with greater increases in activity levels than was the placebo. However, these side effects were usually mild (NIMH, Medication).

FDA-Approved Psychoactive Medications for Children Under 12

Most psychoactive medications currently prescribed for children under age 12 do not as yet have specific approval by the FDA; such approval requires research demonstrating safety and efficacy. Tables III, IV, V and VI highlight the medications currently approved by the FDA for children (NIMH, Treatment).

Abuse-Specific Interventions

Limited empirical evidence is available to guide practitioners in the treatment of abused and neglected children. Most early treatment programs focused on the needs of parents rather than children, which likely explains, in part, the

Part I: Review of the Literature (continued)

Table III

Stimulants Approved by the FDA for Children		
Brand Name	Generic Name	Approved Age
Adderall	amphetamines	3 and older
Concerta	methylphenidate	6 and older
Cyclert*	pemoline	6 and older
Dexedrine	dextroamphetamine	3 and older
Dextrostat	dextroamphetamine	3 and older
Ritalin	methylphenidate	6 and older

** Due to the potential for serious side effects damaging the liver, Cyclert should not be considered first line drug therapy for ADHD.*

Table IV

Mood Stabilizing Medications Approved by the FDA for Children		
Brand Name	Generic Name	Approved Age
Cibalith-S	lithium citrate	12 and older
Depakote	divalproex sodium	2 and older (for seizures)
Eskalith	lithium carbonate	12 and older
Lithobid	lithium carbonate	12 and older
Tegretol	carbamazepine	Any age (for seizures)

(NIMH, Treatment)

Part I: Review of the Literature (continued)

Table V

Antidepressant and Antianxiety Medications Approved for Children		
Brand Name	Generic Name	Approved Age
Anafranil	clomipramine	10 and older (for OCD)
Luvox	fluvoxamine	8 and older (for OCD)
Sinequan	doxepin	12 and older
Tofranil	imipramine	6 and older (for bed-wetting)
Zoloft	sertraline	6 and older (for OCD)

Antidepressant and Antianxiety Medications <u>Not</u> Approved for Children Under 18		
Brand Name	Generic Name	Approved Age
BuSpar	bupirone	18 and older
Effexor	venlafaxine	18 and older
Paxil	paroxetine	18 and older
Prozac	fluoxetine	18 and older
Serzone	nefazodone	18 and older
Wellbutrin	bupropion	18 and older

(NIMH, Treatment)

Part I: Review of the Literature (continued)

Table VI

Antipsychotic Medications Approved by the FDA for Children		
Brand Name	Generic Name	Approved Age
Haldol	haloperidol	3 and older
(generic only)	thioridazine	2 and older
Orap	pimozide	12 and older (for Tourette's)
		Data for age 2 and older indicate similar safety profile.

Antipsychotic Medications <u>Not</u> Approved for Children Under 18		
Brand Name	Generic Name	Approved Age
Clozaril (atypical)	clozapine	18 and older
Risperdal (atypical)	risperidone	18 and older
Seroquel	quetiapine	18 and older
Zyprexa (atypical)	olanzapine	18 and older

(NIMH, Treatment)

Despite FDA approval for many medications, long-term research is still needed to assess the safety and effectiveness of psychoactive medications in children. There is still very little that is known about the effects of medication on a child's developing neurotransmitter system, requiring those involved in the child's treatment to very carefully evaluate the benefits and risks associated with any proposed medication regimen.

Part I: Review of the Literature (continued)

paucity of evidence. Even though more children are now receiving services for abuse and neglect, there continues to be limited empirical information available documenting the most effective treatments. This section of the paper will examine what *is* available in the treatment outcome literature by maltreatment type.

Treatment for Physically Abused Children

The literature on treatment outcomes related to child physical abuse primarily addresses parent, rather than child, interventions. The evidence that is available includes empirical studies of therapeutic daycare, one study that utilized play therapy with preschool children, and one study comparing abuse-specific cognitive behavioral therapy (CBT) to standard community intervention. Research indicates that therapeutic daycare programs have resulted in improved developmental outcomes for physically abused children (Culp, Heide, and Richardson, 1987; Parish, Myers, Brander, and Templin, 1985, cited in Becker, et al., 1995). Children who participated in the programs demonstrated more advanced cognitive, social/emotional, fine motor, gross motor and language scores on the Early Intervention Developmental Profile than did a matched control group.

In the only empirical study of individual therapy with physically abused children, Nicol and colleagues examined the relative impact of individual play therapy and family-centered casework on pro-social and aggressive family interaction. (Nicol, et al, 1988, cited in Becker, et al., 1995). The study found that families participating in family-centered casework displayed more positive and fewer negative family interactions than did the families participating in play therapy.

Kolko (1996) reported the only outcome data from a random assignment study with physically abused

children. The study compared the treatment outcomes in 55 cases of child physical abuse randomly assigned to either individual child and parent cognitive behavioral therapy (CBT) or family therapy (FT), with those who received routine community services (RCS). Participants in CBT and FT were associated with greater improvements in child-to-parent violence, child externalizing behavior, parental distress and abuse risk, and family conflict and cohesion. However, the children in the study, regardless of intervention, made little progress in overall aggression or hostility. Kolko suggested that aggression may need to be targeted more specifically, possibly through the use of a group intervention.

Treatment for Sexually Abused Children

The most recent studies examining treatment outcomes in sexually abused children employed randomized designs. In addition, standardized instruments, treatment manuals and treatment fidelity measures were used. The studies primarily compared some form of abuse-specific cognitive behavioral therapy (CBT) to more non-directive approaches or standard community treatments. Deblinger, Lippman and Steer (2000) compared standard community care to a 12-week abuse-specific CBT intervention provided to children only, to parents only, and to both parents and children. The children in this study ranged in age from 7 to 13. The results indicated that children in all of the study groups improved on symptoms of posttraumatic stress disorder (re-experiencing the event with intrusive thoughts or flashbacks, avoidance of reminders and hyperarousal); however, CBT provided directly to children resulted in the greatest improvements. In addition, CBT offered to non-offending parents (those not responsible for the abuse) resulted in improvements in children's depressive symptoms, as well as improvements in the parenting skills of the participating parents.

Part I: Review of the Literature (continued)

Celano, Hazzard, Webb, and McCall (1996, cited in Saywitz, et al., 2000) reported the results of a study that examined outcomes for sexually abused girls and their parents who were randomly assigned to CBT or non-specific treatment. Treatment effects were greatest for parents in the CBT condition. Specifically, non-offending parents showed improvements in support for their children, had fewer expectations that the abuse would have negative effects on the children, and engaged in less self-blame than parents receiving non-specific treatment. However, children in the CBT condition did not show more improvement in posttraumatic stress disorder symptoms than controls.

Cohen and Mannarino (1996, 1998) have published the findings from two studies, comparing abuse-specific CBT to non-directive supportive therapy. Both studies employed random assignment designs and included the non-offending parent in treatment. In the first study, 3 to 7 year old children assigned to the CBT condition showed significantly greater improvement in PTSD symptoms, sexually inappropriate behaviors, and externalizing symptoms. These differences were sustained at the one-year follow-up (1996). In a second study with 7 to 14 year olds, children receiving CBT showed significantly greater improvement in depression and social competence than those receiving non-directive, supportive therapy (1998). However, consistent with other research with this age group, there was no difference in the symptoms of PTSD between children receiving CBT and those children receiving non-directive supportive therapy.

Treatment for Neglected Children

As is the case with physically abused children, most of the treatment programs available to address the needs of neglected children involve therapeutic day care. Overall, therapeutic day care programs

have resulted in significant developmental gains in preschoolers (Culp, et al, 1987; Culp, et al., 1991, cited in Becker, et al., 1995).

Fantuzzo, Jurecic, Stovall, Hightower, Goins, and Schachtel (1988) conducted social skills training with maltreated preschoolers referred to a day care program. Eighteen of the children were neglected, 9 were physically abused and 12 were from families at risk for abuse and/or neglect. The children were rated on a social behavior measure and randomly assigned to three experimental groups: peer initiation, adult initiation, or an untreated control. In the peer initiation group, peers facilitated social interaction, whereas adults (teachers) facilitated the social interaction in the adult initiation group. Researchers then measured children's positive social behaviors (i.e. play organization and sharing) through observations of peer interaction. Results demonstrated greater improvements for the peer initiation group. These results reinforce the weight of peer mediated social skills, even with preschool children.

As this review demonstrates, the number of treatment outcome studies with random assignment of children to treatment conditions has been quite small. The results do, however, consistently favor abuse-specific CBT over the other forms of treatment to which it has been compared, although CBT does not always perform as expected. When considered in conjunction with the treatment-outcome literature as a whole, the abuse-specific treatment results are bolstered by the findings that support the efficacy of cognitive-behavioral interventions.

Part I: Review of the Literature (continued)

Evidence for Institutional and Comprehensive Community-Based Interventions

This section continues the discussion of evidence-based interventions for children with mental health problems. Where research is available on the appropriate mental health treatments specifically for children in foster care it is included. The information contained in this section of the paper is extrapolated from the Surgeon General's Report on Mental Health (1999), Burns, Hoagwood, and Mrazek (1999) and a conference presentation by Barbara Burns (2000).

Rather than using the terms efficacious and effective to describe the evidence-based treatments in the next section, the terms used are: strong, moderate and weak. A decision was made to use these terms rather than efficacious and effective because the research on comprehensive community-based and institutional interventions has a different tradition than does research on diagnosable mental disorders delivered in an outpatient context. In general, research examining outcomes for community-based and institutional interventions has not used efficacy trials in which an active intervention is compared to a "passive" one such as placebo or wait-list controls.

The terms strong, moderate and weak not only refer to the scientific rigor of the research design, but also to the number of studies carried out and the outcomes obtained. For example, the clinical trials of multisystemic therapy, a treatment supported by strong evidence, all studies have employed a random assignment design, there have been seven replications *and* positive long-term outcomes have been consistently obtained. Interventions with moderate evidence are those where either there is less rigor in the design or there has only been

one study demonstrating a positive outcome for the intervention. Finally, interventions with weak evidence either show poor outcome or do not employ rigorous research designs.

Strong Evidence

The interventions for which there is strong evidence include 1) multisystemic therapy (MST), 2) intensive case management and wraparound, and 3) treatment foster care. Adolescents referred by the juvenile justice system appear to receive the greatest benefit from MST. To date, there have been seven randomized clinical trials of MST. Statistically reliable outcome effects include fewer arrests, fewer placements and decreased aggressive behavior. Five randomized clinical trials of intensive case management found that services resulted in less restrictive placements and some increased functioning for youth receiving the intervention. Finally, in the four randomized clinical trials for treatment foster care, children and youth receiving the service showed more rapid improvement, decreased aggression and better post-discharge outcomes than those not receiving the service. These effects were found for child welfare, mental health and juvenile justice system clients.

The community-based interventions listed above, for which there is strong evidence, have many characteristics in common. Specifically, these interventions:

- § Adhere to System of Care values (e.g., providing treatment in community settings, parents as partners, sensitivity to culture)
- § Are provided in neighborhoods, homes, and schools – not in an office
- § Are provided by parents and paraprofessionals (except MST)

Part I: Review of the Literature (continued)

- § Can be operated by any human service sector
- § Have been developed and studied in the real world – not in university settings
- § Are less expensive than institutional care

In addition to the strong evidence base, these community-based interventions can be transferred to a variety of service systems — mental health, child welfare, and juvenile justice — because they provide both tools and training to ensure effective dissemination. For example, the developers of MST have written a treatment manual, measure treatment fidelity (effective implementation), and provide systematic training, consultation and supervision. The intensive case management intervention offers a treatment manual, regulations, measures of treatment fidelity, training videos and brief workshops. Finally, those wishing to implement treatment foster care programs have access to fidelity measures and standards for practice.

Moderate Evidence

The interventions for which there is moderate evidence include 1) family education and support, 2) mentoring, 3) partial hospitalization and 4) respite care. The one randomized clinical trial of family education and support showed increased knowledge and self-efficacy (perceived ability to deal with emotional and behavioral issues in their children) for participating families. In the only randomized clinical trial of mentoring, participating youth demonstrated less substance use and aggression, and better school, peer, and family functioning. There has been one randomized clinical trial for partial hospitalization, which compared participants in the treatment condition to wait-list controls. At

the six-month follow-up, participants were found to have a reduction in behavioral symptoms and improvement in family functioning. Finally, the one study examining outcomes from the provision of respite care to the families of mentally ill children employed a quasi-experimental design and found that participants had fewer placements and reduced family stress.

Weak Evidence

Finally, the evidence is negative, mixed, or shows no effect for institutionally-based interventions – in hospital, residential or group home settings. There have been three randomized clinical trials for hospital care and in all three the findings supported better outcomes for the community comparison group. The two quasi-experimental design studies of residential treatment both examined outcomes of the Project Re-Ed model.¹⁰ In one study, Project Re-Ed was compared to untreated emotionally disturbed children in the community. Results favored the residential treatment intervention. In the second study, the residential treatment intervention was compared to treatment foster care. In this case, the gains made in residential treatment were equal to those in treatment foster care, but treatment foster care was half the cost of residential treatment. The two quasi-experimental design studies examining the outcomes for group home interventions show mixed results. Gains were made in some areas of functioning, (e.g., decreases in the symptoms of psychopathology), while there was deterioration in others, (e.g., higher arrest rates) after the intervention.

¹⁰ *Project Re-Ed is a model developed in 1966 by Nicholas Hobbs as an alternative to traditional residential treatment programs. The program design includes working with emotionally disturbed children using educational, psychological and ecological strategies. Teacher-counselors provide treatment with support from consultant mental health specialists. The residential schools are located in local communities to facilitate work with the family. Children go home on the weekend.*

Part I: Review of the Literature (continued)

Table VII

Institutional and Community-Based Interventions, by Relative Level of Supporting Evidence	
Strong Evidence	1) Multisystemic Therapy (MST) 2) Intensive Case Management, Wraparound 3) Treatment Foster Care
Moderate Evidence	1) Family Education and Support 2) Mentoring, 3) Partial Hospitalization 4) Respite Care
Weak Evidence	1) Institutional Interventions Hospital, Residential or Group Homes

Additional Resources

Practice Guidelines

As stated earlier, this project employed specific recognized effectiveness criteria in identifying treatments to include in this report. There are, however, treatments for specific childhood disorders that, while not meeting the effectiveness criteria, are informed by research and have been published as practice guidelines by the American Academy of Child and Adolescent Psychiatry. Guidelines can be found in the following practice journals:

- 1) Supplement to the Journal of the American Academy of Child and Adolescent Psychiatry, Volume 36 (10) 1997, includes guidelines for the following:
 - § Psychiatric Assessment of Children and Adolescents

- § Psychiatric Assessment of Infants and Toddlers
- § Forensic Evaluation
- § Child Custody Evaluation
- § Anxiety Disorders
- § Attention-Deficit/Hyperactive Disorder
- § Conduct Disorders
- § Substance Use Disorders
- § Bipolar Disorder
- § Schizophrenia
- 2) Supplement to the Journal of the American Academy of Child and Adolescent Psychiatry, Volume 37 (10) 1998, includes guidelines for the following:
 - § Posttraumatic Stress Disorder
 - § Obsessive Compulsive Disorder

Part I: Review of the Literature (continued)

- § Language and Learning disorders
- § Depressive Disorders
- 3) Supplement to the Journal of the American Academy of Child and Adolescent Psychiatry, Volume 38 (12) 1999, includes guidelines for the following:
 - § Mental Retardation and Comorbid Mental Disorders
 - § Autism and Pervasive Developmental Disorders
 - § Children and Adolescents who are Sexually Abusive of Others

In addition, the Journal of Consulting and Clinical Psychology, Volume 66 (1) 1998 includes a special section on empirically supported psychological therapies, as developed by the American Psychological Association. Of particular note is an article in the section authored by Alan Kazdin and John Weisz, entitled “Identifying and Developing Empirically Supported Child and Adolescent Treatments.”

Guidelines for Seeking Psychiatric Consultation

These guidelines are suggested by Dr. Penny Knapp, Medical Director, California State Department of Mental Health, and are consistent with those suggested by the National Institute of Mental Health.

In order for child psychiatrists to conduct effective assessments of children and to prescribe psychopharmacological intervention, they need good information and participation in treatment by the child’s caregivers. No psychiatrist should be expected to provide a medication evaluation for a child without having at least the following:

- § A complete history on the child (as complete as possible)

- § An understanding of the circumstances that necessitated the child’s removal from their home
- § A recent placement history
- § School information, including recent moves from one school to another

In addition, when the child is in foster care, the foster parent should accompany the child to the visit (and all subsequent appointments).

Foster parents, mental health practitioners, and child welfare caseworkers must be informed “consumers” on behalf of children. The following principles offer some additional guidelines for those involved in a child’s care and treatment:

Understand and Agree on the Purpose of the Medication- Therapist, physician, child and foster parent must work together to identify the target symptom, along with the diagnosis, that medication is intended to affect. For example, for a child diagnosed with ADHD, participants must be clear as to whether the medication is intended to affect inattention, impulsivity and/or hyperactivity.

Agree on how the Medication will be Evaluated- Foster parents, physicians and children need to know how the symptom(s) will be tracked or measured, allowing everyone to eventually agree on the success or failure of the medication.

Ask the Right Questions- Foster parents and therapists should make sure that the physician will be available to parent and child should questions or problems arise, and should ask the prescribing physician the following questions prior to beginning any medication:

- § Has the medication being prescribed been tested specifically for safety and effectiveness with children?

Part I: Review of the Literature (continued)

- § How do the potential benefits outweigh the potential risks?
- § What are the possible side effects and what course of action should be taken if the side effects become severe?
- § If more than one medication is prescribed, what are the potential drug interactions?

The next section contains the results of key informant interviews to gather an array of first-hand experiences and perceptions about the needs and treatment of foster youth with mental health needs.

References

- Barbell, K. (1997). Foster care today: a briefing paper. Washington, D.C.: Child Welfare League of America.
- Becker, J. V., Alpert, J. L., Bigfoot, D. S., Bonner, B. L., Geddie, L. F., Hennigler, S. W., Kaufman, K. L., & Walker, C. E. (1995). Empirical research on child abuse Treatment: report by the child abuse and neglect working group, American Psychological Association. Journal of Clinical Child Psychology, 24 (Suppl.), 23-46.
- Boris, N. W., and Zeanah, C. H. (1998). Clinical disturbances of attachment in infancy and early childhood. Current Opinion in Pediatrics, 10, 365-368.
- Block, J. (1978). Effects of a rational-emotive mental health program on poorly achieving disruptive high school students. Journal of Counseling Psychology, 25, 61-65.
- Bourdin, C. M., Mann, B. J., Cone, L. T., Henggeler, S.W., Fucci, B. R., Blaske, D. M., & Williams, R. A. (1995). Multisystemic treatment for serious juvenile offenders: Long-term prevention of criminality and violence. Journal of Consulting and Clinical Psychology, 63, 569-578
- Brestan, E. V., & Eyberg, S. M. (1998). Effective psychosocial treatments of conduct-disordered children and adolescents: 29 years, 82 studies, and 5,272 kids. Journal of Clinical Child Psychology, 2, 180-189.
- Bricker, D., Bailey, E., & Bruder, M. (1984). The efficacy of early intervention and the handicapped infant: A wise or wasted resource. Advances in Developmental and Behavioral Pediatrics, 5, 373-423.
- Bricker, D., & Cripe, J. W. (1992). An activity based approach to early intervention. Baltimore: Brookes.
- Burns, B. J. (2000). Evidence-based practice in the real world. Paper presented at the first international Multisystemic Therapy Conference, Savannah, GA.
- Burns, B. J., Hoagwood, K., & Mrazek, P. J. (1999). Effective treatment for mental disorders in children and adolescents. Clinical Child and Family Psychology Review, 2, 199-254.
- Burns, B. J., & Goldman, S. K. (Eds.) (1999). Promising practices in wraparound for children with serious emotional disturbances and their families. Systems of Care: Promising Practices in Children's Mental Health, 1998 Series, Volume IV. Washington, D. C.: Center for Effective Collaboration and Practice, American Institutes for Research.
- Celano, M., Hazzard, A., Webb, C., & McCall, C. (1996). Treatment of traumagenic beliefs among sexually abused girls and their mothers: An evaluation study. Journal of Abnormal Child Psychology, 24, 1-16.
- Chamberlain, P. (1996). Intensified foster care: Multi-level treatment for adolescents with conduct disorders in out-of-home care. In E. D. Hibbs, & O. P. Jensen (Eds.), Psychosocial treatments for child and adolescent disorders: Empirically-based strategies for clinical practice (pp. 475-496). Washington, D.C.: American Psychological Association.
- Chamberlain, P. (1998). Family Connections: A Treatment Foster Care Model for Adolescents with Delinquency. Eugene, Oregon: Northwest Media, Inc.
- Chamberlain, P., & Reid, J. (1998). Comparison of two community alternatives to incarceration of chronic juvenile offenders. Journal of Consulting and Clinical Psychology, 6, 624-633.

References (continued)

- Chernoff, R., Combs-Orme, T., Risley-Curtiss, C., & Heisler, A. (1994). Assessing the health status of children entering foster care. *Pediatrics*, *93*, 594-601.
- Clark, H. B., Lee, B., Prange, M. E., & McDonald, B.A. (1996). Children lost within the foster care system: Can wraparound service strategies improve placement outcomes? *Journal of Child and Family Studies*, *5*, 39-54.
- Clarke, G. N., Hops, H., Lewinshon, P. M., Andrews, J. Seeley, J. R., & Williams, J. (1992). Cognitive-behavioral group treatment of adolescent depression: Prediction of outcome. *Behavior Therapy*, *23*, 341-354.
- Clausen, J. M., Landsverk, J., Ganger, W., Chadwick, P., & Litrownik, A. (1998). Mental health problems of children in foster care. *Journal of Child and Family Studies*, *7*, 283-296.
- Cohen, J. A., & Mannarino, A. P. (1996). A treatment outcome study for sexually abused preschool children: Initial findings. *Journal of the American Academy of Child and Adolescent Psychiatry*, *35*, 42-50.
- Cohen, J. A., & Mannarino, A. P. (1998). Interventions for sexually abused children: Initial treatment findings. *Child Maltreatment*, *3*, 17-26.
- Culp, R. E., Heide, J., & Richardson, M. T. (1987). Maltreated children's developmental scores: Treatment versus nontreatment. *Child Abuse and Neglect*, *11*, 29-34.
- Culp, R. E., Little, V. Letts, D., & Lawrence, H. (1991). Maltreated children's self-concept: Effects of a comprehensive treatment program. *American Journal of Orthopsychiatry*, *61*, 114-121.
- Deblinger, E., Lippman, J., & Steer, R. (1996). Sexually abused children suffering post-traumatic stress symptoms: Initial treatment outcome findings. *Child Maltreatment*, *1*, 310-321.
- Dishion, T. J., McCord, J., & Poulin, F. (1999). When interventions harm: peer groups and problem behavior. *American Psychologist*, *54*, 755-764.
- Dubner, A. E., & Motta, R. W. (1999). Sexually and physically abused foster care children and posttraumatic stress disorder. *Journal of Consulting and Clinical Psychology*, *67*, 367-373.
- Eyberg, S. M., Boggs, S., & Algina, J. (1995). Parent-child interaction therapy: A psychosocial model for the treatment of young children with conduct problem behavior and their families. *Psychopharmacology Bulletin*, *31*, 83-91.
- Fantuzzo, J. W., Jurecic, L., Stovall, A., Hightower, A. D., Goins, C., & Schachtel, D. (1988). Effects of adult and peer social initiations on the social behavior of withdrawn, maltreated preschool children. *Journal of Consulting and Clinical Psychology*, *56*, 34-39.
- Feindler, D. L., Marriott, S. A. A., & Iwata, M. (1984). Group anger control training for junior high school delinquents. *Cognitive Therapy and Research*, *8*, 299-311.
- Fisher, P. A., Ellis, B. H., & Chamberlain, P. (1999). Early intervention foster care: A model for preventing risk in young children who have been maltreated. *Children's Services: Social Policy, Research and Practice*, *2*, 159-182.
- Fisher, P. A., Gunnar, M. R., Chamberlain, P., & Reid, J. B. (in press). Preventive intervention for maltreated preschoolers: Impact on children's behavior, neuroendocrine activity, and foster parent functioning. *Journal of the American Academy of Child and Adolescent Psychiatry*.
- Franck, E. J. (1996). Prenatally drug-exposed children in out-of-home-care: Are we looking at the whole picture? *Child Welfare*, *75*, 19-34.

References (continued)

- Freisen, B.J., Kruzich, J.M., Robinson, A., Jivanjee, P., Pullmann, M., & Bowles, C. (2001). Straining the ties that bind: Limits on parent-child contact in out-of-home care. Focal Point, 15 (1), 20-22.
- Garland, A. F., Landsverk, K., Hough, R. L., & Ellis-MacLeod, E. (1996). Type of maltreatment as a predictor of mental health service use for children in foster care. Child Abuse and Neglect, 20, 675-688.
- Garland, A. F., Hough, R. I., Landsverk, J., McCabe, K. M., Yeh, M., Ganger, W. C., & Reynolds, B. J. (2000). Racial and ethnic variations in mental health care utilization among children in foster care. Children's Services: Social Policy, Research, and Practice, 3, 133-145.
- George, C., Kaplan, N., & Main, M. (1985). Attachment interview for adults. Unpublished manuscript, University of California, Berkeley.
- Glisson, C., Bailey, J. A., & Post, J. A. (2000). Predicting the time children spend in state custody. Social Service Review, 74, 253-280.
- Halfon, N., Berkowitz, G., & Klee, L. (1992). Mental health service utilization by children in foster care in California. Pediatrics, 89, 1238-1244.
- Halfon, N., Mendonca, A., & Berkowitz, G. (1995). Health status of children in foster care. The experiences for the center for the vulnerable child. Archives of Pediatric and Adolescent Medicine, 149, 386-392.
- Hamilton, S. B., & MacQuiddy, S. L. (1984). Self-administered behavioral parent training: Enhancement of treatment efficacy using a time-out signal seat. Journal of Clinical Child Psychology, 13, 61-69.
- Hanson, R. F., & Spratt, E. G. (2000). Reactive attachment disorder: What we know about the disorder and implications for treatment. Child Maltreatment, 5, 137-145.
- Henggeler, S. W., Schoenwald, S. K., Bourdin, C. M., Rowland, M. D., & Cunningham, P. B. (1998). Multisystemic treatment of antisocial behavior in children and adolescents. New York, NY: Guilford Press.
- Horowitz, S. M., Simms, M. D., & Farrington, R. (1994). Impact of developmental problems on young children's exits from foster care. Developmental and Behavioral Pediatrics, 15, 105-110.
- Huey, W. C., & Rank, R. C. (1984). Effects of counselor and peer led group assertiveness training on black adolescent aggression. Journal of Counseling Psychology, 31, 95-98.
- Kazdin, A. E., Esveldt-Dawson, K., French, N. H., & Unis, A. S., (1987). Effects of parent management training and problem solving skills training combined in the treatment of antisocial child behavior. Journal of the American Academy of Child and Adolescent Psychiatry, 26, 416-424.
- Kazdin, A. E., Esveld-Dawson, K., French, N. H., & Unis, A. S. (1987). Problem-solving skills training and relationship therapy in the treatment of antisocial child behavior. Journal of Consulting and Clinical Psychology, 55, 76-85.
- Kendall, P. C., and Treadwell, K. R. H. (1996). Cognitive-behavioral treatment for childhood anxiety disorders. In E. D. Hibbs, and P. S. Jensen (Eds.), Psychosocial treatments for child and adolescent disorders: Empirically based strategies for clinical practice. Washington, D. C.: American Psychological Association.
- Kinard, E. M. (1999). Perceived social skills and social competence in maltreated children. American Journal of Orthopsychiatry, 69, 465-481.

References (continued)

- Kirgin, K. A., Braukmann, C. J. & Atwater, J. D. (1982). An evaluation of teaching-family (achievement place) group homes for juvenile offenders. Journal of Applied Behavioral Analysis, *15*, 1-16.
- Klee, L., Kronstadt, D., & Zlotnick, C. (1997). Foster care's youngest: a preliminary report. American Journal of Orthopsychiatry, *67*, 290-299.
- Kolko, D. J. (1996). Individual cognitive behavioral treatment and family therapy for physically abused children and their offending parents: A comparison of clinical outcomes. Child Maltreatment, *1*, 322-342.
- Landsverk, K., Davis, I., Ganger, W., Newton, R., & Remmer, J. (1996). Impact of child psychosocial functioning on reunification from out-of-home placement. Children and Youth Services Review, *18*, 447-462.
- Leslie, L. K., Landsverk, J., Ezzet-Lofstrom, R., Tschann, J. M., Slyment, D. J., & Garland, A. F. (2000). Children in foster care: Factors influencing outpatient mental health service use. Child Abuse and Neglect, *24*, 465-476.
- Lochman, J. E., Burch, P. R., Curry, J. F., & Lampron, L. B. (1984). Treatment and generalizations effects of cognitive-behavioral and goal-setting interventions with aggressive boys. Journal of Consulting and Clinical Psychology, *52*, 915-916.
- McDonald, B. A., Boyd, L. A., Clark, H. B., & Stewart, E. S. (1995). Recommended individualized wraparound strategies for foster children with emotional/behavioral disturbances and their families. Community Alternatives, *7*, 63-82.
- McIntyre, A., & Kessler, T. Y. (1986). Psychological disorders among foster children. Journal of Clinical Child Psychology, *15*, 297-303.
- McLeer, S. V., Deblinger, E., Atkins, M. S., Foa, E. B., & Ralphe, D. L. (1988). Post-traumatic stress disorder in sexually abused children. Journal of the American Academy of Child and Adolescent Psychiatry, *27*, 650-654.
- McLeer, S. V., Deblinger, E., Henry, D., & Orvashel, H. (1992). Sexually abused children at high risk for PTSD. Journal of the American Academy of Child and Adolescent Psychiatry, *31*, 875-879.
- McNeil, C. B., Eyberg, S., Eisenstadt, T., Newcomb, K., & Funderburk, B. W. (1991). Parent-child interaction therapy with behavior problem children: Generalization of treatment effects to the school setting. Journal of Clinical Child Psychology, *20*, 140-151.
- Milan, S. E., & Pinderhughes, E. E. (2000). Factors influencing maltreated children's early adjustment in foster care. Development and Psychopathology, *12*, 63-81.
- Needell, B., Webster, D., Barth, R. P., Monks, K., & Armijo, M. (1995). Performance indicators for child welfare services in California: 1994. Berkeley, CA: University of California at Berkeley, School of Social Welfare, Child Welfare Research Center.
- National Institute of Mental Health. *Medication Effective in Treating Anxiety Disorders in Children and Adolescents*. April 25, 2001 press release. [Online.] www.nimh.nih.gov/events/prrupp.cfm June 2001.
- National Institute of Mental Health. *Treatment of Children with Mental Disorders*. [Online.] www.nimh.nih.gov/publicat/childqa.cfm. June 2001.
- Newton, R. R., Litrownik, A. J., & Landsverk, J. A. (2000). Children and youth in foster care: Disentangling the relationship between problem behaviors and number of placements. Child Abuse and Neglect, *24*, 1363-1374.

References (continued)

- Nicol, A. R., Smith, J., Kay, B., Hall, D., Barlow, J., & Williams, B. (1988). A focused casework approach to the treatment of child abuse: A controlled comparison. Journal of Child Psychology and Psychiatry, *29*, 703-711.
- Noble, D. N., & Gibson, D. (1994). Family values in action: Family connectedness for children in substitute care. Child and Youth Care Forum, *23* (5), 315-328.
- Parish, R. A., Myers, P. A., Brandner, A., & Templin, K. H. (1985). Developmental milestones in abused children, and their improvement with a family-oriented approach to the treatment of child abuse. Child Abuse and Neglect, *9*, 245-250.
- Patterson, G. R. (1976). Living with Children. Champaign, IL: Research Press.
- Patterson, G. R. (1982). Coercive family process. Eugene, Oregon: Castalia Publishing Company.
- Patterson, G. R. (1985). Beyond technology: The next stage in development of a parent training technology. In L'Abate (Ed.), Handbook of family psychology and therapy. Vol 2, (pp. 1344-1379). Homewood, IL: The Dorsey Press.
- Parker, J. G., Rubin, K. H., Price, J. M., & DeRosier, M. E. (1995). Peer relationships, child development and adjustment: A developmental psychopathology perspective. In D. Cicchetti and D. J. Cohen (Eds.), Developmental Psychopathology: Risk, Disorder and Adaptation. Vol. 2, 96-161. New York: Wiley.
- Peed, S., Roberts, M., & Forehand, R. (1977). Evaluation of the effectiveness of a standardized parent training in altering the interaction of mothers and their noncompliant children. Behavior Modification, *1*, 323-350.
- Pilowsky, D. (1995). Psychopathology among children placed in family foster care. Psychiatric Services, *46*, 906-910.
- Price, J. M., & Brew, B. (1998). Peer relationships of foster children: Developmental and mental health service implications. Journal of Applied Developmental Psychology, *19*, 199-218.
- Saywitz, K. J., Mannarino, A. P., Berliner, L., & Cohen, J. A. (2000). Treatment for sexually abused children and adolescents. American Psychologist, *55*, 1040-1049. "Seeking a child's love, a child's life is lost," (2001, February) Los Angeles Times, February 4, 2001.
- Silver, J., DiLorenzo, P., Zukoski, M., Ross, P. E., Amster, B. J., & Schlegel, D. (1999). Starting young: Improving the health and developmental outcomes of infants and toddlers in the child welfare system. Child Welfare, *78*, 148-165.
- Simms, M. D. (1989). The foster care clinic: A community program to identify treatment needs of children in foster care. Developmental and Behavioral Pediatrics, *10*, 121-128.
- Stark, K. D., Rouse, L., & Livingston, R. (1991). Treatment of depression during childhood and adolescence: Cognitive-behavioral procedures for the individual and family. In P. C. Kendall (Ed.), Child and adolescent therapy (pp. 165-206). New York: Guilford Press.
- Stovall, K. C., & Dozier, M. (1998). Infants in foster care: An attachment theory perspective. Adoption Quarterly, *2*, 55-88.
- Stovall, K. C., & Dozier, M. (2000). The development of attachment in new relationships: Single subject analyses for 10 foster infants. Development and Psychopathology, *12*, 133-156.
- Tam, T.S., & Ho, M.K.W. (1996). Factors influencing the prospect of children returning to their parents from out-of-home care. Child Welfare, LXXV (3), 253-268.

References (continued)

- Trickett, P. K., & McBride-Chang, C. (1995). The developmental impact of different forms of child abuse and neglect. Developmental Review, 15, 311-337.
- Tremblay, R.E., Pagani-Kurtz, L., Masse, L.C., Vitaro, F., & Phil, R. (1995). Abimodal preventive intervention for disruptive kindergarten boys: Its impact through mid-adolescence. Journal of Consulting and Clinical Psychology, 63, 560-568.
- Tyrrell, C., & Dozier, M. (1999). Foster parents' understanding of children's problematic attachment strategies: The need for therapeutic responsiveness. Adoption Quarterly, 2, 49-64.
- Urquiza, A. J., Wirtz, S. J., Peterson, M. S., & Singer, V. A. (1994). Screening and evaluating abused and neglected children entering protective custody. Child Welfare, 123, 155-171.
- U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999. [Online] http://www.surgeongeneral.gov/library/mental_health
- Vitaro, F., & Tremblay, R. E. (1994). Impact of prevention program on aggressive children's friendships and social adjustment. Journal of Abnormal Child Psychology, 22, 457-475.
- Webster-Stratton, C. (1996). Early intervention with videotape modeling: Programs for families of children with oppositional defiant disorder or conduct disorder. In E. D. Hibbs, & P. S. Jensen (Eds.), Psychosocial treatments for child and adolescent disorders: Empirically based strategies for clinical practice. Washington, D.C. American Psychological Association.
- Zima, B. T., Bussing, R., Crecelius, G. M., Kaufman, A., & Belin, T. R. (1999). Psychotropic medication treatment patterns among school-aged children in foster care. Journal of Child and Adolescent Psychopharmacology, 9, 135-147.
- Zima, B. T., Bussing, R., Freeman, S., Yang, X., Belin, T. R., & Forness, S. R. (2000). Behavior problems, academic skills delays and school failure among school-aged children in foster care: Their relationship to placement characteristics. Journal of Child and Family Studies, 9, 87-103.

Part II: The Views of Participants in the Foster Care Paradigm

Research information regarding evidence-based practice can be utilized effectively only when considered in the context of today's foster care environment. Understanding the perceptions and assessment of key stakeholders enables us to look for research information that best meets the unique needs of each community. For example, if those in the field identify a shortage of clinicians as an important obstacle to providing mental health services to foster children, choosing an evidence-based practice that focuses upon training existing caretakers to deliver an intervention introduces a proven service and helps address problems associated with the clinician shortage. Responding to input from key stakeholders also increases the likelihood that they will support efforts to integrate evidence-based practices into the foster care service system.

This section of the report contains a synthesis of information gathered from interviews with key informants and a focus group of foster parents. In addition, this section highlights the findings of an unpublished survey of child welfare professionals conducted by the National Technical Assistance Center for Children's Mental Health at Georgetown University. Finally, to incorporate the views of children in the system, this section highlights findings from the June 2000 report by the California Youth Connection, entitled "Foster Youth Proposals to Improve Mental Health Services."

Methodology: Key Informant Interviews

For this section of the report the author interviewed representatives from county child welfare and mental health; drug and alcohol services; health; education; academia; private children's agencies (providing placement and intervention services to clients from mental health, child welfare and education); and the State and County Departments of Mental Health and Social Services. With few exceptions, the

staff interviewed was from middle and upper management; and in some cases informants were special project managers. The following disciplines were represented among the informants: psychiatry, psychology, social work, marriage and family therapy, education and nursing.

The key informant interview process was generally an informal process and the author did not use a structured interview protocol. The author used broad questions to guide discussion regarding the informants' perceptions of the mental health needs of foster children, identification of gaps in services, and their knowledge of effective intervention models or practices. Interview results from child welfare staff and staff providing services to foster children are presented separately.

Child Welfare Staff

There was remarkable uniformity among the interviews with staff from child welfare agencies. Primary issues discussed by informants included: the high service need for foster children with chronically unstable placements; the need for training and support services for foster parents; the perceived benefits of collaboration among disciplines and the problems associated with high staff turnover in child welfare.

Child welfare staff reported that the greatest need is for effective services for children whose placements were described as "chronically unstable." These children not only tend to have a series of unsuccessful placements, but also are often unsuccessful in the *most* restrictive placements (e.g. level 12 and 14 residential treatment facilities and psychiatric hospitals). For those counties with shelters, these are the "revolving door children," who often spend as much time in the shelter as they do in placement. Other observations about these children included:

Part II: The Views of Participants in the Foster Care Paradigm (cont.)

- § They are typically characterized as being highly aggressive and disruptive, having grossly inadequate social skills and very poor academic skills.
- § They frequently engage in behavior that puts them or others at risk for injury, and run away or destroy property in response to negative emotions; and
- § While they represent a small percentage of the caseload in child welfare, they tend to consume a disproportionate share of resources - staff tends to spend more time and energy on these children than they do with the other children on their caseloads.

The second area of greatest need identified by child welfare staff was services to support foster parents. Informants acknowledged that foster parents were a vital resource although they emphasized that there are insufficient numbers of foster parents available. According to informants, foster care agencies report having a difficult time recruiting and retaining foster parents, and the agencies have not been successful in offering the kind of training and support necessary to help foster parents care for increasingly disturbed and disturbing children. Child welfare staff interviewed identified the pressing need for effective foster treatment, including interventions that enable foster parents to more effectively care for troubled children in the foster home setting.

Many informants reported that collaborative efforts between the child welfare, mental health and juvenile justice systems were useful at the staff level in meeting the needs of foster youth. According to informants, collaboration among departments improves communication, increases knowledge, and makes referrals more efficient than where there is no collaboration. Specific examples of successful collaboration included: interagency screening and placement committees;

co-location of mental health staff in child welfare departments; shared caseloads, and monthly administrative meetings where practice, policy and fiscal issues of concern to mental health, juvenile justice and child welfare are discussed. None of the staff interviewed were able to state with any certainty if these efforts improved service quality or outcomes for foster youth.

The final concern consistently articulated by child welfare supervisors and administrators was the appalling staff turnover and vacancy rates for many of the front line positions in child welfare. Most admitted that they were struggling to meet the safety needs of the children served and had little time for anything else. Needless to say, all were wary of any intervention that may put more demands on their already scarce resources.

Staff Providing Health and Mental Health Services to Foster Children

There was a wide diversity of responses articulated by service delivery staff, falling into three distinct categories: systems issues that are often barriers to providing effective treatment, practice issues for mental health providers, and training needs.

System Issues

Informants identified a number of system issues that hinder collaboration on behalf of and treatment for foster children.

According to those interviewed, one of the most frustrating problems encountered by mental health professionals is the lack of information they generally receive when foster care children are referred for treatment. Mental health practitioners identified the need to better communicate with and educate referring agencies on the need for developmental, school, and behavioral information, including the original

Part II: The Views of Participants in the Foster Care Paradigm (cont.)

reason for child welfare intervention, as critical elements in mental health assessment and treatment planning.

Most of those interviewed felt that staff roles and responsibilities are often unclear when mental health staff and child welfare staff work together. For example, when both agencies are involved, mental health staff often feels that they need to intervene, following a referral by child welfare, to link children to special education, developmental, recreational, and health services, because those referrals were not made by child welfare. Mental health staff reported that they are also not familiar with all the intricacies of the child welfare system or individual caseworker roles with various kinds of cases. For example, few staff providing treatment to foster children understand the judicial time frames for reunification, what rights are retained by parents when their children are in foster care, or how the role of the child welfare case worker varies with guardianship, family maintenance, family reunification, or permanency cases.

In addition, service providers working with foster children highlighted the potential conflict in their relationship to the juvenile court. Treatment providers generally see their role as engaging a client in a therapeutic relationship for the purpose of improving functioning and decreasing symptoms. Treatment is seldom specifically directed toward ensuring a particular outcome in a juvenile court decision. Mental health practitioners reported being hesitant to become involved in treatment of foster youth, and reluctant to testify in court regarding diagnosis and treatment, because of confidentiality concerns and the potential to negatively impact the therapeutic relationship.

Informants reported significant challenges in maintaining continuity of care for foster children. These challenges include children missing many

appointments, and children moving from one placement to another without consultation or notification to the mental health provider. In addition, once a child is reunified, children often do not continue to participate in the treatment programs. Service providers expressed frustration with these barriers, particularly because the problems that are the focus of mental health treatment are frequently also the primary cause for removal from parental custody in the first place.

Practice Issues

The second theme that emerged from interviews with key informants in the mental health field concerned practice issues. Specifically, providers expressed a need for practice guidelines and/or evidence-based treatment addressing the practice issues associated with treating foster youth. Informants overwhelmingly agreed that foster youth should be treated as a specialized treatment group. Informants identified multiple issues for which there did not appear to be practice guidelines to direct treatment. The gaps identified are listed below.

- § Developmental assessment protocols, training in their use and identification of effective interventions for infants and toddlers
- § Identification of and treatment protocols for special issues, including:
 - Reaction to trauma and separation
 - Adjustment to new living and school environments
 - Working with two sets of parents: biological and foster
- § Guidelines for providing services to foster youth in a variety of settings, including:
 - Group care
 - Non-relative foster care
 - Kinship care
 - Guardianship

Part II: The Views of Participants in the Foster Care Paradigm (cont.)

- § The integration of “new” services into foster care, such as:
- Wraparound
 - Day treatment
 - School-based interventions
 - Therapeutic behavioral services
- § Working with foster parents
- Integrating them as full members of a treatment team
 - Interventions that enable them to better manage children’s behavior
 - Empowering foster parents

Training Issues

Finally, informants identified the need for training for those involved in the care and treatment of foster children. They highlighted the importance of training to ensure that the specialized foster care populations receive effective intervention services. Specifically, informants felt that juvenile court judges, mental health practitioners (both public and private sector), child welfare workers, administrators in child welfare and mental health, and foster parents could benefit from improved training opportunities.

Results of Georgetown Survey on Information Needs

In 1997, Joan Dodge and Eric Burns from the National Technical Assistance Center for Children’s Mental Health conducted a national “needs sensing survey” to elicit from child welfare professionals their understanding of the needs of children with emotional/behavioral disturbance. The results of the study have not been published because the response rate was so low. However, because many of the responses identify issues similar to those highlighted by staff interviewed for this report, survey findings are presented here for illustrative purposes.

Researchers received responses from 48 child welfare professionals. Of those responding, 60 percent were supervisors or administrators, the single biggest staff classification category. Survey participants were asked about their need for information regarding children and adolescents with emotional/behavioral disturbance. Information areas were broken into the following categories: a) assessment, b) interventions, c) problem areas, d) working with families, e) working with the juvenile court, f) community resources, g) system of care, and h) financing. The final section of the survey asked respondents to identify the various sources from which they currently get practice information.

The Georgetown survey findings parallel the perceptions of child welfare and mental health professionals interviewed for this project. One of the areas of greatest need identified in the survey is for strategies and resources for working with aggressive and oppositional youth. In addition, survey participants felt they need better information on working effectively with the juvenile court.

The findings from both the informal interviews and the Georgetown survey reveal that child welfare professionals are struggling to provide services to youth they believe are increasingly disturbed, but feel that as professionals they do not have the information and resources required to meet these needs. In addition, mental health practitioners, working with vulnerable youth to help prevent maladaptive outcomes in adolescence and adulthood, often intervene with limited information concerning the most effective interventions. Professionals in both service systems will likely benefit from knowing what kinds of interventions increase the probability of success for foster youth.

Part II: The Views of Participants in the Foster Care Paradigm (cont.)

Foster Parents

This section highlights the views of foster parents as presented in focus groups conducted specifically for this report in three Southern California counties. There was consensus among foster parents who had been in the program for ten or more years that the children in foster care today have more problems than they did in the past. Foster parents strongly agreed that there are not enough services to meet the needs of these children. Three themes emerged:

Access to Mental Health Services is Delayed and/or Inadequate- Foster parents are the ones who most frequently notify the child welfare worker assigned to the child when they believe the foster child is in need of mental health services. Most said that they had to make frequent requests before a referral was made. The problem is further complicated when a child is a resident of another county. Some foster parents said that it took as long as six months for authorization for treatment to be received. For many foster parents, there had already been a decision to ask for the child's removal because of their inability to handle the behavior; the delay only serves to increase the chance of the child having to move to another placement. Foster parents also felt that there were just not enough mental health resources for foster children – particularly child psychiatrists.

Foster Parents Do Not Feel Part of the Team- Most foster parents report that they are not treated as part of a mental health or child welfare team. Decisions are often made on behalf of the children in their care, without their input or knowledge. Examples cited include: children prescribed medication without the observations of the foster parent; decisions to return children to biological parents without information from the foster parents and, in some cases, without the knowledge of foster parents. Foster parents reported that they are seldom included in the

mental health treatment plan for the child; and all stated that they have infrequent contact with the child's social service worker.

Training and Resources for the Most Difficult Children Are Inadequate- Foster parents reported that children who were aggressive, destructive and hostile were the most difficult for them to deal with. Most felt that foster parent training was not specific nor extensive enough to help them feel confident about handling extremely difficult behavior problems. Many foster parents felt training should include ongoing “coaching” and support. They all felt it would be helpful to have someone to consult when the strategy didn't work or when the foster parent was not sure how to implement it in the real situation, as opposed to talking about it in a training seminar. Foster parents stated that “therapy” tended not to help really aggressive kids. They thought that most of these kids ended up in group homes and residential treatment facilities. When asked to describe their understanding of therapy, most said that the child was seen once a week in an outpatient clinic where the child “talked about their feelings” to a therapist.

Foster Youth

This section highlights the findings from multiple focus groups of foster youth conducted for the June 2000 California Youth Connection report, entitled “Foster Youth Proposals to Improve Mental Health Services.” The report highlighted the following recommendations:

Increase Knowledge of Services and Access to Information- According to the youth participants, youth suffer from a lack of knowledge about mental health issues and services. They felt there were inadequate information resources available specifically focused on informing youth and answering their questions.

Part II: The Views of Participants in the Foster Care Paradigm (cont.)

Allow Youth Input- Professionals in the mental health system do not solicit youth input on treatment or services provided. Many youth reported that no one ever asked for their opinions regarding treatment preferences.

Increase Participation and Involvement of Youth- Participants shared their perceptions that they lack control within the mental health system and, in turn, over their lives.

Eliminate Stigma and Misconceptions- Participants reported that they often hide the fact that they are receiving mental health services or fail to request services because of negative perceptions of mental health within their peer groups.

Develop More Creative Service Delivery Methods- Participating foster youth characterized the traditional 50-minute, in-office therapeutic hour as too structured and would prefer mental health services to be more integrated into the fabric of their lives. When asked to rank a variety of mental health services in order of importance, the top five choices included: individual counseling, mentor programs, family counseling, group counseling and mental health education programs. When asked about specific mental health interventions, youth participating in the focus groups offered the following feedback:

§ ***Individual Counseling-*** Participating youth stated a preference for counseling that is more interactive between the provider and the client. In its current form, many youth stated that they find counseling extremely intimidating and off-putting.

§ ***Group Counseling-*** Opinions were mixed. Some youth expressed concerns about confidentiality, privacy and the reactions of their peers. Others could see the benefits of having a peer group who identified with the same issues and problems.

§ ***Medication Management-*** Group discussions revealed that youth lacked information or had misinformation contributing to fears and concerns about psychotropic medication. Youth also feel that they have no control over their medication and treatment.

§ ***Mental Health Provider/Youth Relationships-*** Participants stated that they would be more comfortable with a mentor-like interaction between provider and client.

§ ***Transitional Services-*** Once they turn 18, many youth had their services terminated or restricted. Participants reported that they would have liked to continue receiving mental health services after the age of 18.

The findings in this report, from the available literature and from the interview and survey data, suggest specific implications for both intervention strategies with foster children and the training of professionals and foster parents working with foster children. These findings are discussed in the next section of the report.

Part III: Conclusions

Implications for Planning & Practice

Social Service and Mental Health Systems Coordination is Necessary to Support Service Improvement

Child welfare and child mental health systems operate with somewhat different goals in the service of children, including foster children. These fundamental differences may account for the tension that can exist between professionals in each area as they struggle to collaboratively address the needs of foster children. The primary goals of the child welfare system are immediate child safety and permanency. By contrast, the primary goal of mental health agencies serving children and adolescents is to improve functioning so that young people are able to fulfill age-appropriate roles in their families, school and communities.

Child Well-Being is defined as families having the capacity to provide for their children's needs, children having educational opportunities and achievements commensurate with their abilities, and children receiving medical and mental health services adequate to meet their needs (Child Welfare Outcomes 1998 Annual Report, 2000). Although the broader goal of child well-being is a federal goal for child welfare services, the practical reality is that with limited resources, most local child welfare agencies struggle to meet their basic responsibility to provide for child safety and permanency. In addition, the scope of total child well-being is significantly influenced by factors beyond the control of local child welfare agencies.

An anecdote provided by one of the key informants interviewed for this report offers a real-life illustration of the potential tension that can arise between the two systems.

A mental health worker outstationed in a school was providing services to a 13-year-old boy referred by a teacher for behavior problems. At age 4, the youth had been placed by the local child welfare agency into the home of his maternal aunt (due to parental drug abuse). Everyone agreed that the aunt was providing good care for the boy and his sister and that there were strong affectional ties among the family members. However, both this boy and his sister were removed from the aunt's home when her boyfriend, who had a criminal record, moved in. The boy and his sister were separated, he had to attend a new school, his behavior problems escalated, and he was acting aggressively toward others. From the mental health worker's perspective, the child's emotional well being had been jeopardized, while the child welfare worker felt that the boyfriend's presence in the home presented a significant risk to the safety of the children.

The interviewee felt that the situation was endemic of the need for enhanced collaboration between child welfare and mental health in the interest of achieving permanency for children in foster care.

This example only serves to illustrate both the complexities of the systems and interventions being brought to bear in the service of foster children, and the potential negative consequences when the two systems fail to understand or coordinate their efforts. The following sections include specific recommendations to enhance proficiency, training and coordination among professionals and families working with foster children and specific areas for additional research and study. At the system level, in local communities, and at the state and federal level, policy makers, program administrators, practitioners and families need to more explicitly acknowledge the practice implications of disparate goals for mental health and child welfare; implement improved lines of communication and ongoing inter-disciplinary dialogue; and work toward agreement on compatible, complementary and realistic

Part III: Conclusions (continued)

strategies to meet the total needs of foster youth. This report is in part intended to initiate, inform and encourage that dialogue.

Evidence Regarding Services and Foster Youth is Available That Can Help to Improve the Foster Care System

The evidence reviewed in the first part of this report showed that the children who are least likely to exit the foster care system, either through reunification or adoption, are children with externalizing disorders and very young children with developmental delays. In addition, children who are aggressive, defiant, and disruptive are more likely to experience placement instability than children without these problems. The empirical evidence is confirmed by the perceptions of staff working in child welfare and foster parents, because they find children with externalizing disorders the most difficult to place and support. This evidence should influence the foster care system design and the service and treatment choices being implemented by service professionals and families working with foster youth.

There are at least two mental health treatment interventions reviewed in the empirical literature that may prove beneficial with children who are disruptive, aggressive, and defiant and who experience unstable placements. One is the parent-mediated therapeutic foster care model developed by Chamberlain and her colleagues at the Oregon Social Learning Center. (The Oregon approach, discussed in more detail in Part 1, relies on foster parents as the primary mental health interveners, utilizing behavioral strategies to decrease antisocial behavior.) The other is the wraparound intervention developed by Clark and Associates at the University of South Florida. (The South Florida model, also discussed in Part 1, employs individual wraparound services to facilitate reunification and/or adoption.)

The primary goal of these two programs was to improve permanency outcomes for foster children with emotional and behavioral disturbances. These interventions offer several advantages to children, families and staff working in the mental health and child welfare service system. Specifically:

- § First and foremost, both programs meet the criteria for effective intervention, and the evidence suggests that, if implemented as intended, foster youth will benefit.
- § The programs promote the child welfare system goals of permanency and placement stability, helping to ensure that mental health and child welfare professionals share the same outcome goals for children in foster care.
- § They are consistent with system of care principles (e.g., establishing parents as partners, being sensitive to a child's culture and providing treatment in the least restrictive environment possible).
- § In addition to increasing placement stability and improving child behavior, the parent-mediated foster care intervention has the potential to increase foster parent retention. Past research with the model has demonstrated increases in foster parent competencies and decreases in foster parent stress, which may lead to greater satisfaction with their role and fewer dropouts from the foster parent ranks.
- § Neither intervention is heavily dependent upon professional staff, which is important given the critical staffing shortages in child welfare and (increasingly) in the mental health service system.
- § Legislation passed in 1997 authorized the use of foster care group home funds to support pilot projects in wraparound services, creating

Part III: Conclusions (continued)

the opportunity to implement the wraparound service as a proven method of treatment¹¹

- § These interventions are amenable to transfer to a variety of service systems, because they provide both tools and training to help ensure effective implementation.

Effective Practices from General Mental Health Research, for Those Conditions That Most Negatively Impact Foster Youth, are Valuable Resources

In addition to the therapeutic foster care and wraparound interventions mentioned above, the evidence can facilitate outpatient mental health services that are targeted to the problems most frequently experienced by foster youth. The empirical literature describing the problems of foster children consistently characterizes them as having poor peer relationships, poor social competencies, and as being aggressive and disruptive. These problems not only contribute to poor permanency outcomes, but also lead to peer rejection and school failure, which in turn predict maladaptive outcomes in adolescence and adulthood.

In treating these “conduct” problems, mental health practitioners have several options since there are two interventions that have proven to be effective and ten which had been judged to be efficacious (referenced in the literature review section of the report). In addition to providing intervention targeted to improving outcomes for the most commonly reported problems for foster youth, these interventions have the following advantages:

- § There is a strong evidence base and reason to believe that when implemented as

intended the interventions will reduce the symptoms and increase age-appropriate functioning for youth.

- § The interventions are relatively short-term, which is important in overburdened service delivery systems.
- § Most of these treatments have manuals, practice guidelines and/or training to help ensure effective implementation.
- § Some of the interventions can be delivered in school settings.
- § While the interventions primarily target conduct problems, the effects tend to generalize to peer relationships and social competencies.
- § Some of the interventions (Living with Children, parent-child interaction therapy, and videotaped modeling) assume that parents are partners in treatment, which is consistent with system of care values in mental health practice and child-centered, family-focused intervention in child welfare.

While the foster care interventions for infants and preschoolers described in the literature (Dozier’s attachment model and the Oregon Social Learning Center’s parent-mediated model) have not yet achieved the status of “effective intervention,” the research is promising. In addition, the intervention is being developed with enough detail to allow for transfer of program elements to the child welfare and mental health service systems. The foster parent training components may be particularly useful to agencies serving infants and preschoolers.

¹¹ *SB 163 (Solis), Chapter 163, Statutes of 1997, authorized any county in the state to implement the wraparound service model as had been developed in a pilot project in Santa Clara County. In the program, intensive and comprehensive social, mental health and health services are “wrapped” children in their own home, serving children who are in group homes or are at risk of placement. Counties receive the same level of funding for each child as they would for group home services.*

Part III: Conclusions (continued)

Recommendations

The information contained in this report strongly suggests that improvements in the quality and effectiveness of services to foster children will most likely result from providing treatment informed by evidence rather than by traditional, popular or familiar practices. In addition, the evidence overwhelmingly speaks to the need to recognize foster children as a specialized population with unique and distinctive problems and needs. The following guidelines are offered as first steps to improving outcomes for this vulnerable population of children and youth.

Treatment Should Have an Evidence-Base

Children should be offered treatment targeted to specific symptoms and/or syndromes and the intervention should have a strong evidence base. To echo the words of Peter Fonagy, noted psychodynamic theorist and researcher at University College London: “The era of generic therapies is over. No treatment can be equally applicable without modifications to every disorder..... Nonspecific, poorly structured treatments, such as generic counseling, nonfocused dynamic therapy and a variety of experiential therapies are unlikely to be effective with severe presentations. (1998)”

The evidence reviewed on psychosocial interventions for various conditions in children supports the use of behavioral and cognitive behavioral treatments. This is particularly true for children who have disruptive behavior disorders, as there is no empirical justification for nonbehavioral psychotherapies.

Additionally, research on the effectiveness of specific community based services supports the use of intensive case management including wraparound, therapeutic foster care, and home-based interventions such as multisystemic

therapy. Studies utilizing these intervention strategies demonstrate that there are alternatives to inpatient and residential treatment that can allow a child to live in his or her community.

Finally, while hospitalization, residential treatment and group homes are common treatments for children and youth with complex emotional and behavioral disorders, the evidence on these treatments consistently fails to show long term effects. Not only does the existing research indicate that improvements are not maintained once the child is returned to the community (Kirigin, Braukman, Atwater, & Wolf, 1982), but a recent study indicated that peer group-based interventions might actually increase behavior problems among high risk adolescents (Dishion, McCord, & Poulin, 1999).

Despite the evidence, hospitals, residential treatment centers and group homes continue to be widely used, in large part, because most communities do not have viable alternatives (e.g. wraparound services, treatment foster care, multisystemic therapy) easily available. When there are no other alternatives, and group care is used, the evidence suggests the following principles be utilized in choosing a particular placement:

- § Ensure that behavioral and cognitive behavioral psychotherapies are used, especially if the child suffers from a disruptive behavior disorder
- § The one study of residential treatment that utilized a comparison group and demonstrated positive post discharge outcomes was the Project Re-Ed model. This approach to residential treatment places a strong emphasis on working with the family and ensures that gains made generalize to the community to which the child will be discharged. Therefore, choosing placements that (a) provide education, recreation and employment (in the case of older adolescents)

Part III: Conclusions (continued)

in the community, (b) ensure that parents are taught behavior management skills and (c) provide for weekend visits between parents and their children may yield more improvements than other group care models.

- § Ensure that group care providers do not have program policies or staff practices that limit parent-child contact. For example, many residential treatment centers and group homes employ points and level systems where privileges are conditioned on positive behavior. Parent-child contact is often considered one of these “privileges”, so that contact may be denied at any time (Friesen, Kruzich, Robinson, Jivanjee, Pullman, Bowles 2001). In contrast to practices that limit parent-child contact there is a consistent body of research which suggests that ongoing contact with a caregiver is related to improved behavior of children in care, the child’s ability to adapt to care and more rapid family reunification from foster care (Davis, Landsverk, Newton, & Ganger, 1996; Noble & Gibson, 1994; Tam and Ho 1996).

Focus on Common Problems

Foster children should be provided services to address the problems of aggression, peer rejection, defiance and poor school performance. Not only does the literature indicate that these are the most common mental health problems of foster children, but they are also the same problems that, if left untreated, will diminish the likelihood of children achieving permanency.

Use Caution in Diagnosing and Treating Foster Children

A primary goal of this report is to emphasize the evidence and the research as a way to refine current methods of treating foster children with behavioral and mental health problems. In two areas in

particular – attachment disorders and post-traumatic stress disorder – the evidence strongly suggests that conventional wisdom and common practice may be in conflict with the evidence.

Attachment Disorders- There is no evidence to support the widely held belief that a disproportionate number of foster children suffer from attachment disorders. Further, there are NO efficacious or effective treatments and some treatments, such as physical holding, may even be dangerous for children.

Posttraumatic Stress Disorder- There is sufficient evidence that PTSD occurs not only in children who may fit the most commonly recognized profile of a child likely to experience PTSD – victims of sexual abuse – but may also frequently occur in children who have been witness to community and/or domestic violence. The evidence also clearly points to the need to more carefully screen preadolescent girls for PTSD.

Specialized Training

The information contained in the literature review section of the report clearly indicates that a high percentage of foster children evidence emotional and behavioral problems significant enough to warrant mental health intervention. In addition, there is a relatively high rate of developmental delays in young children entering foster care. The findings in this project suggest that training should be provided to both child welfare and mental health services practitioners to help them identify children with emotional and behavioral disorders and developmental delays and to increase appropriate referrals and treatment. There are three key groups for whom training should be provided in order to improve the quality of services provided to children in foster care: juvenile court judges; direct service and administrative staff in child welfare; health, and mental health agencies; and foster parents.

Part III: Conclusions (continued)

Juvenile Court Judges- Mental health service providers interviewed for this report consistently expressed concerns with the juvenile court orders regarding medications, psychosocial interventions, or placements. Informants reported that it was not unusual to have judges order interventions inconsistent with sound mental health practice. Examples given included: judges requiring individual therapy when group interventions might be just as successful; and judges reducing medication dosage, eliminating medication or prohibiting physicians from initiating medications, particularly in younger children. In addition, judges may order costly and higher levels of services when less intrusive and potentially more effective interventions might be warranted, including moving a child to residential placement before treatment foster care or outpatient treatment is attempted.

One solution to this problem is to offer training for judges on effective interventions for the problems most commonly seen in foster children. Training could be provided in any number of formats. For example, the annual “Beyond the Bench” conference, sponsored by the National Council of Juvenile and Family Court Judges, is one opportunity for reaching a wide audience of juvenile court judges. In addition, the juvenile court judges in Los Angeles County in partnership with the Department of Children and Family Services (DCFS) and local universities sponsor a yearly conference meant to improve intervention for children and adolescents served by DCFS. Furthermore, fact sheets (similar to those done by the Academy of Child and Adolescent Psychiatry) could be made available to judges. This format could communicate information about effective outpatient psychosocial and psychopharmacological interventions for specific diagnoses and effective comprehensive community-based interventions.

Administrators & Service Delivery Staff- Training for administrators and direct service staff should include the following content:

- § Information to enhance identification of problems (assessment) and the availability of resources- Particular attention needs to be paid to the assessment of young children, children of color, children who are victims of child neglect, children who have been exposed to community and domestic violence, and children whose placements are disruptive.
- § Specific information on the mental health and child welfare service systems- Mental health professionals working with children in foster care should understand the goals of the child welfare system, the role of the juvenile court, the time frames for court review, and the criteria for various kinds of child welfare services, including family reunification, family maintenance, and permanency planning. Child welfare professionals should have knowledge about mental health system of care values, and policies and practices employed in mental health services. In addition, the curriculum should include training that clearly articulates the respective roles and responsibilities of staff providing intervention services to foster children in each service system.
- § Direct service providers, as well as case managers and administrators should be knowledgeable about interventions with proven effectiveness. Staff providing interventions to foster children and their caretakers must be provided extensive training in evidence-based models so that they can deliver the most effective services available.

Part III: Conclusions (continued)

Foster Parents- Finally, foster parents should be provided training that helps them to manage the aggressive and disruptive behaviors that often lead to placement breakdown. Specifically, the training modules created by the developers of therapeutic foster care at the Oregon Social Learning Center offer a good template for foster parent training and education. Any training involving foster parents should be directed toward enhancing their participation as full treatment team members.

Conduct More Focused Research

This report highlights the general lack of evidence and research to support and explain the mental health problems and the appropriate interventions for foster children. In addition, the literature provides only limited insight into the real consequences of inadequate, neglectful or abusive home situations, and the intervention of removing them from those situations, for children who are placed in foster care. For example, even though a relatively high percentage of children are removed from their homes due to parental alcohol or drug abuse, there is virtually no research in either the child welfare or the mental health literature which describes drug and alcohol use among foster children, particularly adolescents. Moreover, there is no information on either effective preventive interventions or ameliorative interventions. Clearly, this entire field requires at the very least, descriptive and exploratory research. Specifically, there is a pressing need for research that acknowledges foster children as a distinct and specialized population requiring individualized management and treatment.

Evaluate Evidence-Based Interventions in Community Contexts

While we now have an array of evidence-based treatments available for many child and adolescent disorders, based on the interviews of

this project, the literature in the field, and the experience of many practitioners and experts who provided input for this project, evidence-based treatments are not always selected in the everyday practice of working with children. As a consequence, those treatments for which there is an evidence base, supported by the results of controlled efficacy trials, are not always being effectively implemented in community settings. One approach to solving this problem is to “transport” evidence-based treatments into community service delivery systems. Treatment manuals and practice guidelines may help to ensure effective implementation of evidence-based treatments. In addition, local mental health agencies could partner with social work and psychology departments in universities to help evaluate the effectiveness of evidence-based, manualized treatments, more directly within the context of community service delivery systems.

Provide Services to Children in Need Regardless of the Form of Abuse

The literature indicates that there is a greater likelihood of children who have been sexually abused being referred for treatment than children who were neglected or abused in other ways. Professionals may be assuming that, given the seriousness of child sexual abuse, these children are somehow more damaged than children who have experienced other forms of child maltreatment. There is no research evidence to suggest that any one type of child maltreatment has more negative effects than any other. Children should be referred based upon the frequency, duration and chronicity of symptoms. It may be just as likely that a child who witnesses domestic violence will experience untoward consequences as it is for a child who experiences sexual abuse.

Part III: Conclusions (continued)

Address Cultural, Ethnic and Gender Disparities

While the evidence regarding racial, ethnic, and gender variation in mental health service use by children in foster care is equivocal, it does raise concerns about equal access to and utilization of services by all foster children with mental health problems.

For example, the research finding that Latinos in foster care are the least likely to receive services, despite the identified need for treatment, suggests the possibility of inequity and certainly results in lack of access to critical services for Latino children. All parties to the foster care system must work to ensure that there is no systematic bias in the referral process. In addition, child welfare and mental health staff will likely need to increase their outreach efforts to this population, and actively address cultural differences among families regarding their willingness to accept external help and support for “family problems.”

The literature also reveals gender differences in diagnosis and treatment of foster children. For example, evidence from two samples of foster children (Los Angeles and San Diego) suggests that girls who have been diagnosed with ADHD are prescribed medication with much less frequency than are boys. It may be that girls are not as aggressive or disruptive as boys, even with the ADHD diagnosis, so teachers and foster parents may not follow through with medication recommendations as often as they do with boys. In any case, mental health and child welfare professionals need to be vigilant in ensuring that girls are accurately diagnosed, particularly as it relates to ADHD, and that they receive appropriate treatments.

Finally, professionals cannot assume that interventions that have been shown effective for

one group will necessarily be successful with another. As always, treatment must be designed to fit the needs of the clients, rather than clients having to fit the needs of treatment providers.

Involve Foster Parents, and Family When Appropriate, as Active Partners

Treatments for foster children must include foster parents as partners. Foster care remains the primary resource for children in need of out-of-home care, and if it is to be an effective intervention for children, foster parents need support and training to ensure that they are able to provide care to the children placed with them. This necessitates a shift in how foster parents are viewed. They need to be seen as primary interventionists rather than custodial caretakers. In addition, when foster parents are provided with the skills and support to manage the difficult behaviors of the children in their care, not only do children improve, but also foster parent stress is lower and satisfaction is higher. Lastly, many effective interventions used by foster parents should be provided through families that are involved with their children who are in foster care as well.

Involve Foster Youth in Their Own Treatment

Professionals and practitioners providing services and direction to youth in foster care must increasingly empower youth to participate in and help to influence the services and treatments they receive. Youth in foster care whose opinions are highlighted in this report clearly feel that mental health professionals do not solicit their input on treatment or services provided. Many youth reported that no one ever asked for their opinions regarding treatment preferences. Youth participating in the focus groups had good and clear ideas on services and treatments that will make the greatest impact in their lives and recovery. Systems serving youth should rely on and build on their innate good sense and

Part III: Conclusions (continued)

experience with services in developing effective models to improve the lives, health, and mental health of children in the foster youth system.

Foster children are clearly a vulnerable population who demonstrate higher rates of psychopathology than do children in the general population. They are disproportionately poor, lag behind in school, and have suffered the pernicious effects of having lived in chaotic, often violent, family and community environments. Intervention should be provided to alleviate their suffering, restore their hope, and prevent maladaptive outcomes in adulthood. These goals are best accomplished by ensuring that foster children receive interventions and treatments with demonstrated effectiveness.