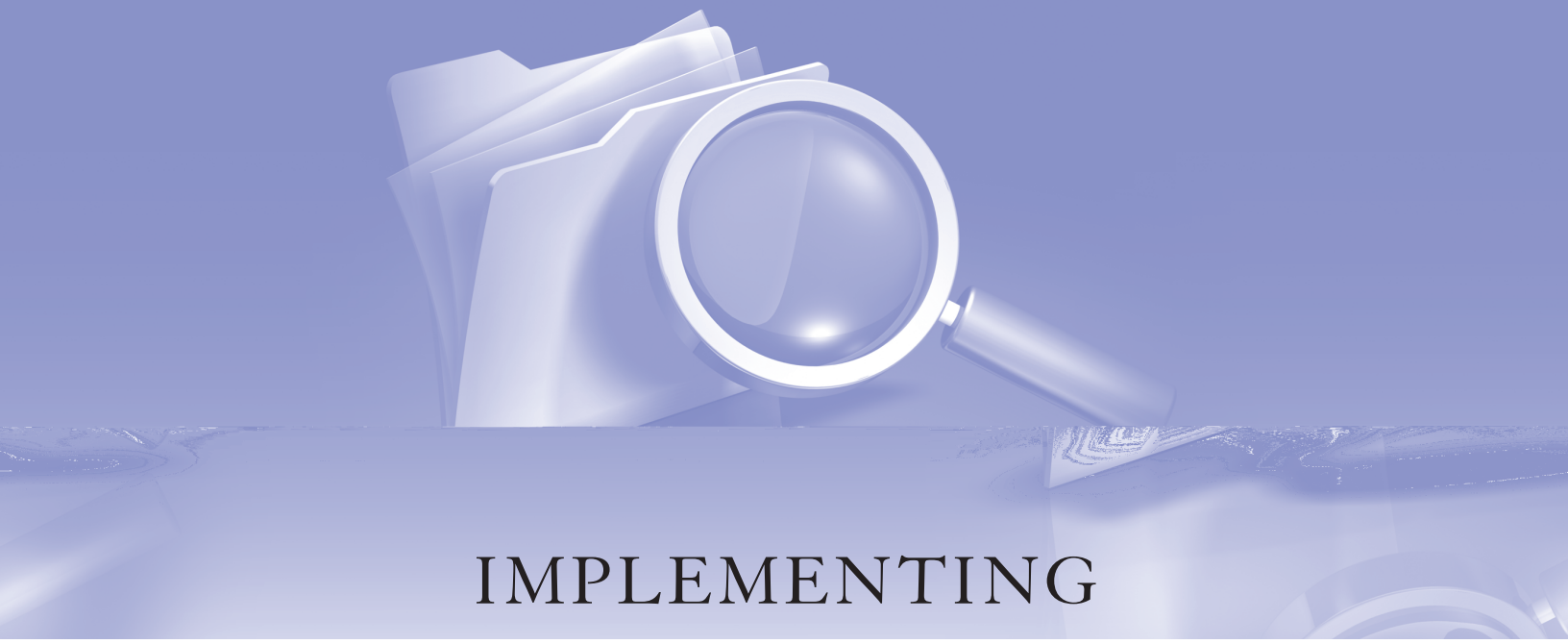

IMPLEMENTING

Evidence-based Practice

in Treatment Foster Care

A Resource Guide

FFTA

Foster Family-based Treatment Association

Implementing Evidence-based Practice in Treatment Foster Care

A Resource Guide

The Foster Family-based Treatment Association is the leading advocate for the development, evaluation, recognition, and expansion of Treatment Foster Care. Its membership is comprised of over 400 treatment foster care agencies, which are located throughout the United States and Canada.

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Foreword

The Foster Family-based Treatment Association (FFTA) is committed to assisting member agencies to provide the most effective services and to achieving the best possible outcomes. Helping member agencies integrate the best available science into their practice represents an important goal for FFTA's Research Committee. In fact, a 2006 FFTA member survey revealed two of the top program development priorities as identifying evidence-based practices that are relevant to Treatment Foster Care (TFC) and learning how to better integrate them into their treatment foster care programs.

What This Guide is

This *Resource Guide* is a partial response to the needs of FFTA member agencies by summarizing a systematic review of the evidence base of practices relevant to providers of Treatment Foster Care. There are a number of sources that list mental health treatments that have been found effective with child and adolescent populations after rigorous evaluation. Yet, there are few resources that look at the broader range of effective practice tools, interventions, and comprehensive models through the lens of the treatment foster care provider. While there has been some research on factors related to implementation that providers face when trying to adopt evidence-based practices, there is limited information on the challenges of applying these models into ongoing TFC services. To this end, this Guide seeks to avoid duplicating available resources by focusing on a summary review of some of the most relevant evidence-based practices, and pointing to additional resources that are available. Moreover, the Guide aims to include practical guidance for anticipating how these evidence-based practices will be applied in TFC agencies.

What This Guide is Not

This *Resource Guide* is not a comprehensive inventory of all treatments that may be valuable to apply in treatment foster care settings. It focuses on the **treatment** in Treatment Foster Care, drawing from the deepest end of the pool of evidence. In contrast, research on many of the unique and challenging dimensions of providing family-based care are not included (e.g., evidence-based recruitment of caregivers, training of staff and foster parents, treatment teaming, collaborative planning, etc).

Given the limitations in the knowledge base, as supported by rigorous evaluation, the FFTA Research Committee continues to work with other child welfare partners to describe the state of evidence-based practice. FFTA hopes to accelerate the pace of progress through focused literature reviews and FFTA briefs, promoting partnerships to add to the knowledge base, and educating member agencies to be informed and persuasive advocates and consumers.

The FFTA Board of Directors and the FFTA Research Committee, as well as our colleagues at the REACH Institute, hope that current FFTA member agencies and other professionals in the field will find this a useful and frequently referenced addition to their resource library.

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Table of Contents

Introduction

Treatment Foster Care (TFC), also known as Therapy Foster Care, Therapeutic Foster Care, Specialized Foster Care, and Multidimensional Foster Care (1), has its roots in social learning principals. Although multiple definitions of TFC exist, we define TFC broadly and in accordance with the Foster Family-based Treatment Association (FFTA) as:

> *…a distinct, powerful, and unique model of care that provides children with a combination of the best elements of traditional foster care and residential treatment centers. In Treatment Foster Care, the positive aspects of the nurturing and therapeutic family environment are combined with active and structured treatment. Treatment foster programs provide, in a clinically effective and cost-effective way, individualized and intensive treatment for children and adolescents who would otherwise be placed in institutional settings.*

The FFTA *Program Standards for Treatment Foster Care* operationalize TFC by identifying the essential elements of the model with regards to the program, treatment parents, and the children, youth, and families that are served. All TFC programs may not meet the *Program Standards*, but FFTA believes they "define the essence of TFC" and can serve as a guide for TFC providers seeking to improve the quality of their services (2).

This *Resource Guide* complements the *Program Standards* by offering TFC providers with valuable information, references, resources, and tools for implementing Evidence-based Practices (EBPs) in their service settings. Whereas the *Program Standards* detail the core elements of high quality TFC, the *Resource Guide* identifies specific models, interventions, and tools that TFC providers can use to deliver effective services to the children, youth, and families in their care. More importantly, the Guide provides valuable "how-to" information to help TFC providers successfully implement desired EBPs in their settings.

Recent years have been marked by a growing emphasis on EBP in the fields of medicine, children's mental health, education, and child welfare. Although the value of EBP in all of these fields is widely recognized, the actual implementation of these practices continues to be a challenge for service providers. Given the relatively small empirical research base on child welfare practices, child welfare providers face the additional challenge of identifying EBPs relevant to their work. In light of these challenges, FFTA felt a resource guide devoted to helping TFC providers identify and implement relevant EBPs was needed and issued a Request for Proposals (RFP) to develop the guide.

The REsource for Advancing Children's Health (REACH) Institute was selected to develop the *Resource Guide* in close collaboration with the FFTA. Since there are relatively few EBPs specific to TFC, the Guide draws from the research literature on EBP in child welfare and related fields, as well as the practical experiences of FFTA member organizations that have implemented EBPs in their settings.

The section of this Guide devoted to an overview of specific EBPs in child welfare draws heavily from critical papers commissioned by the REACH Institute as part of the *Best Practices for Mental Health and Child Welfare Consensus Conference* held in Arlington, Virginia, October 9-10, 2007 and sponsored by Casey Family Programs, the Annie E. Casey Foundation, and the REACH Institute. These papers, written by leaders in the child welfare field, are critically reviewed best practices

for screening and assessment, psychosocial interventions, psychopharmacologic interventions, youth support, and parent support in child welfare. As part of the process of writing the *Resource Guide*, the REACH Institute carefully reviewed these papers for information relevant to EBP in TFC.

This Guide differs from others in its greater emphasis on how to implement EBPs within a TFC program. Although the Guide provides information about various evidence-based models, interventions, and tools, it is neither a detailed treatment manual designed to assist a TFC provider in implementing a specific evidence-based program nor a comprehensive listing of all the EBPs in child welfare. Rather, the Guide provides an overview of TFC-relevant EBPs and details an organizational process to facilitate the implementation of any one of these practices within a TFC program. More specifically, the Guide aims to help TFC providers:

- Expand their knowledge of relevant EBP models, interventions and tools;
- Assess the availability of EBP resources that correspond to their needs in the domains most commonly encountered by TFC providers; and
- Establish EBP dissemination and implementation plans that draw on their organizational strengths.

Since emotional/behavioral disturbances, psychiatric diagnoses, and delinquency are among the primary reasons that youth enter TFC, the Guide mainly focuses on EBPs related to these issues.

The Guide begins with an overview of EBP in child welfare. This section defines EBP, differentiates between efficacy and effectiveness, and reviews specific TFC-relevant EBPs. The review of EBPs focuses on six key areas of particular relevance to TFC providers: 1) Screening and Assessment, 2) Psychosocial Interventions, 3) Psychopharmacologic Approaches, 4) Comprehensive Interventions, 5) Parent Support, and 6) Youth Support. For each of these areas, a summary of EBPs in the area is presented along with "voices from the field" — real world examples from FFTA member organizations that have implemented some of the EBPs described.

Following the review, the Guide presents information about how to implement EBPs within an organizational context. This section discusses organizational factors that may influence the implementation of EBPs, instructs TFC providers on how to identify their needs for EBPs, and offers methods for assessing organizational readiness and fit for any given EBP. The final section of the Guide contains tools and resources designed to assist TFC providers in their efforts to implement EBPs.

Evidence-based Practice in Child Welfare: An Overview

Defining Evidence-based Practice

In recent years, use of the term EBP and its synonyms (i.e., proven practice, best practice, effective practice, evidence-based medicine, etc.) has proliferated. From 1900 through 1995, the term EBP appeared in only 76 Medline citations. From 1995 through 2002, by contrast, 5,425 citations included these words (3). Most of the literature on EBP pertains to the fields of medicine, mental health, and education; these disciplines were the first to embrace the movement. Although child welfare has been slow to adopt EBP, several developments, such as state and federal funding initiatives supporting the replication of evidence-based child welfare programs, a special issue of *Child Welfare* devoted to the topic, and the creation of databases cataloging evidence-based child welfare practices, indicate that the time for evidence-based child welfare programs and policies is near (4). Although many disciplines, including child welfare, now use the term EBP, confusion still exists about what it really means.

Put most simply, an EBP is an intervention, program, or tool with empirical research to support its *efficacy and effectiveness*. Efficacy refers to how well an intervention works to bring about change in a targeted area when tested under carefully controlled conditions (5). These conditions usually include screening and selection of clients who receive the intervention, highly trained interventionists, and intensive supervision (5). How well an intervention works in a real-world setting defines the essence of its effectiveness (6). Research typically focuses on establishing the efficacy of an intervention before testing its effectiveness.

EBPs differ in the quality and quantity of available research to support their efficacy and effectiveness. When thinking about EBP implementation in TFC, it is important to understand that EBP is a process that involves the selection of the most appropriate and effective interventions when providing services (4). EBP is "clinical practice that is informed by evidence about interventions, clinical expertise, and patients' needs, values, and preferences and their integration in decision making about individual care" (7, p. 147). Service providers adopting EBP do not simply implement an intervention because it has been deemed evidence-based; rather, they carefully integrate their clinical expertise with available research evidence to make decisions about the best interventions for an individual client (8).

Clinical expertise and judgment are critical components of effective EBP implementation. Service providers using EBPs must constantly use their judgment and draw on their expertise to determine if a practice, as described in this manual, is appropriate for a given client. Additionally, service providers may need to adapt an EBP to meet the unique needs of a client. Thus, the importance of clinical judgment and the potential need for adaptation must never be overlooked when implementing EBP.

Although the value of EBP may seem obvious, it is not without controversy. Some feel that the EBP emphasis on manualized interventions overlooks the unique needs of individual clients (9). Frequent concerns have been raised about the ability to generalize research used to establish the efficacy of EBP since the key conditions and characteristics of treatment research differs significantly from those of practice settings (7). Concerns have also been raised about the typically homogenous client populations used to validate EBP (10). The reliance of EBP research on statistical significance, to determine whether or not an intervention is empirically supported, has been criticized because "statistical significance does not necessarily mean that patients have improved in ways that are reflected in their every day functioning" (7, p. 148). Lastly, EBP research has been criticized for not paying adequate attention to nonspecific therapeutic factors (i.e., attention, therapeutic alliance, positive regard) that may mediate therapeutic change (11). Although these concerns do not negate the value of EBP, they do emphasize the need for service providers to become educated consumers when it comes to implementing EBP in their settings.

This section of the *Resource Guide* will help TFC providers learn more about EBP by describing relevant EBPs in six general areas:

- Screening and Assessment
- Psychosocial Interventions
- Psychopharmacologic Approaches
- Comprehensive Interventions
- Parent Support
- Youth Support

When applicable, each practice described is rated in the following scale presented below to provide a quick indication of the level of evidence in support of its use.

Evidence-based Practice Rating Scale

1 = Well Supported – Effective Practice
2 = Supported – Efficacious Practice
3 = Promising Practice
4 = Emerging Practice

This scale represents the top four rating categories of the California Clearinghouse Scientific Rating Scale (12). A summary of the specific criteria used to determine each rating follows. Since this Guide is devoted to EBP, practices without any supporting evidence or that have been identified as concerning, are not included.

Criteria for Evidence-based Practice Rating Scale*

CRITERIA	RATING			
	1	2	3	4
No clinical or empirical evidence that the practice causes risk or harm	X	X	X	X
A book, manual or other written material exists documenting how to implement the practice	X	X	X	X
At least two randomized controlled trials (RCTs) conducted in different **usual care** or **practice settings** and published in peer-reviewed journals have shown the practice to be superior to a comparison practice. In at least two of these RCTs, the effect of the practice has been sustained over one year post treatment and there is no evidence that the effect is lost after this time	X			
At least two RCTs conducted in **highly controlled settings** and published in peer-reviewed journals have shown the practice to be superior to a comparison practice. In at least two of these RCTs, the effect of the practice has been sustained over one year post treatment and there is no evidence that the effect is lost after this time		X		
At least one controlled study published in a peer-reviewed journal, has found the practice comparable or better than an appropriate comparison practice			X	
The outcome measures used in the RCTs are reliable and valid	X	X		
Multiple outcome studies, if conducted, support the **effectiveness** of the practice	X			
Multiple outcome studies, if conducted, support the **efficacy** of the practice		X	X	
Clinical practice generally accepts the practice as appropriate for use with children and families receiving services from child welfare or related systems				X
There is inadequate published, peer reviewed research to support the efficacy of the practice				X

**Adapted from the scientific rating scale developed by and with permission from the California Evidence-Based Clearinghouse for Child Welfare*

Mental Health Screening and Assessment Tools

Specific Evidence-based Practices in Child Welfare

Although children typically enter TFC with identified emotional/behavioral disturbances or psychiatric diagnoses, regular mental health screening and assessment is critical to ensure the provision of appropriate services and track service outcomes. This section reviews selected evidence-based screening and assessment tools, which can help TFC providers identify children in need of more comprehensive mental health services, as well as track treatment outcomes for children already receiving services.

A variety of sources, including medical and psychological databases (i.e., Medline and PsychInfo), psychological testing manuals, and child welfare-relevant Web sites were referenced for this section of the *Resource Guide*. In addition, this section draws heavily from *Mental Health Assessment in Child Welfare*, a critical paper by Jessica Mass Levitt, Ph.D., commissioned for the *Best Practices for Mental Health and Child Welfare Consensus Conference* (13).

When discussing screening and assessment measures, an understanding of reliability and validity is important. Reliability refers to how consistently an instrument measures what it is intended to measure (14). A measure is considered reliable if it yields similar scores when given to the same people under comparable conditions at different times. Validity refers to the extent to which an instrument measures what it is supposed to measure (14). There are multiple forms of validity, including content, criterion-related, concurrent, predictive, and construct validity. Efficacious measures are those that demonstrate adequate reliability and validity. Effectiveness refers to how feasible, practical, and acceptable an efficacious measure is in a given setting (13).

Unfortunately, relatively few screening or assessment measures have been specifically validated in child welfare settings (13). We identified only five measures, such as:

- Child and Adolescent Functional Assessment Scale (CAFAS)
- Child and Adolescent Needs and Strengths, Mental Health (CANS-MH)
- Ohio Youth Problems, Functioning and Satisfaction Scales (Ohio Scales)
- Strengths and Difficulties Questionnaire (SDQ)
- Child Behavior Checklist (CBCL)

In addition to these measures, there are a few screening and diagnostic measures that have been extensively studied and well validated in clinic settings that could be valuable in TFC. These include:

- Diagnostic Interview Schedule for Children (DISC)
- Diagnostic Interview Schedule for Children Predictive Scales (DPS)
- Behavior Assessment System for Children (BASC)
- Child and Adolescent Level of Care Utilization System (CALOCUS)
- Child and Adolescent Service Intensity Instrument (CASII)

Voices *from the* Field

Child and Adolescent Functional Assessment Scale (CAFAS)

Omni Visions, Inc., a multi-state placement agency based in Nashville, TN, that works with youth in therapeutic foster homes, has been using the CAFAS primarily at intake and discharge as an outcome measure for approximately three years. The decision to use the CAFAS was largely driven by the fact that CAFAS raters do not have to be licensed mental health providers. Rather, raters need, at a minimum, a Bachelors level education.

According to Shane Frazier, MIS Coordinator for Omni Visions, Inc., the most difficult part of implementing the CAFAS has been getting service level providers to see it as a tool, rather than one more commitment. Youth at Omni Visions have responded well to the CAFAS, especially when the results at different time points are charted and the youth "see" themselves improving.

Mr. Frazier advises other agencies that are considering using the CAFAS to "hand-pick" the staff members chosen to be raters. It is not feasible to train everyone to be a rater, and the data obtained through the CAFAS is only as reliable as the individual collecting it (20).

Key characteristics of the measures described in this section are summarized in Table 1. A more detailed description of each measure follows. Additional information for each measure including purchasing, Web site, and training information is provided in the *Tools and Resources* section of this Guide.

Child and Adolescent Functional Assessment Scale (CAFAS) (15)

The CAFAS measures functional impairment in children ages 6-17 who have, or are at risk for developing, emotional, behavioral, substance use, psychiatric, or psychological problems (15). The measure contains 315 multiple choice items and takes about ten minutes to administer (16). The PECFAS is a version of this same scale for children ages 3-7. In 2000, the CAFAS was specifically modified for use with children in out-of-home placements. The CAFAS Self-Training Manual (17) details these modifications.

The CAFAS has shown internal consistency (18), high inter-rater reliability with clinicians and lay raters across sites, and test-retest reliability (18). Additionally, the CAFAS has demonstrated content validity, concurrent validity, and predictive validity (18). It works equally well for youth in multiple placements, including child welfare settings, as well as mental health, juvenile justice, and educational settings (19).

Child and Adolescent Needs and Strengths (CANS) (21)

There are five versions of the CANS for children and adolescents, including youth involved in the child welfare system (CANS-CW), youth with developmental disabilities and their families (CANS-DD), youth involved in the juvenile justice system (CANS-JJ), youth with mental health challenges (CANS-MH), and youth with sexual development issues (CANS-SD) (21). Most research has been conducted on the CANS-MH; as such, that measure is the focus of this section.

The CANS-MH assesses strengths, as well as mental health risk factors for children ages 0-5 and 5-18 in three domains: risk behaviors, behavior/emotions, and functioning (22). The scale has 42 items that are used to assess the child, or the child's family, currently or retrospectively (21). It can be completed in about ten minutes (23). The CANS-MH is designed to assist service providers with mental health treatment planning and management, and should be adapted for the local population with which it is to be used (24). Because the CANS is an

item-level tool, items can be included, created, or removed for use with any given population (24). The measure has been used to monitor outcomes for youth in TFC (24).

The reliability of the CANS-MH was shown in a study conducted in a comprehensive treatment facility. In the study, 60 cases were selected from the population of the facility through abstracted medical records, and the CANS-MH was administered independently by two non-clinical researchers. Inter-rater reliability between researchers and caseworkers was .81 and among researchers was .85. Item-level coding differences between researchers and caseworkers, and among caseworkers, did not affect service planning (25). This study supported previous findings that the CANS is reliable at assessing the psychological and clinical needs and strengths of children.

The discriminant and concurrent validity of the CANS-MH has been tested in a comparison study with the CAFAS. The study, conducted in a juvenile justice setting, showed that the CANS-MH and the CAFAS are comparable, but that they measure slightly different aspects of functioning (24). A study assessing the predictive validity of the CANS-MH used the measure to determine the correct setting for a youth using clinical charts from residential, intensive community-based, and outpatient treatment settings. Results indicated the CANS-MH was able to correctly determine placement setting for 63% of the charts reviewed (24).

Voices *from the* Field

Child and Adolescent Needs and Strengths (CANS)

Murielle Elfman, CANS Coordinator for the Department of Human Services in Philadelphia, believes that the CANS is "one of the best things to hit child welfare services." At first, she was skeptical about the CANS, because it is completed without ever meeting the child, but she soon realized its value. Ms. Elfman describes the CANS as an "information integration document, not an assessment tool" and thinks "everybody should use the CANS." The Department of Human Services (DHS) in Philadelphia started using the CANS to reduce the number of out-of-state placements of youth in care. The CANS helped DHS identify those youth who would be most appropriate for a treatment foster care level of care, based on a cluster of needs of the local population. DHS uses the CANS to assess youth at entry into care, at 12-month follow-up, then every six months thereafter. This allows DHS to know when it is appropriate to step the child down in placement.

Although there was a lot of initial resistance to using the CANS in Philadelphia, Ms. Elfman reported the resistance was largely towards the non-collaborative implementation process. As a result of this process, some service providers felt that the use of the CANS would limit their decision-making on behalf of the youth. With time, however, service providers, including treatment foster care providers, have realized that the CANS is incredibly helpful.

Ms. Elfman suggests that any agency interested in using the CANS should "have a clear focus about what it is (they) are trying to accomplish" and to build the capacity to collect data (26).

Ohio Youth Problem, Functioning and Satisfaction Scales (Ohio Scales) (27)

The Ohio Scales assess problem severity, functioning, hopefulness, and satisfaction with behavioral health services in youth ages 5-18. The scales have three parallel forms that can be completed by the youth's parent or primary caregiver, the youth (12 and over), and the youth's caseworker. The Ohio Scales were created in the state of Ohio to assess the outcome of youth receiving publicly funded mental health services. (27).

Internal consistency for each scale (problem severity, functioning, hopefulness, and satisfaction) in clinical and comparison samples is rated as "adequate or better," with the problem severity scale showing infrequent endorsement (28). Few individual items were rated as "poor." Test-retest reliability, on all but one scale (youth rated functioning scale) of the parent and youth versions of the measure, was rated as "adequate or better" when the scale was given at two time points in separate locations (while waiting for an appointment and while at home) (28). Data obtained from adolescents in outpatient treatment supported adequate test-retest reliability when the measure was given at three different time periods at irregular intervals (28).

The Ohio Scales are currently being used in a pilot project to measure the outcomes of children in residential treatment and foster care, including youth in TFC in Ohio. The scales have also been used with foster care youth in New York City, Austin, Seattle, and San Diego as part of a pilot project sponsored by Casey Family Programs.

Strengths and Difficulties Questionnaire (SDQ) (30)

The SDQ is a brief questionnaire consisting of 25 items assessing positive and negative attributes on five scales (emotional, conduct, hyperactivity, peer problems, and pro-social behavior). An Impact Supplement is also available to assess chronicity, distress, and social impairment. The SDQ has been used for clinical assessment, epidemiological studies, research, and screening purposes. A self-report version of the measure exists for adolescents, age 11-17, as well as teacher and parent versions for children 4-10 and 11-17. Follow up questionnaires for

Voices *from the* Field

Ohio Youth Problem, Functioning and Satisfaction Scales (Ohio Scales)

Specialized Alternatives for Families and Youth of America, Inc. (SAFY) is a non-profit treatment foster care and mental health agency that operates in eight states. In Ohio, SAFY has used the Ohio Scales in their nine Divisions since the Ohio Department of Mental Health (ODMH) began to require their use.

According to Roger Smith, Ph.D., Vice President of Mental Health at SAFY, the Ohio Scales are "pretty self-explanatory" and do not require a lot of formal staff training. While some staff members view the scales as another piece of paperwork that they have to complete, many of them appreciate the value of the scales and their help in identifying client strengths and problem areas. Dr. Smith has been pleased with the agency's experiences with the Ohio Scales and would "absolutely" implement them again if given the choice.

One of the challenges that SAFY has experienced is ensuring that the Ohio Scales are completed and entered into SAFY's database so SAFY can send ODMH the aggregate data. With this data, the ODMH issues reports comparing an individual agency to the state's total database.

Dr. Smith recommends that agencies not only look at the aggregate data, but also look at change scores for individual clients. This information can be very helpful in the development of treatment plans and measuring a client's progress. He suggests that agencies considering implementing the Ohio Scales make sure they have good tracking procedures and "help the staff understand the clinical values of the scales." (29)

both age ranges should be given approximately one month following the last visit. All versions of the SDQ are available in 46 languages (30).

The SDQ has been evaluated specifically for use with youth in the child welfare system (31). One study showed that the SDQ reliably predicted psychiatric diagnosis, but that obtaining the youth information did not provide much more significant information than that provided by an adult (a caregiver or a teacher) (31).

Child Behavior Checklist (CBCL) (32)

The CBCL is a standardized, norm-referenced measure of social competence and behavioral functioning in four general domains (externalizing symptoms, general symptomatology, internalizing symptoms, and mood and anxiety symptoms) (33) for children age 1½-18 (34) that has been used in TFC settings. Parent/teacher and child-completed (ages 11-17 only) versions of the measure exist (33). Each version has 113 items and takes approximately 15-20 minutes to complete. A version of the CBCL for younger children (ages 1½-5), only takes 10 minutes for parents to complete (34). The CBCL yields scores for internalizing and externalizing disorders, as well as total problems and DSM-IV related scales (33). The measure has demonstrated internal consistency, test-retest reliability, and inter-rater reliability, as well as content, construct, and criterion validity (35).

Diagnostic Interview Schedule for Children (DISC) (36)

The DISC is a highly structured diagnostic instrument based on the Diagnostic and Statistical Manual of Mental Disorders (DSM) that can be administered by lay interviewers/non-clinicians (37) and is available in a computerized format (37). There are parent and youth versions of the instrument. The parent version is for parents of children age 6-18 years. The youth version can be directly administered to children ages 9-18 (37) and is also available in a computerized, voice version that allows for self-administration.

The DISC is organized as a series of modules. The first module assesses demographic information (e.g., age, grade, names and ages of siblings, etc.). The next six modules target disorder areas (i.e., Anxiety, Mood, Disruptive, Substance Use, Schizophrenia, and Miscellaneous Disorders) and assess whether or not a respondent meets the criteria for a specific diagnosis within these broad disorder areas. There is an optional Whole Life module that assesses whether or not a specific diagnosis was ever present in the child's life after age 5 and prior to the current year.

DISC Predictive Scales (DPS) (38)

The DPS is a brief, diagnostic screening measure based on the DSM. Parent and Youth versions of the DPS exist for children ages 9-17. The DPS has approximately 90 items and takes about ten minutes to complete. It accurately predicts whether or not a child is likely to meet criteria for a DISC diagnosis (38). Although the DPS has not been formally evaluated in child welfare settings, it has been used in several foster care agencies in New York City, Austin, Seattle, and San Diego as part of a pilot project sponsored by Casey Family Programs.

Behavior Assessment System for Children (BASC) (39)

The BASC is a comprehensive and developmentally-sensitive measure of the emotions and behaviors of youth ages 2-25 with demonstrated test-retest reliability and built-in validity checks (39). Eight scales (anger control, bullying, developmental social disorders, emotional self-control, executive functioning, negative emotionality, and resiliency) compose the measure (40).

Versions of the BASC exist for youth (self-report), parents (parent rating scales, structured developmental history, and parenting relationship questionnaire), and teachers (teacher rating scale, student observation system, and portable observation program). Each version takes approximately 10-30 minutes to complete (40).

Child and Adolescent Level of Care Utilization System (CALOCUS) (41)

The CALOCUS, developed by the American Association of Community Psychiatrists (AACP) (41), is designed to determine the level of care that a child needs based on the child's clinical needs. It is not a diagnostic measure, but rather assesses the presenting problems and related co-morbid conditions of a child (41). The CALOCUS may be used at multiple time points (i.e., admission, continued stay, and discharge), eliminating the need to use different tools at different time points (42). Information for the CALOCUS is obtained by a professional conducting a clinical assessment (41, 42).

A computerized version of the CALOCUS has been developed by Deerfield Behavioral Health, Inc. The software has the capability of retrieving, reporting, and aggregating data of each set of results stored in the system, thus facilitating tracking of a child's progress (43).

The Child and Adolescent Service Intensity Instrument (CASII) (44)

The CASII is an adaptation of the CALOCUS used to measure the strengths and needs of children, ages 6-18, who are seriously emotionally disturbed or have a mental health, developmental, or substance use disorder (45). The instrument helps service providers determine the appropriate level of service intensity for a child and may be completed by multiple informants. The CASII measures six dimensions, including risk of harm, functional status, co-occurrence of conditions, recovery environment, resiliency and/or response to service, and involvement in services. The measure should be used upon entry into service, when there are any significant changes for the youth, and upon completion of service (44). A study conducted by the AACP showed that the CASII can be used reliably among different clinicians (physicians and non-physicians) and is valid when compared with the CAFAS and the Child Global Assessment Scale (CGAS) (44).

Summary

A variety of evidence-based mental health screening and assessment measures exist that can assist TFC providers in identifying children in need of mental health services and monitor service outcomes. Some of these measures (i.e., CAFAS, CANS-MH, CBCL, Ohio Scales, and SDQ) have been specifically validated in child welfare settings. Others (i.e., DISC, DISC DPS, BASC, CALOCUS, and CASII) have been validated in clinic settings, but have applicability in child welfare. All of these measures may be completed by multiple informants (child, teacher, parent, and/or clinician) thus facilitating information gathering from different sources. The measures are also feasible for use in TFC settings in terms of completion time. The *Tools and Resources* section of this Guide provides information about how to obtain all of the measures described in this section. With a few exceptions (i.e., SDQ, Ohio Scales), most of the measures must be purchased for use.

Psychosocial Interventions

Children in TFC often require mental health treatment to supplement the support they receive from their foster parents and caseworkers. This section of the *Resource Guide* describes evidence-based psychosocial interventions for psychiatric disorders most commonly found in children involved with the child welfare system. These disorders include: Post Traumatic Stress Disorder and Abuse-related Trauma, Disruptive Behavior Disorders, Depression, and Substance Abuse.

The material presented in this section draws heavily from a comprehensive review of mental health care for children and adolescents in foster care prepared for Casey Family Programs and the *Best Practices for Mental Health and Child Welfare Consensus Conference* by John Landsverk, Barbara Burns, Leyla Faw Stambaugh, and Jennifer Rolls Reutz (46). Only a few of the interventions, described below, have been specifically used in child welfare settings. Most have been used with success in mental health clinics or schools – two settings that TFC providers often collaborate with.

Table 2 summarizes all the psychosocial interventions described here. Additional information about each intervention, including how to purchase the intervention manual, training requirements, and contact information is provided in the *Tools and Resources* section.

Interventions for Post-Traumatic Stress Disorder (PTSD) and Abuse-Related Trauma

Children who have been abused or neglected tend to experience Interventions for PTSD and Abuse-Related Trauma at rates higher than youth in the general population. The 2007 Casey Family Programs Field Office Mental Health Study revealed that 13.4% of youth in care were diagnosed with PTSD as compared to 5.2% of youth in the general population (47). Several trauma-focused interventions have been developed to address the physical, emotional, and behavioral symptoms experienced by abused or neglected children. These interventions include:

- Trauma-Focused Cognitive Behavioral Therapy
- Trauma-Focused Cognitive Behavioral Therapy for Childhood Traumatic Grief
- Abuse-Focused Cognitive Behavioral Therapy
- Parent-Child Interaction Therapy
- Child-Parent Psychotherapy for Family Violence
- Structured Psychotherapy for Adolescents Responding to Chronic Stress

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) (48)

TF-CBT is an intervention designed to help children, ages 4-18, and their parents overcome the negative effect of traumatic life experiences. Comprised of 12-16 one-hour sessions, the intervention focuses on teaching children new skills to cope with their traumatic experience. These skills include emotion regulation, stress management, personal safety, coping with future trauma reminders, and linking trauma-related thoughts, feelings, and behaviors (46). In addition, TF-CBT teaches parents how to encourage the use of these skills in their children, as well as parenting skills (49).

Several randomized, controlled trials (RCTs) have compared TF-CBT to other treatments for childhood trauma (i.e., non-directive play therapy, supportive therapies) (46). Results have shown that TF-CBT is associated with sustained improvement in PTSD symptoms, depression, anxiety, behavior problems, and sexualized behaviors, as well as reduced feelings of shame and mistrust. In addition, TF-CBT has been found to be highly effective with foster care youth populations, reducing trauma symptoms and placement interruptions (i.e., running away, arrests) (50). Parental involvement in TF-CBT increases the positive effects of the treatment for children (51). Thus, the involvement of both a treatment foster parent and

birth parent in TF-CBT is highly desirable, particularly when reunification is a goal. TF-CBT allows for substantial flexibility to facilitate birth parent participation (52).

TF-CBT for Childhood Traumatic Grief (54)

TF-CBT for Childhood Traumatic Grief is a relatively new treatment for children suffering from traumatic grief as a result of the traumatic loss of a loved one (46). These children often experience symptoms of PTSD, depression, anxiety, and/or behavior problems that make it difficult for them to grieve their loss. Each TF-CBT for Childhood Traumatic Grief session lasts one hour and the entire treatment is brief (12-16 sessions). The treatment is similar to TF-CBT, but focuses more on fear and sadness associated with bereavement.

TF-CBT for Childhood Traumatic Grief has some evidence of effectiveness. Two open trials assessed outcomes associated with the treatment for children age 6 to 17 who lost parents in the September 11, 2001 terrorist attacks (46). Results of these trials indicated specific treatment components were linked to changes in symptoms over time (46).

Abuse-Focused Cognitive Behavioral Therapy (AF-CBT) (55)

AF-CBT is a 12-18 session (one-hour per session) intervention for physically abusive parents and their children, ages 4 to 18, designed for delivery in clinic or home settings. The intervention addresses both the risks and consequences associated with physical abuse and draws from learning and behavior theory, family systems, and cognitive therapy (46). AF-CBT teaches a variety of skills to parents and children including interpersonal skills, thinking and feeling skills, coping, relaxation, and anger management. In addition, the promotion of prosocial behavior and discouragement of coercive or aggressive behavior are key components of the intervention. When feasible, both birth parents and treatment foster parents are encouraged to take an active role in the child's treatment and strive for joint treatment goals (56).

Research indicates that AF-CBT is associated with decreases in parental anger and the use of physical discipline and force. In addition, studies have found AF-CBT leads to more rapid decreases in child-to-parent aggression, child behavior problems, parental abuse potential, psychological distress, and drug use, as compared to family therapy (57, 58).

Voices *from the* Field

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

Counseling4Kids, a community mental health agency located in Southern California, has been implementing Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) for two years with good success. On average, the agency treats 600 children per year with TF-CBT. Positive outcomes have included reductions in PTSD, depressive and behavioral symptoms after six months with significantly more youth-reported strengths as measured by the Child and Adolescent Needs and Strengths (CANS) Assessment.

Counseling4Kids utilizes a home-based service delivery model to provide TF-CBT to foster youth. According to Doug Johnson, Ph.D., former Director of Research and Evaluation and current consultant for the agency, this model has allowed clinicians to attain a 90% participation rate by avoiding cancellations, no-shows, and transportation issues. Overall, family reactions to the treatment have been positive, but some parents were initially concerned with how quickly the intervention proceeds.

Dr. Johnson reported that implementing TF-CBT at Counseling4Kids has been a challenge. Clinician turnover and transition to the program have posed issues along with the extra supervision initially needed for clinicians to progress through the new model. The theoretical orientation of clinicians has influenced the ease of transition to the TF-CBT model with clinicians well-versed in cognitive-behavioral therapy (CBT) having a smoother transition than those with a psychodynamic orientation.

Dr. Johnson recommends that agencies considering TF-CBT should use the Plan-Do-Study-Act (PDSA) implementation method to get the intervention started and to stay on track. In addition, he suggests beginning program implementation with a small number of competent clinicians and gradually increasing the number, as needed, as a way of avoiding difficult agency-wide transitions (53).

Parent-Child Interaction Therapy (PCIT) (59)

PCIT is a structured, yet brief intervention ranging from 12 to 20 one-hour sessions depending on problem severity. This intervention was originally developed for children with behavioral problems and has been specifically adapted for use with physically abusive parents and their children (ages 4 to 12 years old). PCIT sessions involve live coaching during which parents learn how to apply specific parenting skills (i.e., relationship-enhancing, positive discipline, and compliance) while playing with their children in the presence of a clinician (46). If reunification is a goal, both the birth parent and the treatment foster parent are encouraged to participate in the treatment. For optimal results, the birth parent must be available to practice the various intervention skills with the child at least three times a week through arrangements made with the foster parent or the child's school (60).

Voices *from the* Field

Parent-Child Interaction Therapy (PCIT)

Parent-Child Interaction Therapy (PCIT) has been implemented at FamiliesFirst, a child welfare agency located in Northern California. Jim Diel, Ed.M., an administrator and clinician at FamiliesFirst, reported that the agency chose to implement PCIT to increase the number of evidence-based practices available and reduce dependency on a single modality.

Clinicians from FamiliesFirst received training in PCIT at the University of California-Davis Medical Center. In order to be certified in the intervention, clinicians had to attend two didactic training sessions and receive six months of consultation.

According to Mr. Diel, most staff members at the agency enjoy the tools available through the intervention (i.e., videos). Overall, families have been pleased with the outcomes of the intervention, which include increased social-emotional functioning and compliance with parents, as well as reduced destructive behaviors.

There have been some challenges associated with implementing PCIT at FamiliesFirst. Most notable, attendance difficulties due to transportation needs of clients.

Mr. Diel recommends agencies considering PCIT should secure grants to fund the training and equipment needed to successfully implement the intervention and to arrange for transportation assistance for families that might need it (61).

Several research studies have indicated that PCIT is associated with positive, long-term outcomes for children with behavior problems (46). Studies have also shown that PCIT leads to reductions in subsequent reports of physical abuse or risk for abuse for parents with child maltreatment histories (46). Overall, PCIT has strong support for its effectiveness with parents of children with behavior problems, as well as abuse histories, making it an intervention of great value for TFC.

Child-Parent Psychotherapy for Family Violence (CPP-FV) (62)

CPP-FV targets young children (infancy to age 5) and their parents who have witnessed domestic violence or who display violence-related trauma symptoms (46). The intervention draws from psychodynamic, attachment, trauma, cognitive-behavioral, and social-learning theories and is delivered in one-hour weekly sessions over the course of approximately 12 months. Sessions include both the parent and child and address the parent-child relationship and the child's functioning. If reunification is a goal, birth parent participation in treatment, coupled with foster parent consultation, can be effective. It is also possible to begin treatment with foster parent participation and transition to birth parent participation (63).

In research, CPP-FV has been compared to psychoeducational home visitation, standard community treatment, and no treatment (64-66). Results indicated improvement in behavioral problems and symptoms of traumatic stress, as well as decreased maternal avoidance for children who received CPP-FV (46).

Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS) (67)

SPARCS is a 16 session (one-hour per session) group intervention for adolescents, ages 12-21, who have experienced chronic trauma and have developed problems in several areas of functioning. SPARCS uses cognitive-behavioral and dialectical-behavioral techniques in order to both enhance current strengths and foster resilience (68). The goals of the intervention include improving adolescents' abilities to cope more effectively in the moment, cultivate awareness, enhance self-efficacy, connect with others, and create a sense of meaning in their lives. SPARCS can include a brief parental component with parent-clinician meetings held independently of the adolescent group (68, 69).

Pilot data research on an earlier 22-session version of SPARCS revealed improvements in overall functioning, particularly in levels of behavioral dysfunction and interpersonal relationships, as well as effective coping and improved support seeking behavior for youth who participated in the group (69). A trial of the 16 session SPARCS, versus a standard of care comparison group, found that adolescents in foster care receiving SPARCS were half as likely to run away, and one-fourth less likely to experience placement disruptions (i.e., arrests, hospitalizations, runaways, etc.) (50). Other trials are currently being conducted.

SPARCS draws from several interventions that have been empirically supported to work effectively with traumatized individuals. These include Trauma Adaptive Recovery Group Education and Therapy—TARGET (70), Dialectical Behavior Therapy—DBT (71), and the University of California Los Angeles Trauma/Grief Program (72). The development of SPARCS has differed from traditional practice in treatment design. SPARCS was created, refined, and evaluated in collaboration with multiple clinicians and community agencies that have been members of the National Child Traumatic Stress Network over the past few years. These agencies, which include urban, suburban, and rural sites that span the U.S. and serve many diverse populations, have provided valuable feedback, thereby enhancing the cultural competence of SPARCS.

Interventions for Disruptive Behavior Disorders

Children in TFC frequently suffer from disruptive behavior disorders (DBD). These disorders include Attention Deficit Hyperactivity Disorder (ADHD), Oppositional Defiant Disorder (ODD), and Conduct Disorder (CD). Youth in care have higher rates of ADHD (15.1%) and CD (20.7%) compared to youths in the general population, 4.5% and 7.0%, respectively (47). Several psychosocial interventions have been developed to address DBD. These interventions fall into two broad categories:

Parent-focused Interventions

- Parent-Child Interaction Therapy *(see page 18 for a complete description)*
- Parent Management Training
- Incredible Years
- Time Out plus Signal Seat
- Project Keep

Child-focused Interventions

- Anger Coping
- Problem Solving Skills Training
- Assertiveness Training
- Anger Control Training with Stress Inoculation
- Rational Emotive Behavior Therapy

Parent-focused Interventions

Parent Management Training (PMT) (73)

PMT typically targets the parents of young children (under 5 years of age) with behavioral problems. The intervention uses principles of operant conditioning to teach parents behavioral management skills, such as rewarding positive behavior, ignoring, and appropriate use of punishment. The intervention can be conducted in groups or with individual families. Numerous studies have shown that when compared to psychodynamic therapy and no treatment, PMT produces superior outcomes for children with conduct disorder (73). Within TFC, PMT should involve both the birth and foster parents, if reunification is a goal. (74)

Voices *from the* Field

Incredible Years

FamiliesFirst, a child welfare agency located in California, has been implementing Incredible Years for three years. According to Jim Diel, M.Ed., an administrator and clinician at the agency, FamiliesFirst decided to implement the program because of the appeal of its adaptable nature, psycho-educational and group support components.

Mr. Diel and Nan Thibodeaux, M.A., L.M.F.T., a clinician and supervisor at the agency, reported positive feedback from staff members and families participating in the Incredible Years program. Families enjoy its flexible, but structured format, as well as the opportunities for social support during and post-treatment. Staff members find the program helpful for improving parent skills and family interactions. Participation in the program has been associated with improved outcomes for children as measured by the Child and Adolescent Functional Assessment Scale (CAFAS).

As with implementation on any program, there have been a few challenges. For some families, transportation to the group meetings has been difficult and the agency has had to request assistance from the county to address this issue. The lack of Spanish materials and access to timely training have also been a concern. Despite these challenges, Mr. Diel and Ms. Thibodeaux would implement the program again. Mr. Diel recommends that agencies that are considering the implementation of Incredible Years should offer training on a quarterly basis in the event of clinician turnover and consider training with other agencies as a way of minimizing costs (77).

Incredible Years (75)

Incredible Years shares a common theoretical foundation with PMT and also targets the parents of young children with behavior problems. This intervention uses parent-child videotape vignettes to illustrate and teach key behavioral management techniques to parents (46). The intervention is delivered in a group format by a trained clinician over the course of 12 two-hour sessions. Incredible Years has strong research evidence indicating that it leads to improvement in parenting skills (75). If reunification is a TFC goal, the birth parent and case worker or the birth parent and foster parent of a child may attend an Incredible Years group together. Alternatively, parallel work with the birth and foster parents can occur (76).

Time Out plus Signal Seat (78)

Time Out plus Signal Seat is a self-instructive intervention for parents of young children (2-7 years) with behavior problems (46). The intervention is based on the principles of operant conditioning and teaches parents how to use positive reinforcement and time-out to manage behavior. The signal seat is a seat wired to produce a noise if a child leaves it before a time-out period has expired. A study comparing the intervention to a wait-list control found children receiving the intervention displayed fewer negative behaviors (78).

Project Keep (Keeping Foster and Kin Parents Supported and Trained) (79)

Project Keep is a 16-week group intervention that provides seven to ten foster and kinship parents with coping tools and support for their work with children (ages 5-12) who exhibit externalizing symptoms and other behavioral and emotional problems. A comprehensive set of skills are covered in Project Keep, including, but not limited to, effective limit setting, encouraging participation, strengthening interpersonal relationships, and parental stress management. Findings from a controlled randomized study found parents who participated in Project Keep reported reduced rates of child problem behaviors, fewer placement disruptions, and increased rates of family reunification and adoption (79).

Child-focused Interventions

Anger Coping (80)

Anger Coping is a 12-18 session group intervention designed for children (ages 8-12) with disruptive behavior problems. The intervention can be implemented in school or clinic settings and uses a social-cognitive perspective to teach problem recognition, physiological awareness, and problem solving skills. Within school settings, teachers are responsible for making child referrals and may have the opportunity to co-lead sessions with a school psychologist (80). Birth and/or foster parents are highly encouraged to come into the school to learn about the intervention and provide consent. Furthermore, parallel parental involvement within a PMT program is highly recommended and can further reduce aggressive behaviors (81).

RCTs of Anger Coping have revealed reductions in childhood aggression (both in and out of the home) and improved child perceptions of social competence, self-esteem, and on-task class room behavior with improvements being sustained after one-year follow-up (81, 82). Coping Power, a longer (33 sessions), multifaceted version of Anger Coping that includes concurrent child and parent components has resulted in improved and longer-lasting outcomes (i.e., lower levels of fearlessness and externalizing behavior, improved peer acceptance, etc.) (82).

Problem Solving Skills Training (PSST) (83)

PSST is a 12-20 session (30-50 minutes each) individual intervention for children (ages 6-14). Treatment focuses on teaching cognitive problem-solving skills that address interpersonal problems and impulsivity through various procedures including modeling, role play, and reinforcement, as well as critical reliance on the therapeutic provision of social reinforcement (83). Concurrent work with custodial parents is essential for helping parents learn about the problem-solving steps and promoting their child's use of these steps (74).

RCTs reveal that PSST helps to reduce internalizing and externalizing behaviors, as well as child aggression, while increasing prosocial behaviors and adjustment. Changes have been maintained at one-year follow-up. The involvement of the child's family in treatment has been associated with increased positive outcomes (i.e., less aggression) (83).

Assertiveness Training (85)

Youth assertiveness training programs provide opportunities and support to help youth with aggressive behaviors gain the improved self-control and interpersonal skills needed to meet the various challenges they will face as they mature. Assertiveness training is frequently used as a component within the context of therapy for youth with various issues, including anger control problems.

Research indicates that assertiveness training programs lead to improvements in youth confidence and social skills by helping youth to become more outgoing, to learn how to effectively resolve conflicts, and to overcome fears. Positive results have been maintained up to one-year post-treatment (85). Controlled studies on assertiveness training curricula have shown improvements in the use of assertiveness skills among school age youth (86, 87).

Anger Control Training with Stress Inoculation (88)

Anger Control Training with Stress Inoculation focuses on helping adolescents (age 12-18) to understand the causes and consequences of their anger. This 10-session group treatment is typically delivered in a school or clinic setting and teaches anger management and coping skills. The stress inoculation component provides opportunities to practice learned skills by exposing the adolescent to a trigger situation in a constructive environment. Controlled studies have supported the efficacy of Anger Control Training with Stress Inoculation and reported reduced delinquency or disruptive classroom behavior (88).

Rational Emotive Behavior Therapy (REBT) (89)

REBT is an individual, short-term treatment (10-20 sessions) with therapeutic aspects similar to cognitive behavioral therapy (CBT) (90). REBT is designed to improve the moral reasoning and judgment skills of youth with conduct disorder (46). REBT seeks to challenge thinking and irrational beliefs, while promoting rational self-talk and various strategies to achieve these goals. Some strategies include disputing irrational beliefs, reframing, problem solving, behavior reversals, role-playing, and modeling (91).

Research has found that children and adolescents who received REBT demonstrate fewer disruptive behaviors and higher school achievement as compared to adolescents who received client-centered therapy or no treatment (46, 92). Positive results were maintained at six months (93) and one-year follow-up (94). Although REBT does not include a parent component, a birth or treatment foster parent can be invited to join sessions depending on the treatment goals (95).

Interventions for Depression

Depression is one of the most frequently diagnosed mood disorders among children and adolescents (96) and is commonly experienced by children in the child welfare system, especially those who have experienced abuse and neglect. Youth in care report higher lifetime rates of major depressive disorders as compared to youth in the general population (19% to 11.9%) (47). Mood disorders, such as depression, place youth at an increased risk for suicide, which is the third leading cause of death among youth 15-24 years of age (96). Several psychosocial interventions for depression in children and adolescents have research supporting their efficacy. These interventions are listed and described here.

Evidence-based Interventions for Depression

- Coping with Depression
- Interpersonal Psychotherapy for Adolescents
- Self-Control Therapy
- Relaxation Therapy
- Cognitive Behavioral Therapy

Coping with Depression (CWD-A) (97)

CWD-A is a 16-session (two hours per session) group intervention designed to teach depressed adolescents specific skills for combating depression. Skills covered in the group include mood monitoring, relaxation training, and conflict resolution skills. The intervention includes an optional parent component designed to help parents learn these skills and assist their children in using them.

CWD-A has strong research supporting its efficacy. Three large, controlled trials have produced positive results for the intervention as compared to wait-list control with improvements in depression symptoms maintained at two years post-treatment (46). Furthermore, the involvement of a stable custodial parent in treatment can contribute to increased positive outcomes (98).

Interpersonal Psychotherapy for Adolescents (IPT-A) (99, 100)

IPT-A, an adaptation of Interpersonal Psychotherapy (IPT), is a brief treatment originally developed for the treatment of depressed, non-bipolar adults (101). IPT places the depressive episode in the context of interpersonal relationships and focuses on current interpersonal conflicts. IPT aims to decrease depressive symptomatology and increase interpersonal functioning.

IPT-A has been adapted to treat outpatient adolescents who are suffering from a nonbipolar, nonpsychotic, depressive episode. It is a 12 session (60-90 minutes per session) manualized, individual or group treatment that addresses developmental issues most common to adolescents, including separation from parents; development of dyadic, romantic interpersonal relationships; initial experiences with the death of a relative or friend; and peer pressures. Both birth and foster parents, as well as other family members, may be involved in various phases of IPT-A, as needed (102), and to address special issues that arise in the treatment of adolescents (e.g., school refusal, physical or sexual abuse, suicidality, aggression, and involvement of a child protective service agency) (103). IPT-A has been found to reduce depressive symptoms and increase social functioning. It has demonstrated efficacy and has been proven effective in school-based mental health clinics (99, 100).

Self-Control Therapy (104)

Self-Control Therapy is a brief 10-12 session treatment for depressed children which incorporates cognitive and behavioral techniques, including self-monitoring, managing aversive events, assertiveness, relaxation training, and the development of self-reinforcement patterns (46). The treatment may be delivered on an individual or group basis.

In a study comparing self-control therapy, behavioral problem-solving therapy, and a wait-list control, results indicated that both interventions, as compared to the wait-list control, led to significant improvements (104). Enhanced self-control therapy, which includes twice as many sessions and monthly family meetings, has also shown superior results compared to traditional counseling with results maintained at seven month follow-up (105, 106).

Relaxation Therapy (107)

Relaxation Therapy is a 10 session (50 minutes per session) group treatment focusing on the relationship between stress, muscle tension, and depression that teaches adolescents the skills needed to facilitate self-relaxation. It is commonly included as a component of therapy for depression or anxiety. Two RCTs have been conducted comparing Relaxation Therapy to CBT (107) and self-modeling (108), respectively. These studies found that relaxation therapy decreased depression and anxiety while increasing self-esteem among adolescents (46).

Cognitive Behavioral Therapy (CBT)

CBT for depressed children and adolescents is a brief, structured intervention that focuses on the relationship between thoughts, feelings, and behavior. Numerous CBT for depression manuals, designed for use with children and adolescents exist. These include Adolescent Coping With Depressing Course (CWD-A) (109), Collaborative Care, Cognitive-Behavioral Program for Depressed Youth in a Primary Care Setting (110), and Cognitive Therapy Treatment Manual for Depressed and Suicidal Youth (111). The treatment described in all of these manuals share a common focus on psychoeducation, mood monitoring, behavioral activation, and cognitive restructuring.

Research on CBT for depressed children and adolescents has produced mixed results (46). A few controlled studies and meta-analyses have demonstrated positive results (112, 113). Two studies have reported no superior effects compared to control groups (114, 115). In addition, limited long-term follow-up research has not produced promising results (116). Some research suggests that monthly, CBT booster sessions following treatment completion can help to reduce relapse (117).

Interventions for Substance Abuse

Children in the child welfare system who suffer from PTSD, disruptive behavior disorders, and/or depression often experience problems related to substance use during adolescence. Approximately 45% of youth in foster care report using alcohol or illicit drugs within the last six months, almost half of the youth report having tried drugs at some point during their lifetime, and nearly a third meet criteria for a substance use disorder (118). The following interventions have evidence supporting their use for the treatment of adolescent substance abuse.

Evidence-based Interventions for Substance Abuse

- Brief Interventions
- Cognitive Behavioral Therapy
- Family-based Interventions
  - Brief Strategic Family Therapy
  - Functional Family Therapy
  - Multidimensional Family Therapy

Brief Interventions

Brief Interventions address an adolescent's motivation to attend treatment and aim to reduce the harmful consumption of alcohol, tobacco, and other drugs (46). Motivational interviewing and health education programs are examples of brief interventions. Research has shown that brief interventions, conducted in one to four sessions, lasting up to 15 minutes in duration, typically result in small to moderate effects, including decreases in consumption and increased engagement in treatment (119). Results have been stronger for adolescents with heavier substance use or lower motivation at intake (120).

Cognitive Behavioral Therapy (CBT) for Substance Abuse (121)

CBT for Substance Abuse is a 5-12 session individual or group intervention that assists adolescents in identifying and avoiding high-risk situations that may trigger substance use by teaching coping, self-efficacy, and relapse prevention skills (46). Research on CBT as a treatment for substance abuse has revealed positive outcomes for both group-based and individual CBT (120). The long-term effect of CBT on substance use is unclear. One study found continued improvement at nine-month follow-up (122), but others have reported leveling off of improvement at six-month follow-up (123) and an increase in relapse rates at 12-month follow-up (124).

Family-based Interventions

Family-based interventions for substance abuse recognize the role that the family environment frequently plays in the successful recovery of adolescents with substance use problems (46). These treatments typically address several family factors (i.e., conflict, parenting practices) that may contribute to and exacerbate substance abuse. Research has supported the use of Brief Strategic Family Therapy (BSFT), Functional Family Therapy (FFT), Multisystematic Therapy (MST), and Multidimensional Family Therapy (MDFT) as family-based treatments for adolescent substance abuse. MST is fully described on page 32. BSFT, FFT and MDFT are described here.

– Brief Strategic Family Therapy (BSFT) (125)

BSFT is a 12-15 session treatment (60-90 minutes per session) which targets children (age 6-17) exhibiting emotional and behavioral problems, and families with problematic relations (i.e., anger, blaming, etc.). Therapists seek to change maladaptive family interaction patterns as they occur in session by coaching the

family on how to interact more functionally. Additional techniques used include joining or engaging with the family, identifying maladaptive interactions and family strengths, and restructuring maladaptive interactions (126). BSFT can be delivered in home, clinic, and community-based settings. Research has predominantly evaluated the effect of BSFT on children with behavior disorders. Study results have demonstrated several positive effects for Caucasian and Hispanic youth receiving BSFT, including decreased behavior problems, decreased association with antisocial peers (125), increased family involvement in therapy (127), and increased family communication and warmth (128). Given the association between behavior problems and substance abuse, BSFT appears to be a promising intervention for adolescents with substance abuse problems.

– Functional Family Therapy (FFT) (129)
FFT is a brief intervention for children, ages 11-18 years, at risk for, or presenting with, disruptive behavioral disorders and/or substance abuse (46). FFT typically involves 8-15, one-hour sessions and may be delivered in a variety of settings, including the home, clinic, or a juvenile facility. The intervention aims to enhance protective factors and reduce risk factors within the family through processes of engagement, motivation, assessment, behavior change, and generalization. Research comparing FFT to residential treatment has reported positive findings in the reduction of re-offending (130) and the onset of behavioral problems in siblings (131).

– Multidimensional Family Therapy (MDFT) (132)
MDFT is the only family-based model that was developed to treat substance abuse as the primary disorder. The intervention is focused on three domains: the adolescent, the adolescent's interaction with his or her family, and the family's interaction with the social environment. In a study comparing MDFT to CBT for substance abusing adolescents, both treatment groups experienced significant reductions in substance use and disruptive behaviors (132). However, one year post treatment termination, the MDFT group was more successful at maintaining these positive outcomes. In another randomized trial comparing MDFT to a peer group therapy intervention for early-age substance users (11 to 15 years) with comorbid behavior problems, MDFT was superior to the comparison condition in decreasing substance use, reducing risk factors, and increasing protective factors in family and community domains (133).

Summary

Youth in foster care experience mental health disorders, such as PTSD, ADHD, ODD, CD, Depression, and Substance Abuse at rates higher than youth in the general population (2). As such, TFC providers must be able to connect these youth to appropriate and effective mental health interventions. Unfortunately, few interventions have been specifically developed and validated for youth in TFC. However, a variety of evidence-based interventions for youth mental health disorders exist that have applicability to TFC youth.

This section described several evidence-based interventions for the treatment of PTSD and abuse-related trauma, Disruptive Behavior Disorders, Depression, and Substance Abuse in Youth. The *Tools and Resources* section of this Guide provides additional information on how to access training and materials for these interventions. Most of the interventions described are short-term and based on cognitive-behavioral or behavioral principles. Although these interventions were not specifically developed for TFC or foster care youth, they can involve birth parents and foster parents when indicated.

Psychopharmacologic Approaches

Children in TFC with diagnosed psychiatric disorders may require medication, in addition to psychotherapy, to adequately address their mental health needs. Unfortunately, with the exception of research on stimulants to treat ADHD, there is not enough research evidence available to support the efficacy of most psychotropic medications used to treat childhood psychiatric disorders (134). Thus, prescribing clinicians must use research conducted with adults and clinical experience to make medication decisions for children.

Clearly, more research is needed to guide the use of psychotropic medications in children. This research, however, will take time and prescribing clinicians need guidance now. Numerous expert consensus guidelines for the use of psychotropic medications in children exist (for a list, refer to the *Tools and Resources* section of this Guide). These guidelines are particularly helpful for primary care and pediatric clinicians who often prescribe psychotropic medications to children, but do not have the expert training of child psychiatrists (134).

Children involved in the child welfare system are no different than other children with respect to how medications work (134). These children do have unique circumstances that necessitate the close monitoring and evaluation of prescribed medications. The Texas Department of State Health Services developed a set of parameters for the use of psychotropic medications with foster children. These parameters are presented in this section of the *Resource Guide* along with a brief overview of medications for the treatment of Trauma, Disruptive Behavior Disorders, Depression, and Substance Abuse.

Pharmacotherapy Best Practices for Children with Mental Disorders in Foster Care

The following guidelines were developed by the Texas Department of State Health Services to guide the use of psychotropic medications among children in foster care (134). A more detailed explanation of each guideline is available at www.dshs.state.tx.us/mhprogram/psychotropicMedicationFosterChildren.shtm

Guidelines for the Use of Psychotropic Medications Among Children in Foster Care

- An extensive review of child's clinical status should be conducted prior to administering psychotropic medication.
- The identification and documentation of symptoms and treatment goals should be provided during the initial evaluation and subsequent treatments along with appropriated clinical rating scales.
- The exploration of all potential risks and side effects of psychotropic medication should be conducted prior to implementation.
- The completion of a comprehensive informed consent form by the parent and an assent form by youth under age 18 must be obtained prior to the implementation of psychotropic medication.
- The presence of or lack of medication side effects should be noted during each visit.
- The child's weight, height, blood pressure and other essential laboratory findings should be closely monitored.
- The provision of a single psychotropic medication should be enacted prior to polypharmacy.

- Medication doses should start low and be gradually adjusted as needed.
- It is recommended that only one medication be changed at any given time unless solid rationale is provided for doing otherwise.
- Clinical follow-up visits should be appropriated based on disorder severity and the assurance of effective treatment response monitoring.
- Suicidality should be assessed and monitored particularly among child populations suffering from depression.
- Prescriptions made by a clinician rather than a psychiatrist should include consult with a psychiatrist if the treatment does not improve the child's status in a given amount of time.
- Multiple factors, such as adherence, accuracy of diagnosis, disorder comorbidity, and psychosocial stressors, should be assessed prior to the addition of additional psychotropic medications to a treatment.
- If a psychotropic medication is in use for a disruptive behavior disorder (i.e., conduct disorder, ADHD) that has been in remission for six months, tapering and discontinuation of the medication should be considered. If this does not occur evaluations should be continued every six months.
- Medical records should clearly contain information on care provided (i.e., history, mental status assessment, intended medication use, treatment plan, etc.).

Overview of Medications for Specific Mental Health Disorders

As mentioned previously, inadequate research has been conducted to fully support the efficacy of psychotropic medications for children suffering from most mental health problems except ADHD. Findings from the research that has been conducted are presented here. The information draws mainly from the comprehensive review of mental health care for children and adolescents prepared by Landsverk et al. for the *Best Practices in Mental Health and Child Welfare Consensus Conference* (46) and a presentation by M. Lynn Crismon at the same conference (134).

Medication for Trauma-related Disorders

Medication is generally not considered a first line treatment for children suffering from abuse-related trauma, but may be prescribed in addition to behavioral treatment for children who do not respond to behavioral treatment alone or have severe PTSD symptoms. Selective Serotonin Reuptake Inhibitors (SSRIs) (e.g., Prozac, Zoloft, and Celexa) may be prescribed to address symptoms of sleep disturbance, irritability, hypervigilance, depression, and panic associated with trauma. Adrenergic agents, such as Catapres, Inderal, and Tenex may be used for symptoms of hyperarousal and impulsivity. The emotional dyscontrol associated with PTSD may respond to mood stabilizers (e.g., Lithium, Depakote, Tegretol). Lastly, atypical antipsychotics (e.g., Risperdal) may be prescribed to address symptoms of severe self-harm, psychosis, aggression, or dissociation (46).

A small, highly controlled study comparing TF-CBT plus placebo to TF-CBT plus an SSRI (i.e., sertraline) in children, ages 10 to 17 years, with PTSD related to sexual abuse found a significant effect for TF-CBT plus sertraline over the effect of TF-CBT alone (135). Given the small sample size of 20 children, these findings must be interpreted cautiously. Until there is more evidence on the efficacy and safety of SSRIs for the treatment of trauma-related disorders in abused children, these medications should be prescribed cautiously (46).

Medication for Disruptive Behavior Disorders

A variety of medications have been used to treat disruptive behavior in children. These medications include stimulants, atypical antipsychotics, mood stabilizers, and SSRIs. A strong research base exists supporting the efficacy of stimulants for ADHD (136).

Risperidone and other atypical antipsychotics have been prescribed to treat aggressive behavior in children. Results from two clinical trials suggest that risperidone may be effective for reducing disruptive behaviors with improvements maintained at one-year post-treatment (137). Due to the negative side effects often associated with atypical antipsychotics (i.e., vomiting, weight gain, fatigue, headache) they should be prescribed cautiously (46).

Mood stabilizers (i.e., lithium) have also been studied in controlled trials with children exhibiting behavior problems. Lithium has shown positive results in reducing aggression (138) and disruptive behaviors (139). The negative side effects reported with this medication include vomiting, ataxia, enuresis, fatigue, and weight gain.

Lastly, a small study of 12 children has shown the SSRI Celexa to have a positive effect on disruptive behavior (140). SSRIs, however, may cause behavioral disinhibition (i.e., insensitivity to punishment, preference for immediate rewards, etc.) in children with disruptive behavior disorders and should be prescribed cautiously until more research is available (46).

Medication for Depression

The use of psychotropic medication to treat depression in children has increased in recent years with SSRIs being the most commonly prescribed medication. Clinical trials comparing SSRIs to placebo for childhood depression have produced positive findings in several studies (141-144), while tricyclic antidepressants have not shown positive results (145, 146). When SSRIs are prescribed, close monitoring, especially during the early weeks of treatment, is essential due to the increased risk of suicidal symptoms in some (46).

Childhood depression may also be treated with a combination of medication and psychotherapy. The Treatment for Adolescents with Depression Study (TADS), a large multi-site study, examined the effects of psychotherapy combined with medication for adolescent depression (147). Results indicated adolescents who received an SSRI in combination with CBT showed the greatest improvement and SSRI alone was superior to CBT alone. Although these results are promising for the combined treatment of depression, additional research and replication of these findings are needed to fully understand how depressed children can benefit from medication and psychotherapy.

Medication for Substance Abuse

For the treatment of substance abuse, medication has been used to treat comorbid mental health conditions (i.e., depression, ADHD, anxiety, and disruptive behavior disorders) and as substitution therapy for addiction or dependence (46). Limited research evidence is available to support either of these uses of medication in substance abusing adolescents.

Although methadone and naltrexone have been used with success to treat severely opiate-addicted or alcohol-addicted adults who have been unresponsive to behavioral interventions (148), no research exists on the use of these medications in adolescents. Pharmacological interventions for adolescent addiction are generally not recommended, since adolescents rarely suffer from long-term addictions (46).

Limited research also exists on the use of medication to treat comorbid psychiatric diagnoses in adolescents with substance abuse. One controlled trial with adolescents found positive effects from treating substance abusing adolescents with mood disorders with lithium (138). Another randomized study involving ten adolescents with comorbid depression and alcohol abuse compared CBT plus sertraline to CBT plus placebo (149). After 12 weeks of treatment, the two groups demonstrated similar reductions in depression and alcohol use. Given these findings, medication for adolescents with substance use problems should only be prescribed with serious caution and consideration, especially given the high rates of psychiatric comorbidity and abuse potential in this population (46).

Summary

Medication, in addition to psychotherapy, may be necessary for the effective treatment of children in TFC who have diagnosed psychiatric disorders. Unfortunately, with the exception of research on stimulants to treat ADHD, there is not enough research evidence available to support the efficacy of most psychotropic medications used to treat childhood psychiatric disorders (133). Thus, when prescribing psychotropic medications to children, physicians must rely on research conducted with adults, as well as their clinical experience.

This section summarized what is known about the use of medication for the treatment of trauma-related disorders, disruptive behavior disorders, depression, and substance abuse in children. For most of these disorders, medication is not considered a first-line treatment and is usually recommended in addition to psychotherapy.

There is some research to support the use of SSRIs, in combination with psychotherapy, to treat trauma-related disorders (135) and depression (147). Research has strongly supported the use of stimulants to treat ADHD (136). Limited research exists on the use of other medications (risperidone, lithium, and SSRIs) to treat behavior problems. No research exists on the use of naltrexone or methadone to treat addiction in youth and the use of these pharmacological agents in youth is generally not recommended. Similarly, medication is generally not recommended for the treatment of youth substance abuse.

Given the limited research on the use of psychotropic medications for children, it is important for prescribing clinicians to follow expert consensus guidelines on the use of these medications. The *Tools and Resources* section provides information on how to access these guidelines.

Comprehensive Interventions

Children in TFC often have complex mental health and service needs that require intervention at multiple levels (i.e., home, school, community, individual, and family). Several comprehensive interventions exist that target these multiple systems in a child's life. These interventions include:

- Multidimensional Treatment Foster Care (MTFC)
- Multisystemic Therapy (MST)
- Intensive Case Management (ICM)
- Wraparound

All of these interventions are summarized in Table 3 and are described here. Additional information about each intervention may be found in the *Tools and Resources* section.

A variety of sources, including medical and psychological databases (i.e., Medline and PsychInfo) and relevant intervention-specific, child welfare and university Web sites, were referenced for this section of the *Resource Guide*. Additional information was obtained from a comprehensive review of mental health care for children and adolescents in foster care prepared for Casey Family Programs and the *Best Practices for Mental Health and Child Welfare Consensus Conference* by Landsverk et al. (46).

Multidimensional Treatment Foster Care (MTFC) (150)

MTFC has its roots in social learning principals and is commonly associated with the work of Patricia Chamberlain who developed the Oregon Multidimensional Treatment Foster Care Program. Children who cannot be effectively managed in traditional foster care settings are often placed in MTFC programs (46). MTFC provides more intensive therapeutic, supervisory, and case management services than traditional foster care for children exhibiting chronic disruptive (151) or anti-social behavior who might otherwise be incarcerated, in residential or group treatment, or in the hospital (152). In addition to MTFC for adolescents, an MTFC program has also been designed for pre-school aged children (153). Treatment typically lasts 6-9 months (154).

MTFC programs require close collaboration between all of those involved in a child's life, including the program supervisor, case worker, parole or probation officer, if any, the child's teachers and/or work supervisors, foster parents, and birth parents. MTFC foster parents receive a great deal of support and training from program staff and are expected to provide a structured, supportive home for the child. Foster parents are contacted seven times per week regarding their foster child, including a two-hour group session, five ten-minute phone calls, and additional calls as needed (154). Foster parents use behavior management techniques with their foster child, provide close supervision, and keep the child away from delinquent peers (152).

The goal of MTFC is to return the child to his/her birth parents. While their child is in MTFC, birth parents receive support from the therapist, who teaches them how to use the behavior management skills being used in the foster home (152). Additionally, birth parents attend a one-hour group session each week to build skills (154).

Throughout a child's placement, birth parents are encouraged to attend supervised home visits with their child and maintain communication with their child's therapist (152).

MTFC has been subject to extensive research. Two studies comparing MTFC to group home or hospital placement found positive effects of MTFC, including improvements in behavior problems, less recidivism, and less movement to more restrictive treatment environments (155, 156). MTFC, in comparison to traditional foster care, was associated with greater behavioral improvement and a lower likelihood of running away or incarceration (157).

Voices *from the* Field

Multidimensional Treatment Foster Care (MTFC)

Marilyn Bamford, FamiliesFirst Regional Director for Children's Mental Health Services in Central California, has been implementing MTFC at FamiliesFirst as part of their Wraparound program since the summer of 2004. FamiliesFirst collaborates with the Foster Family Agency (FFA) and the county for homes regarding the implementation of MTFC. Currently the agency has two MTFC teams.

FamiliesFirst decided to implement MTFC because the agency felt that the program would meet the needs of youth moving through the system. Staff members, foster families, and youth who have been involved in the program have responded favorably. According to Ms. Bamford, MTFC staff "love" the model and view it as an effective intervention.

Foster parents speak positively of MTFC, as well, and "look forward to their support groups and daily contacts." Youth who have graduated from the program have also had positive reactions and some have even returned to speak to the community about the benefits of MTFC.

FamiliesFirst has faced some challenges in implementing MTFC. Addressing cultural needs, maintaining an active pool of available foster parents, and funding have been the biggest challenges. According to Ms. Bamford, MTFC "does not directly address cultural needs." The agency staff members found this difficult at first, but were pleased that MTFC consultants worked closely with staff to implement the model in a culturally sensitive manner while adhering to the model. The agency also initially found it challenging to maintain the interest and availability of foster parents while they awaited appropriate referrals. Educating social workers and probation officers about the MTFC model has helped generate more referrals to the program. Lastly, Ms. Bamford reported that finding fiscal support for the MTFC program at FamiliesFirst was a challenge, but the agency eventually secured support through EPSTD Medi-Cal and SB Senate Bill 163, which re-directs group-home funding to go toward placing youth in Treatment Foster Care, as well as other settings. She advises that agencies wanting to use the model must be willing and able to support it and be "aware of the population that the model is designed to serve" (158).

Voices *from the* Field

Multisystemic Therapy (MST)

Kids Hope United, an Illinois-based agency that works with youth in foster care, has used MST for eight years with youth at risk for juvenile justice involvement or from families involved with methamphetamine manufacturing or use. Nikki Quandt, Director of Programs at Kids Hope United, reported the good fit between MST and the agency's mission, as well as endorsement by the county's chief judge, influenced the decision to implement the program.

Ms. Quandt and other program stakeholders are happy with the program and feel it offers more intensive services than other interventions. The interactive and flexible nature of MST training has also been well received by the agency. According to Ms. Quandt, "if we have issues with one area...the consultant will do more training on this specifically."

Funding MST has been a challenge for Kids Hope United. The Illinois Department of Family Services, in addition to other funding sources, provides the funds for the MST program, but the agency is continually looking for other sources of funding. Given the agency's location in a rural area, finding Masters level clinicians to implement MST has also been challenging. Ms. Quandt suggests that any agency wanting to implement MST should hire "the right people" and secure sustainable funding for implementation costs that include a monthly fee to use MST and consultation costs (162).

Multisystemic Therapy (MST) (159)

MST is a brief (3-6 months) family- and community-based treatment for children with behavior and substance abuse problems, which has been recently applied to children in the child welfare system (46). MST aims to preserve families by empowering parents/caregivers to deal with the difficulties of raising teenagers and empowering youth to manage family, school, peer, and neighborhood problems (152). Although brief, MST is an intensive treatment that requires the active participation of parents and youth and provides 24/7 access to therapists (157, 160).

Extensive research has linked MST to many positive outcomes, including decreased aggressive behavior, fewer arrests, fewer placements, and improvements in family functioning (46). Favorable results have also been reported for the use of MST with maltreated youth (161) and substance abusing youth (46).

Intensive Case Management (ICM) (163)

ICM is a way to plan, monitor, coordinate, and advocate for the needs of children in various settings, including child welfare (46). The various models of case management share a common focus on making service delivery integrated, client-centered, coordinated, goal oriented, accountable, flexible, sequenced, cost-effective, sustained, and comprehensive (163). Intensive case managers achieve these goals through unrestricted availability to their clients and close collaboration with the youth, his/her family and surrogate/foster family, and other professionals involved in the youth's treatment. Services provided and the length of service varies based on the specific needs of the child and his/her family (163).

Research has compared different models of case management to each other, as well as to other types of treatment (46). This research has generally shown that case management is superior to typical services for service access (164) and functional improvement of children with emotional and behavioral disorders (46). Research specifically on ICM indicates that it is as effective, or more effective, than regular case management (165, 166), and more effective than case management provided by a regular therapist (167).

Wraparound (168)

Similar to ICM, Wraparound is a process for identifying, planning, and coordinating the service needs of children and families with complex emotional and behavioral issues (169). Lenore Behar first coined the term in the early 1980's to describe "comprehensive community-based services to individual families" (168, p. 4). Wraparound is a cost-effective (170), promising practice (171) used in child welfare and other service settings (161). Although numerous definitions of Wraparound exist, experts have identified several common elements:

- Voice and Choice
- Youth and Family Team
- Community-based Services
- Cultural Competence
- Individualized and Strength-based Services
- Natural Supports
- Continuation of Care
- Collaboration
- Flexible Resources
- Outcome-based Services

Within the field of child welfare, Wraparound emphasizes the importance of including birth parents in the service planning process for their children (160). Wraparound consists of a team including the child, his/her birth parents and foster parents, and child welfare support networks with both formal and natural supports (170). Wraparound offers "unconditional care," which lasts until desired changes occur in the child's surrounding environment (160).

A number of studies have noted the positive outcomes associated with Wraparound services, including reduced need for services, reduced evidence of abuse and neglect, maintenance of stable adjustment in the home, and positive behavioral change (172).

Summary

Comprehensive interventions such as MTFC, MST, ICM, and Wraparound aim to address the multiple systems (i.e., home, school, individual, and family) often affected by the mental health issues of a child. MTFC and MST are specific interventions that have extensive research to support their effectiveness with children displaying chronic disruptive behavior problems; these interventions have also been used specifically with youth in child welfare settings. ICM and Wraparound are specific treatment interventions, but offer a framework for planning, providing, and monitoring services for families with multiple needs.

The *Tools and Resources* section provides additional information about how to access materials and training for the comprehensive interventions discussed here. TFC providers considering these interventions should be aware of the costs, staff resources, and the organization's ability to implement the comprehensive interventions that are required.

Parent Engagement and Support

Engaging and supporting birth and foster parents in the child welfare system are critical for successful child outcomes. Foster parents typically receive some support from the child welfare system in the form of training and guidance from foster care agency staff. Birth parents, however, are often mandated to meet a variety of requirements with little support (173). This section of the *Resource Guide* reviews parent engagement and support programs for birth and foster parents. Information presented in this section draws primarily from *Engaging Parents in Child Welfare Services: Challenge, Promising Practices, and Policy Opportunities*, a critical paper by Susan Kemp, Maureen Marcenko, William Vesneski, and Kimberly Hoagwood, commissioned for the *Best Practices for Mental Health and Child Welfare Consensus Conference* (173). All of the programs described in this section are summarized in Table 4 with additional information provided in the *Tools and Resources* section.

Although it can be difficult to engage and offer the support needed to assist both birth and foster parents in the child welfare system, research by Mary McKay and her colleagues on engaging families in therapy offers an approach that may prove beneficial in child welfare. McKay's work has shown that family engagement strategies, such as clarifying with the family the roles of those working with the family; discussing service options; laying a foundation for working collaboratively with the family; looking at practical, concrete issues that can be addressed quickly; and developing plans to overcome barriers, increase family inclusion and reduce dropout in the therapy process (4).

Foster Parent Engagement and Support

Besides the mandated training provided to foster parents through foster care agencies, virtually no programs have been developed to specifically engage and support foster parents. The Birth Family-Foster Family Connections Project, and the Parent Engagement and Self Advocacy (PESA) Program are two programs specifically designed to offer support to foster parents. These programs also involve birth parents and are described in the following section.

Birth Parent Engagement and Support

A variety of programs have been developed to support and engage birth parents in the child welfare system. Many of these programs utilize peer support (i.e., parent-to-parent) to supplement the support that a caseworker provides to the parent (169). Promising birth parent engagement and support programs include the following:

- Co-parenting
- Parents Anonymous
- Parent Engagement and Self Advocacy
- Parent Mentoring Program
- Respite
- Shared Family Care
- Powerful Families

Co-parenting (174)

Co-parenting is a 12-week shared training program for birth and foster parents that focuses on creating a collaborative, birth-foster parent partnership to parent the youth in care. Results of a study on the co-parenting approach indicated involvement in the program increased co-parenting flexibility and problem solving at the end of the intervention, but these gains were not maintained over time (174).

Parents Anonymous (PA) (175)

Parents Anonymous is a parent-to-parent support group for parents involved in the child welfare system that can benefit anyone in a parenting role (174). A professionally trained facilitator and a parent run each group. Groups for parents are held weekly for 1½ to 2 hours, with a concurrent child and youth program (176).

The National Council on Crime and Delinquency conducted a longitudinal study examining the direct service component of PA. The results of the study indicate that PA groups reduce child maltreatment (i.e., reductions in parenting distress and rigidity, and reduction of parental physical and psychological aggression), reduce risk factors (i.e., parental stress, life stressors, domestic violence, and drug and alcohol use), and increase protective factors (i.e., quality of life, instrumental and emotional support, feelings of competency as a parent, social support, discipline practices, and family functioning) (175).

Parent Engagement and Self-Advocacy (PESA) (178)

PESA is a relatively new intervention developed through a partnership between Casey Family Programs, the Annie E. Casey Foundation, and the REACH Institute (177). The intervention is adapted from *The Parent Empowerment Program* (PEP) (179) and the *Building a Better Future Program* (181), developed by Sandra Jimenez and Naomi Weinstein as a Family-to-Family Initiative of the Annie E. Casey Foundation.

PESA aims to improve the mental health of children in child welfare by teaching birth parents, foster parents, and agency workers how to work together to advocate for the mental health and educational needs of children in care. Although PESA has not yet been formally evaluated, PEP, on which PESA is partially based, has yielded positive outcomes, including significant changes in self-efficacy, engagement and group management skills, and knowledge of specific disorders, mental health services, and school services (169).

Parent Mentoring Program

The Parent Mentoring Program is a manualized program developed in Washington State. Specially trained foster parents who mentor birth parents on issues related to why their child came into care form the core of the program. The program is currently being tested using a quasi-experimental design. It is hypothesized that involvement in the program will lead to increased rates of reunification, reduced length of stay in foster care, and reduced rates of re-entry to foster care (169).

Respite

Respite is not a program in itself, but rather a resource that provides birth and foster parents with the opportunity to take a break from parenting roles for short periods of time. Respite may be provided in or out of the home by an alternate caregiver. Research has shown that respite care decreases stress and leads to fewer out of home placements (46), but there may be limited awareness of the availability of respite services.

Shared Family Care

Shared Family Care places a parent and one or two children in a community home where they are offered support and mentorship (181, 182) by a trained host family (183). The program works to establish a relationship between the foster and birth parents, and improve the life and social skills of birth parents (184). The guidelines for Shared Family Care were originally developed by Amy Price and Richard Barth, along with the National Abandoned Infants Assistance (AIA) Resource Center at the University of California – Berkeley.

Multiple Shared Family Care programs exist in the United States with various foci, including: families at risk of having their children removed from their home, families involved or at risk of being involved in the child welfare system, families being reunified with their children, severely emotionally disturbed adolescent mothers, and drug addicted mothers (183). The program goals are focused on child safety, well-being, and permanency (184).

A cohort study of the program found that 80% of parents who completed the program felt that they received the support they needed (183). Families who graduated from the program showed an increase in rates of employment and independent living, and only 8% of the children from these families re-entered the foster care system within one year of the family graduating (184).

Powerful Families (185)

Powerful Families focuses on parent empowerment by improving family stability and reducing economic hardship (185). Multiple organizations, including Casey Family Programs, run the program together. The Powerful Families program provides parents under stress, whose children have been removed from their homes, with a network of peer supports. The program teaches birth parents, kinship parents, and youth in the child welfare system how to advocate for their needs and those of their family. This occurs in nine, two-hour weekly sessions for parents. In these sessions, parents and their children are encouraged to arrive up to an hour early to network with other parents. After a meal, daycare or youth activities are provided for the children. At the end of each session, parents are given a task or a topic to discuss with their family (185).

Results of a pilot study assessing outcomes associated with the program showed good attendance rates (66% of participants attended at least six out of nine sessions) and positive outcomes. Parents who participated in the program showed an increase in knowledge of financial literacy and money management; an increase in the ability to advocate for themselves, their families, and others in the social service system; an increase in leadership skills; a decrease in stress with an increase in social support; and increased confidence in parenting roles (186).

Summary

Parent engagement and support programs can help birth and foster parents cope more effectively with the challenges associated with involvement in the child welfare system. Unfortunately, few of these programs exist and those that do exist have not been subjected to extensive research. Most of the existing parent engagement and support programs primarily rely on peer support and mentoring. These programs typically bring together parents who have successfully navigated the child welfare system with those currently involved with the system and encourage mutual sharing and support. Some programs focus on the development of advocacy skills (i.e., PESA and Powerful Families), while others emphasize the development of more collaborative relationships between birth and foster families (i.e., Shared Family Care and Co-parenting). The *Tools and Resources* section provides additional information about how to access all of these programs.

Youth Empowerment and Support

Youth aging out of foster care are disproportionately reliant on human services (i.e., welfare, state unemployment, homeless shelters, etc.) (187). The use of effective youth empowerment and support programs within foster care can combat these outcomes. Youth empowerment programs aim to increase the personal control that youth wield over their life circumstances, to teach life-enhancing skills, and to encourage participation in important community affairs (188, 189).

This section reviews available youth empowerment and support programs in the following areas: 1) general empowerment programs, 2) academic remediation services, 3) mentoring programs, 4) college education attainment services, 5) employment preparation services, and 6) court-related programs. Information presented in this section draws primarily from *Evidence for Youth Support, Training, and Empowerment*, a critical paper written by Sandra Kaplan, Louise Skolnik, and Ayme Turnbull, commissioned for the *Best Practices for Mental Health and Child Welfare Consensus Conference* (190). All of the programs described in this section are summarized in Table 5 with additional information provided in the *Tools and Resources* section.

General Youth Empowerment Programs

Leadership opportunities and the increased quality and intensity of youth participation in decision making are key for the cultivation of positive empowerment outcomes (191). Several general youth empowerment programs that incorporate these key aspects are described here. Additional information about each program is provided in the *Tools and Resources* section.

California Youth Connection (CYC) (192)

CYC, a California-based advocacy program which began in 1989, was developed for, and is guided by, current and former foster care youth, ages 14-24, who seek to improve the foster care system through involvement in policy development and legislative change. CYC members take part in a variety of tasks, including collaborating to identify local issues and initiate positive change. They also attend local and statewide meetings (i.e., Summer Leadership and Policy Conference, CYC Day at the Capitol) to share foster care youth perspectives. CYC's newsletter, *EMPOWER!,* gives foster care youth a voice on individual and systemic needs (192).

Foster Care Alumni of America (FCAA) (192)

FCAA, created in 2004, is an advocacy organization designed to bring the voices of alumni to public policy issues by providing a forum for discussing current issues. A result of the growing alumni movement, FCAA seeks to provide those who share the foster care experience with opportunities to connect and advocate for change, as well as to transform foster care practice and policy, educate professionals and care providers, influence laws, and change the stereotypes held about this population. FCAA maintains an online newsletter, *Connecting Today… Transforming Tomorrow*, which includes member highlights and stories, opportunities for involvement, and organizational updates (193).

Voices of Youth (194)

Voices of Youth, an internet site created by the United Nations Children's Fund (UNICEF) in 1995, advocates for the inclusion of youth in all aspects of child welfare practice, policy development, and operation through the sharing of personal stories and perspectives of foster care youth. The online site includes three sections: 1) *Explore-* to foster knowledge of children's rights and the latest developments, 2) *Speak Out-* to promote communication utilizing discussion boards, and 3) *Take Action-* to spur initiatives and elicit involvement in current projects (194).

Youth Communication (195)

Youth Communication uses training in journalism and the publication of magazines to increase foster care youth's ability to make important life decisions. Youth Communication publishes one magazine, *Represent*, written by foster care youth, and another, *Rise*, written by the parents of children in foster care or families receiving preventive services (196). These magazines provide a forum for foster care youth (and parents) to share issues, perspectives, experiences, and common concerns. The program also provides educational outreach programs for schools and foster care agencies (195).

The Taking Control Program (197)

Taking Control, an adaptation of the Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS©) program (198), is a six session, group program designed to help youth in foster care, ages 12-18, develop the self-awareness and skills to advocate for themselves and get their emotional, psychological, and social needs met. The group, led by a clinician and foster care alumni, provides an engaging and informal learning environment where youth members can learn new skills, support each other, and work together on a meaningful group project. *Taking Control* sessions focus on helping youth members learn new ways to handle the difficult situations that many of them face on a regular basis. The program is currently being piloted in various sites including New York City, San Diego, and Seattle as part of a project sponsored by Casey Family Programs (197).

Getting Beyond the System (GBS) (199)

GBS is a strengths-based, self-advocacy training program for teens and young adults developed by the Youth Advocacy Center, located in New York City. A trained facilitator conducts the GBS Self-Advocacy Seminar which meets for 2½ hours a week over a 12-week period. The seminar covers self-advocacy and other important skills (i.e., career preparation) necessary for youth to take control of their lives. The seminar is intended to complement transitional and educational programming provided by agencies (199).

Academic Remediation Services

On average, youth in foster care have higher high school dropout rates (200) and lower IQ scores (201) than the general population. Therefore, providing foster care youth with academic remediation services may be a valuable form of support and empowerment. One such remediation program for youth in foster care exists and is described here.

Foster Youth Services (FYS) Programs (202)

FYS programs are based in California and provide academic remediation and the coordination of instruction, tutoring, vocational training, counseling, mentoring, and training for independent living. FYS programs strive to increase placement stability and improve the educational performance and achievement of foster care youth (202).

Mentoring Programs

Mentoring is a potentially valuable strategy for empowering youth in foster care, but few programs have been dedicated specifically to this population. Essential goals of mentorship programs for foster care youth include helping youth expand their world views and abilities to gain greater and more diverse life experiences, working to ameliorate the negative effects of being raised in institutional settings, and reducing the stigma associated with being in foster care (203). Several mentoring programs for youth in foster care are described here. The *Tools and Resources* section provides additional information about each program.

Adoption and Foster Care (AFC) Mentoring (204)

AFC Mentoring is a Boston-based program, created in 2001, that identifies, trains, and supervises mentor-mentee relationships between adults (over 18) and youth (7-14) in foster, kinship, residential, or adoptive care. Two programs developed to bring adults and youth together include AFC *Mentors* (one-on-one mentoring) and Team AFC (group mentoring). AFC Mentoring program volunteers, mentors, and staff provide youth with confidence, friendship, and guidance to assist them in reaching their various goals (204). Mentors meet with their mentees for at least eight hours, twice a month, for a minimum of one year. The relationships created through this program are oftentimes the first source of consistency that many youth in care experience while enduring numerous placements, with 88% of matches lasting more than one year (204).

AmeriCorps Foster Youth Mentoring Project (FYMP) (205)

The Americorps FYMP was formed through the Chancellor's Office of the California Community Colleges and is a collaborative effort between the state of California and ten community colleges throughout the state. The program teams community college students/AmeriCorps members with foster care youth, ages 14 to 18, for one-on-one mentoring. Through the mentoring relationship, foster care youth work on improving their social, academic, vocational, and independent living skills. The program also reaches out to youth (ages 18-21) who have aged out of the system to provide them with mentoring and continued support. Mentors meet with mentees for approximately ten hours per week over 9-12 months. The following community colleges participate in the FYMP: Bakersfield College, Butte College, Compton Community College, Citrus Community College, LA Harbor College, LA Southwest College, Modesto Junior College, City College of San Francisco, Santa Ana College, and Yuba College (205).

Fostering Healthy Connections (206)

Fostering Healthy Connections was developed in 2005 through a collaboration between the Child Welfare League of America (CWLA) and FosterClub to facilitate mentoring relationships between former foster youth and youth currently in care. The program aims to improve educational, behavioral, and interpersonal outcomes of youth in foster care (206).

An initial pilot site for the program, Father Maloney's Boys' Haven, located in Kentucky, has reported successful six-month outcomes. The pilot phase of the program will continue through 2008. Eventually, the program will support eight CWLA member agencies in implementing or improving peer mentoring programs (206).

The New York City Administration for Children's Services (ACS) Mentoring Program (207)

The ACS Mentoring Program pairs mentors (over the age of 21) with youth aging out of foster care (ages 14-21) to help

General College and Vocational Preparation Programs

General college and vocational preparation programs provide high school youth with preparatory services and opportunities to obtain educational and vocational internships. For example, Casey Family Programs has devoted an entire Web site – *Casey Life Skills* – to this area of concern. The Web site covers topics applicable to transitioning youth, which range from educational skill and resources to employment seeking and maintenance tips (211).

Scholarship Programs

A variety of scholarship programs provide college scholarships to youth in foster care. For example, the Living Classrooms Foundation/United Parcel Service (UPS) School to Career Partnership provides foster care youth (ages 16-19), recruited from group homes in Baltimore, with UPS job training and entry-level employment. UPS provides scholarships for participating foster care youth to cover community college tuition costs; the Annie E. Casey Foundation and the State of Maryland fund this collaboration (212).

Community Collaborations

Collaborations between public schools and community colleges help empower foster care youth by providing high school mentoring, career counseling, and tutoring opportunities, prior to and during college. For example, Puget Sound Pathways Network (PATHNET) is a community, college-run program that connects youth in Washington to paid work experiences and high wage career development in the areas of technology, manufacturing, and health. Financial assistance is provided through Pell grants and the Workforce Investment Act (WIA) (212).

Orphan Foundation of America (OFA) (213)

OFA provides 350 college scholarships through various sponsors (e.g., Casey Family Scholars Program). OFA also provides online mentoring, internships, and other supports to college students in all 50 states, while administrating Chafee Educational and Training Voucher (ETV) programs in Alabama, Arkansas, Colorado, Indiana, Maryland, Missouri, New York, North Carolina, and Ohio. Approximately 68% of OFA scholarship recipients have been cited to remain in, and complete, higher education programs (213).

Employment Preparation Programs

As stated earlier, foster care youth who have not obtained an education frequently experience unemployment upon transition to adulthood. Services focusing on vocational and employment opportunities for youth in foster care may improve the future economic outcomes of these youth. Several employment preparation programs for foster care youth are described here.

The School-to-Career Partnership of United Parcel Service (UPS) and the Annie E. Casey Foundation (214)

This partnership supports youth in foster care through the provision of business training opportunities along with transportation assistance during and after high school graduation to aid in the successful transition from school to employment. Other FORTUNE 100 companies utilizing this model include Marriott Hotels, Home Depot, and Bank of America (214).

The Project H.O.P.E. Program (Helping Our Young People with Employment and Education) (215)

Project H.O.P.E. is a youth employment program, based in California, that was formed through a collaborative effort between the Alameda County Workforce Investment Board (ACWIB) and the Alameda County Department of Children and Family Services. The program encourages self-sufficiency through leadership development and career and educational preparation by connecting youth in care, ages 16-18, to various employment and community resources provided in the community (215).

Job Corps (216)

Job Corps is a federally-funded program, which has been providing education and employment training services to at-risk youth, ages 16-24, since 1964. Services assist youth in attaining education, vocational training, or entering the military. Approximately 60,000 youth are served by 122 Job Corps Centers nationwide (216). Evaluations of Job Corps have revealed positive youth outcomes, including reduced involvement with the juvenile justice system and increased levels of employment and educational attainment (217).

Court-Related Programs

Youth in Treatment Foster Care often have some involvement in judicial proceedings for custody and placement issues. Court-related programs help to empower youth in foster care by increasing their satisfaction with the judicial system (190). Several of these programs are described here.

Court Appointed Special Advocate & Guardian Ad Litem Programs (CASA/GAL)

CASA/GAL programs provide volunteers to serve as advocates or guardians for children in foster care. These volunteers meet with children and families to gather information about a child's needs, wishes, and his or her family, and then convey this information to the judges. CASA/GAL volunteers also monitor cases and facilitate communication among the child serving agencies, parents, foster parents, and attorneys involved in the child's life.

State Court Improvement Programs (CIPs)

CIPs focus on the timeliness and quality of decisions made by courts in cases of child maltreatment. Model family courts are an example of CIPs. These courts have implemented procedures, such as one judge per family, legal representation for children and parents, and the development of data systems, which specifically focus on case processing to facilitate timely and high-quality decision making in child welfare cases. The Permanency Planning for Children Department of the National Council of Juvenile and Family Court Judges (NCJFCJ) provides technical assistance and training to CIPs.

Law Guardian Interdisciplinary Teams

Teams of attorneys (law guardians) represent foster care youth in judicial proceedings and work together as members of interdisciplinary teams. Lawyers for Children, Inc. is an example of a program that represents children in foster care in the New York City Family Courts using such an approach.

Summary

Empowerment program for foster care youth aim to increase the sense of control that youth have on their own lives by developing skills and increasing opportunities for participation in personal decision making and community affairs (188, 189). A variety of youth empowerment programs and services for foster care youth exist, including general empowerment programs, academic remediation services, mentoring programs, college education attainment services, employment preparation services, and court-related programs. These programs vary in their intensity and scope and are generally available to youth in specific cities or states.

TFC providers working with youth should consider linking youth with an appropriate empowerment program or service, when possible. General youth empowerment programs can help foster care youth develop a sense of identity and connect with peers who share their experience. Youth empowerment services, such as tutoring, mentoring, college scholarships, and job training, can provide foster care youth with the extra support they need to stay in school and secure employment.

Implementing Evidence-based Practices in an Organizational Context

The preceding section described EBPs of relevance to TFC providers. Implementing EBPs, however, entails much more than simply making a selection from the practices described. Rather, EBP implementation is a complex process that involves conducting a needs assessment, identifying and addressing organizational barriers, and working through a series of implementation stages. This section of the *Resource Guide* describes this process and offers strategies to assist TFC providers in successfully implementing EBP in their settings.

Assessing the Need for EBP

Although EBPs are likely to benefit most TFC programs, the need for a given EBP should be carefully assessed before proceeding with implementation. Assessing the need for an EBP, as well as the fit of the EBP with the clients, staff, and administration of a TFC program is critical because premature implementation of ill-fitting EBPs can " 'poison the waters' among these groups not only for the treatment in question but for the use of any empirically validated treatment" (218, p. 1192).

The *Tools and Resources* section of this Guide includes an *Evidence-based Practice Needs Assessment Form* that can be used when conducting a needs assessment. The form lists a series of questions that address EBP for a given TFC program, such as:

- Knowledge of EBP in TFC
- Awareness of EBP currently implemented in the TFC program and associated advantages and disadvantages
- Areas of the program in need of improvement based on program outcomes, consumer feedback, and FFTA Program Standards.
- Available EBP (if any) to address areas of need
- Best EBP to address areas of need that match organizational philosophy and resources
- Advantages and disadvantages of implementing any identified EBP

Responses to the questions listed on the *Evidence-based Practice Needs Assessment Form* should be collected from multiple sources, including program administrators, staff members, treatment families, birth families, and youth. Once the needs assessment is complete, it will be possible to determine the necessity and feasibility of implementing an EBP to improve program outcomes.

EBP Implementation and Organizational Factors

Assuming that the needs assessment indicates that a program should proceed with EBP implementation, the next step is to identify and address organizational factors that may impede or facilitate successful EBP implementation. Several organizational factors including leadership, culture, climate, and social influence play a role in EBP implementation (219). Each of these factors may or may not facilitate the implementation of EBP.

Leadership influences the overall functioning of an organization, as well as individual and team functioning (219). Research shows that good organizational leadership is associated with higher levels of organizational commitment

and job satisfaction (220, 221). Staff employed in organizations characterized by leadership that empowers, excites, and inspires them about the goals and missions of their organizations show more commitment to, and satisfaction with, their jobs (220, 216).

Organizational culture refers to "norms and expectations regarding how people behave and how things are done in an organization" (222, p. 62). Organizational culture can facilitate or impede the implementation and use of EBP. Negative characteristics of organizational culture, including adversary (i.e., the extent to which employees are expected to actively seek out the mistakes of others or oppose things indirectly), control (i.e., the extent to which employees are expected to be dominant), and superiority (i.e., the extent to which employees are expected to excel and be better than coworkers and the competition) are associated with higher levels of estrangement towards EBPs (223). That is, clinicians working in settings characterized by adversary, superiority, and control are more likely to believe that research-based treatments are not clinically useful, that their clinical experiences are more important than using manualized therapy and that they know better than researchers about how to care for their clients (223). Conversely, clinicians working in settings characterized by more positive organizational culture are more open to EBPs (223). This does not mean that all individuals employed by agencies with organizational cultures supportive of EBP will personally support EBP. Rather, the relationship between organizational culture and EBP suggests that organizations can influence the acceptance of EBP by focusing on specific characteristics of organizational culture.

"Employees' perceptions and affective responses to their work environment" defines organizational climate (219, p. 258). Climate includes employees' perceptions of job characteristics (e.g., autonomy, variety, feedback, and role clarity), as well as perceptions of the work group (e.g., cooperation, warmth, and intimacy) (219). Certain aspects of organizational climate (i.e., vision, participative safety, task orientation, and support for innovation) are associated with organizations that are more open to innovation or implementation of new programs, such as EBPs (224, 225).

Social influence refers to how individuals in an organization are affected by "others' social construction of events, ideas, objects, and behaviors and are subject to pressure to conform their behavior, attitudes, and beliefs to that social reality" (219, p. 259). Certain social norms, including support for creativity and risk taking, team work, speed of action, and tolerance of mistakes have been positively associated with organizational innovation (219). Employees working in organizations that embody these norms are more likely to accept the changes required to implement EBPs.

Leadership, organizational culture, organizational climate, and social influence are all organizational factors that influence EBP implementation in any setting. In addition to these factors, there are several factors of specific relevance to child welfare settings attempting to implement EBPs. The *Kauffman Best Practices Project to Help Children Heal from Child Abuse* (226) identified the following organizational barriers that may prevent a child welfare organization from implementing EBP:

Organizational Barriers to EBP Implementation in Child Welfare

- No tradition as an organization that identifies external best practices to adopt and adapt to continually improve quality of care
- Lack of awareness or understanding of EBP
- Lack of tradition adopting EBP
- Few organizational role models
- Lack of training and supervision to support EBP implementation

Assessment of these barriers, as well as the more general factors described previously, may be done formally or informally. There are a variety of measures that may be used to formally evaluate organizational culture and climate, as well as staff attitudes towards EBP. The *Organizational Social Context (OSC) Measure* (227), developed by Charles Glisson and his colleagues, assesses key components of organizational culture and climate. The OSC has been subject to rigorous psychometric testing

and has national norms. The *Tools and Resources* section of this guide provides information about how to obtain the OSC. The *Evidence-Based Practice Attitude Scale* (228) is a helpful measure for assessing staff attitudes towards EBP. A copy of the EBPAS is provided in the *Tools and Resources* section of this guide. Organizational factors that may influence EBP implementation may also be assessed more informally through discussions with program staff and administrators. Regardless of how these factors are assessed, it is important to identify the organizational factors that may impede EBP implementation and work toward changing them before embarking on the challenging task of implementing an EBP.

The EBP Implementation Process

Implementing an EBP within a service setting is a complex process that involves several stages. These stages include: 1) exploration and adoption, 2) program installation, 3) initial implementation, 4) full operation, 5) innovation, and 6) sustainability (229). The *Tools and Resources* section includes an *Evidence-based Practice Readiness Checklist* that can assist TFC providers in preparing for the EBP implementation process.

The first stage of EBP implementation – exploration and adoption – is similar to the needs assessment process described previously. During this step, a TFC program should explore the match between their programmatic needs, what a given EBP can offer, and program resources. If this exploration indicates there is a strong match, then the program may decide to proceed with adoption of the EBP.

The program installation stage focuses on establishing all of the necessary structural supports for EBP implementation (229). This may include securing funding, hiring necessary staff, purchasing new materials and technology, securing space, and developing new policies to support EBP implementation. Ensuring that all of the necessary structural supports are in place prior to EBP implementation is critical for success.

Once structural supports are in place, it is possible to move on to the initial implementation of the EBP. Implementation requires education, practice and time, and leads to change in the overall practice environment (229). A key component of initial implementation is training staff in the EBP. Research shows that traditional "train-and-hope" approaches to implementation do not work (229, p. 40). Effective training consists of presenting information, providing demonstrations of the important aspects of the practice or program, and assuring opportunities to practice key skills in the training setting (behavioral rehearsal) (229). The *Kauffman Best Practices Project to Help Children Heal from Child Abuse* (226) identified the following characteristics of effective mental health EBP training programs:

Characteristics of Effective EBP Training Programs

- Intensive clinical training 3-5 days
- Extensive training materials
- Ongoing, regular supervision by clinical supervisors skilled in the use of the treatment
- Access to consultation with experts for difficult clinical cases
- Formal feedback, evaluation, and comment

As these characteristics indicate, effective EBP training requires access to appropriate supervisors and consultants, a highly motivated organization, and commitment to the implementation of a particular treatment.

In addition to training, the initial implementation stage involves working out organizational details needed to ensure smooth operation of the new program. This process can be frustrating and stressful for staff members. "During the initial stage of implementation the compelling forces of fear of change, inertia, and investment in the status quo combine with the inherently difficult and complex work of implementing something new" (229, p. 16). Given these forces, there is a great risk that new EBPs may never progress beyond the initial implementation stage.

Programs that successfully manage the challenges of initial implementation eventually move on to the full operation stage. During this stage, the EBP is fully integrated into practitioner and organizational practices, policies, and procedures (229). At this point, it is important to evaluate the program to determine whether or not it is contributing to the desired outcomes. Evaluation should not occur before any given EBP is fully operational within an organization. Evaluating a program before this stage may indicate poor results, "not because the program at an implementation site is ineffective, but because the results at the implementation site were assessed before the program was completely implemented and fully operational" (229, p. 18).

Innovation and sustainability are the final stages of the implementation process. During the innovation stage, the EBP may be refined or expanded based on evaluation outcomes, as well as practitioner and consumer feedback. Any changes made to an EBP must be carefully considered to determine whether they represent a threat to the intervention's fidelity or are desirable and necessary innovations (229). During the sustainability stage, program staff work toward the "long term survival and continued effectiveness" of the program "in the context of a changing world" (229, p. 17). During this stage it is important to consider how new staff will be trained in the EBP and how funding will be maintained.

The stages of implementation described above provide a helpful framework for how implementation of an EBP may proceed in a TFC program. These stages, however, do not fully capture the complexity of EBP implementation, particularly in child welfare settings. The highly bureaucratic nature of the child welfare system, variability in client characteristics, and multiple mediators effecting service outcomes make EBP implementation in this system particularly challenging (230).

A recent study of child welfare service providers' perspectives on the implementation of EBP identified six critical determinants of EBP implementation: 1) EBP acceptability to the caseworker and family, 2) EBP suitability to the needs of the family, 3) caseworker motivation for using the EBP, 4) EBP training experiences, 5) organizational support for EBP implementation, and 6) impact of EBP on process and outcome services (230). The study revealed the critical role adaptation, both of the EBP and the perceptions and behaviors of the service providers, play in EBP implementation. Therefore, TFC providers interested in implementing EBP in their settings must be prepared to "evaluate, adjust and adapt in a continuing process that includes give and take between intervention developers, service systems, organizations, providers and consumers" (230, p. 416).

Summary

Before deciding to implement an EBP, TFC providers must be aware that successful EBP implementation is a complex and challenging process. This process begins with a careful needs assessment and identification of the organizational factors that may impede EBP implementation. Once the need for an EBP has been established, an appropriate EBP has been found, and possible organizational impediments have been addressed, moving forward with actual implementation is possible, but requires careful planning and a commitment to working through the inevitable road blocks that may derail successful implementation. EBP implementation is a process that proceeds through six stages: 1) exploration and adoption, 2) program installation, 3) initial implementation, 4) full operation, 5) innovation, and 6) sustainability. Each stage takes time and has its unique challenges. Thoughtfully proceeding through each stage and taking the time to address the associated challenges, however, greatly increases the likelihood of success.

Tools and Resources

General Evidence-based Practice Resources

SAMHSA's National Registry of Evidence-based Programs and Practices
www.nrepp.samhsa.gov/find.asp

Child Welfare-Specific Evidence-based Practice Resources

The California Evidence-Based Clearinghouse for Child Welfare
www.cachildwelfareclearinghouse.org

Guide for Child Welfare Administrators on Evidence-based Practice
www.aphsa.org/home/doc/Guide-for-Evidence-Based-Practice.pdf

Closing the Quality Chasm in Child Abuse Treatment: Identifying and Disseminating Best Practices
www.chadwickcenter.org/Documents/Kaufman%20Report/ChildHosp-NCTAbrochure.pdf

Specific Evidence-based Tools and Programs

Please verify all pricing with the individual developer or publisher.

Mental Health Screening and Assessment Tools

- **Child and Adolescent Functional Assessment Scale (CAFAS)**

Contact Information:
Functional Assessment Systems
Ann Arbor, MI
Phone: (734) 769-9725
E-mail: hodges@provide.net
Web site: www.cafas.com

Available Training:
Self-training and group training materials are available. Self-training entails purchasing a $25 manual and completing the vignettes provided. A letter will then be sent stating that an individual has passed the training and can score the CAFAS, but not train others. Dr. Hodges offers group training 1-2 times per year in Michigan. Group training consists of an intensive two-day workshop that teaches participants how to score the CAFAS and train others. Participants attending group training receive a manual entitled *The Manual of Training Coordinators, Clinical Administrators and Data Managers*. This manual can also be purchased separately.

- **Child and Adolescent Needs and Strengths, Mental Health (CANS-MH)**

Contact Information:
Melanie Buddin Lyons
Phone: (847) 501-5113
E-mail: Mlyons405@aol.com
Web site: www.buddinpraed.org

Available Training:
Training is available through Web sites such as: http://www.dcfscansnu.com/ (online training only) and http://www.communimetrics.com/CansCentralIndiana/ (online or on-site training available). Training at http://www.dcfscansnu.com/ takes close to five hours, and includes a copy of the CANS manual, two videos, practice vignettes, and a certification test. For more training options, or to find a trainer, please contact Melanie Buddin Lyons (information above) or John Lyons (information to follow). The CANS manuals and forms are available at no cost from the Buddin Praed Web site, www.buddinpraed.org, after registration. The Buddin Praed maintains the copyright to ensure intellectual integrity. The manuals explain how to administer and score the CANS.

Additional Information:
The contact information above is for obtaining copies of the CANS-MH. John S. Lyons, Ph.D., the developer of the CANS-MH, may be reached at JSL329@northwestern.edu or (312) 908-8972.

- **Child Behavior Checklist (CBCL)**

Contact Information:
ASEBA / Research Center for Children, Youth and Families
Burlington, VT
Phone: (802) 656-5130
E-mail: cbcl@uvm.edu
Web sites: www.aseba.org/products/forms.html
www.aseba.org/products/manuals.html

Available Training:
No formal training is available. CBCL software, forms and manuals are available at the Web site listed above. The cost of each varies depending on the version of CBCL used.

Additional Information:
Dr. Thomas Achenbach, the developer of the CBCL, can be reached at Thomas.Achenbach@uvm.edu

- **Diagnostic Interview Schedule for Children (DISC)**

Contact Information:
Prudence Fisher, Ph.D. (general or training information)
NIMH-DISC Training Center at Columbia University/NYSPI
Division of Child and Adolescent Psychiatry
New York, NY
Phone: (212) 543-5357 or (212) 543-5189
E-mail: nimhdisc@child.cpmc.columbia.edu
fisherp@childpsych.columbia.edu

Available Training:
Training is available at Columbia University, New York, or at individual sites. The training is 1-2 days and consists of the use and scoring of the computerized and paper versions of the DISC, data analysis, and role-plays. Individuals at sites can be trained to train others on the use of the DISC. Training is $400 per day at Columbia University, New York or $1,200 per day at home sites (for the first 10 people), plus travel expenses. For an additional fee of $600, an additional eight individuals can be trained on-site.

Additional Information:
The DISC is available in two versions for the computer. For the computer assist version an interviewer reads the questions to the participant. For the Voice DISC, the computer reads the question to the participant. Cost for installation of the DISC software varies, starting at $250. For a full study license and support contract, the price is $2,100.

- **Diagnostic Interview Schedule for Children Predictive Scales (DPS)**

Contact Information:
Christopher P. Lucas, M.D., Associate Professor
Institute for Prevention Science
Director, Early Childhood Service
NYU Child Study Center
New York, NY
Phone: (212) 263-2499
E-mail: chris.lucas@med.nyu.edu

Available Training:
Two hour training sessions are available on-site or at New York University. Information about administering and scoring the DPS is also available in the DPS User Guide and the DPS Cheat Sheet, which can be obtained by contacting Dr. Lucas at the phone number or e-mail address listed above.

Additional Information:
Paper versions of the DPS are available at a cost of $1 per form. The computerized version of the measure costs $250 for installation plus a $1,000 site licensing fee.

- **Ohio Youth Problem, Functioning and Satisfaction Scales (OHIO Scales)**

Contact Information:
Office of Program Evaluation and Research
Ohio Department of Mental Health
Columbus, OH
Phone: (614) 466-8651
E-mail: outcome@mh.state.oh.us
Web site: www.mh.state.oh.us/oper/outcomes/instruments.index.html

Available Training:
No formal training is available. The OHIO Scales forms, as well as the user and technical manuals, are available at no cost at the Web site listed above. The manuals provide information about administering and scoring the measure.

Additional Information:
Benjamin M. Ogles, Ph.D., one of the developers of the OHIO Scales, may be reached at (740) 593-1077 or ogles@ohio.edu

- **Strengths and Difficulties Questionnaire (SDQ)**

Contact Information:
Robert Goodman, Ph.D.
Department of Child and Adolescent Psychiatry
Institute of Psychiatry
DeCrespingy Park
London, United Kingdom
Web site: www.sdqinfo.com

Available Training:
No formal training is available. SDQ forms and scoring information are available at no cost at the Web site listed above.

Additional Information:
The SDQ is available in 46 different languages.

- **Behavior Assessment System for Children (BASC-2)**

Contact Information:
James A. Simone, Pearson Measurement Consultant
Clinical Assessment
Phone: (347) 726-7022
E-mail: Jim.simone@pearson.com
Web site: http://ags.pearsonassessments.com/Group.asp?nMarketInfoID=31&nCategoryInfoID=2585&nGroupInfoID=a30000

Available Training:
There are multiple levels of training. The first level of training is a general overview of how to administer and score the BASC-2 and how to interpret the scores. This takes approximately 2½-3 hours. A second level of training includes the interpretation of 2-3 case studies. It takes 5-6 hours to complete both levels of training. Training is done on site and includes materials and handouts. A list of measurement consultants is available. Please contact the measurement consultant in your area to discuss training options.

Additional Information:
The BASC can be administered and scored in a number of ways, including: paper and pencil with manual scoring; paper and pencil with scanned scoring; general "assist" narrative and scoring software; advanced "assist plus" narrative and scoring software; or with client server. "Assist Plus" gives outcomes for ten clinical scales related directly to the DSM-IV.

The cost varies, according to how many copies of the BASC are purchased. A consultant will work with each agency to determine the price of training. The BASC-2 is also available in Spanish.

- **Child and Adolescent Level of Care Utilization System (CALOCUS)**

Contact Information:
Robert D. Benacci, Project Development Specialist
Deerfield Behavioral Health, Inc.
Erie, PA
Phone: (814) 456-2457
E-mail: robb@dbhn.com
Web site: www.locusonline.com

Available Training:
Training is offered on-site and includes information on developing, understanding, and using the instrument. The cost is $1,000 for four hours of training, including 20 training manuals, plus travel expenses.

Additional Information:
The CALOCUS was originally developed by the Child and Adolescent subcommittee of the Child and Adolescent American Association of Community Psychiatrists. The contact information above is to obtain the computerized version of the CALOCUS, created by Deerfield Behavioral Health, Inc. Individuals can "try out" the software, using fictitious information, by visiting the Web site above.

- **Child and Adolescent Service Intensity Instrument (CASII)**

Contact Information:
Jennifer Medicus
Washington, DC
Phone: (202) 966-7300 ext. 137
E-mail: jmedicus@aacap.org
Web site: http://www.aacap.org/cs/root/member_information/practice_information/casii

Available Training:
Two trainings are offered: a one-day training is available for up to 35 participants; a two-day "train-the-trainer" training is also available for up to 35 participants per day. Each trained trainer will receive a copy of the PowerPoint slides to train others with. Both trainings include didactic training and the use of vignettes. Trainers will be on-call after training to answer questions.

Additional Information:
The one-day training costs $2,000 per day, plus travel expenses and training manuals. The two-day training costs $3,750, plus travel expenses and training manuals. The cost of the manuals is $25-35 depending on the quantity purchased.

Psychosocial Interventions – PTSD and Abuse-Related Trauma

- **Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)**

Contact Information:
The Center for Traumatic Stress in Children and Adolescents
Allegheny General Hospital
Department of Psychiatry
Pittsburgh, PA
Phone: (412) 330-4328
Web site: www.pittsburghchildtrauma.org

Available Training:
Introductory, basic, and advanced training is available. The introductory overview is 1-8 hours. Basic training is 2-3 days and advanced training is 1-3 days. In addition, a 10-hour basic web-based training (http://tfcbt.musc.edu) is available through the National Crime Victims Research and Treatment Center at the Medical University of South Carolina. Training may be privately arranged or is available through different organizations (i.e., National Child Traumatic Stress Network TF-CBT Collaborative). Training costs vary.

Additional Information:
Treating Trauma and Traumatic Grief in Children and Adolescents
J. A. Cohen, A. P. Mannarino & E. Deblinger (2006) — The Guilford Press

- **Abuse-Focused Cognitive Behavioral Therapy (AF-CBT)**

Contact Information:
David J. Kolko, Ph.D.
Western Psychiatric Institute and Clinic
University of Pittsburgh School of Medicine
Pittsburgh, PA
Phone: (412) 246-5888
E-mail: kolkodj@upmc.edu
Web site: www.pitt.edu/~kolko

Available Training:
A two-day initial didactic training is available in addition to 3-6 months of case consultation calls. Booster re-training sessions and advanced case reviews are also available. Training can be provided on a flexible basis in a local or independent agency or in the context of a regional program or training institute. Training costs vary.

Additional Information:
Assessing and Treating Physically Abused Children and Their Families: A Cognitive Behavioral Approach
D. J. Kolko & C. C. Swenson (2002) — Sage Publications

- **Parent-Child Interaction Therapy (PCIT)**

Contact Information:
Child Study Center
University of Oklahoma Health Sciences Center
Oklahoma City, OK
Phone: (405) 271-5700 x 45128
E-mail: Darden-white@ouhsc.edu
Web site: www.pcit.org

Available Training:
A five-day workshop is available through the University of Oklahoma Health Sciences Center, Cincinnati Children's Hospital Trauma Treatment Training Center, the University of Florida, the University of California, and the Davis CAARE Center. The workshop is followed by a booster session after three months and one year of weekly group consultation calls. Trainings are limited to 12 trainees and costs vary.

Additional Information:
The PCIT manual is available online at http://pcit.phhp.ufl.edu/

- **Child-Parent Psychotherapy for Family Violence (CPP-FV)**

Contact Information:
Early Trauma Treatment Network, University of California-San Francisco
San Francisco, CA
Phone: (415) 206-5377
E-mail: patricia.vanhorn@ucsf.edu

Available Training:
The training consists of an initial three-day intensive training followed by bi-weekly case consultation calls. Trainings are followed by 8-hour booster sessions every three months for the year following the initial training. Trainings take place at the University of California-San Francisco, onsite at community agencies, and are provided regionally through a series learning collaborative sponsored by the National Child Traumatic Stress Network. The cost of the training is approximately $1,500 a day.

Additional Information:
"Don't hit my mommy!" A manual for child-parent psychotherapy for young witnesses of family violence.
A. F. Lieberman & P. Van Horn (2004) — Zero to Three Press

- **Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)**

Contact Information:
Victor Labruna, Ph.D.
Division of Trauma Psychiatry
Department of Psychiatry
North Shore University Hospital
Manhasset, NY
Phone: (516) 562-3245 or (516) 993-7230
E-mail: vlabruna@nshs.edu
ruth.derosa@bascom.com

Available Training:
The training consists of an initial two-day training (comprised of didactic presentations, demonstrations, role-plays, and mindfulness practice), a 1½ day follow-up training four to six weeks after the start of group, and consultation calls throughout the duration of the implementation phase. Contact treatment developers for information on training location and cost.

Psychosocial Interventions – Disruptive Behavior Disorders

- **Parent Management Training (PMT)**

Contact Information:
The Parenting Center and Child Conduct Clinic
Department of Psychology
Yale University
New Haven, CT
Phone: (203) 432-9993
E-mail: childconductclinic@yale.edu
Web site: www.yale.edu/childconductclinic

Available Training:
The two-day training for therapists costs $500 per attendee.

Additional Information:
Parent Management Training: Treatment for Oppositional, Aggressive, and Antisocial Behavior in Children and Adolescents
A. E. Kazdin (2005) — Oxford University Press

- **Incredible Years**

Contact Information:
Lisa St. George
Incredible Years
Seattle, WA
Phone: (206) 285-7565
E-mail: LisaStGeorge@comcast.net
Web site: www.incredibleyears.com

Available Training:
The training is two to three days in length and certification varies based on level sought – basic to advanced. Trainings are provided at the Seattle, Washington site or privately upon arrangement. The two-day training is $300 and three-day training is $400 per person.

Additional Information:
Inquire further for a training provider near you.

- **Time Out Plus Signal Seat**

Contact Information:
Scott B. Hamilton, Ph.D.
Colorado State University
Fort Collins, CO
E-mail: sham@lamar.colostate.edu

Additional Information:
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.

- **Project Keep**

Contact Information:
Patricia Chamberlain, Ph.D.
Oregon Social Learning Center
Eugene, OR
Phone: (541) 485-2711
E-mail: pattic@oslc.org
Web site: www.oslc.org

Available Training:
There is on-site training for five days, followed by weekly phone supervision for one year and 1½ years of consultation. There is a manual that also explains how to implement this program.

- **Anger Coping**

Contact Information:
John Lochman, Ph.D.
University of Alabama
Department of Psychology
Tuscaloosa, AL
Phone: (205) 348-3535
E-mail: jlochman@gp.as.ua.edu

Additional Information:
Helping School Children Cope with Anger
J. Larson & J. E. Lochman (2002) — The Guilford Press

- **Problem Solving Skills Training (PSST)**

Contact Information:
Alan Kazdin, Ph.D.
The Parenting Center and Child Conduct Clinic
Department of Psychology
Yale University
New Haven, CT
Phone: (203) 432-9993
E-mail: childconductclinic@yale.edu
Web site: www.yale.edu/childconductclinic

- **Anger Control Training with Stress Inoculation**

Contact Information:
Donald Meichenbaum
University of Waterloo
Department of Psychology
Waterloo, Ontario, Canada
E-mail: dmeich@watarts.uwaterloo.ca

Available Training:
Workshops ranging from one, two, and five days are available.

- **Rational Emotive Behavioral Therapy (REBT)**

Contact Information:
Kristene A. Doyle, Ph.D.
The Albert Ellis Institute
New York, NY
Phone: (212) 535-0822
E-mail: info@albertellis.org
Web site: www.albertellis.org

Available Training:
Tiered trainings are available including a one-day workshop, a three-day Primary Practicum (with four lectures and four rounds of supervision) and a four-day Advanced Practicum. Training costs vary.

Additional Information:
Rational Emotive Behavior Therapy: A Therapist's Guide
A. Ellis & C. MacLaren (2007) — Impact Publishers

Psychosocial Interventions – Depression

- **Coping with Depression (CWD-A)**

Contact Information:
Gregory N. Clarke, Ph.D.
Kaiser Permanente Center for Health Research
Portland, OR
Phone: (503) 335-6673
E-mail: greg.clarke@kpchr.org
Web site: www.kpchr.org

Additional Information:
The manual for the Coping with Depression program is available online at www.kpchr.org/public/acwd/acwd.html

- **Interpersonal Psychotherapy for Adolescents (IPT-A)**

Contact Information:
Laura Mufson, Ph.D.
Department of Clinical Psychology
New York State Psychiatric Institute
New York, NY
Phone: (212) 543-5561
E-mail: lhm3@columbia.edu

Additional Information:
Interpersonal Psychotherapy for Depressed Adolescents
L. Mufson & D. Moreau (2004) — The Guilford Press

- **Cognitive Behavioral Therapy for Adolescent Depression**

Contact Information:
STAR-Center, Western Psychiatric Institute and Clinic
Pittsburgh, PA
Phone: (412) 246-5619
E-mail: brentda@upmc.edu
Web site: www.starcenter.pitt.edu/

Additional Information:
Cognitive Therapy Treatment Manual for Depressed and Suicidal Youth
D. Brent & K. Poling (1997) — University of Pittsburgh, Services for Teens at Risk

Psychosocial Interventions – Substance Abuse

- **Cognitive Behavioral Therapy for Substance Abuse**

Contact Information:
Ronald M. Kadden
University of Connecticut Health Center
Farmington, CT
Phone: (860) 679-4249
E-mail: kadden@psychiatry.uchc.edu

Additional Information:
Cognitive Therapy of Substance Abuse
A. T. Beck, F. D. Wright, C. F. Newman & B. S. Liese (2001) — The Guilford Press

- **Brief Strategic Family Therapy (BSFT)**

Contact Information:
Family Therapy Training Institute of Miami
Miami, FL
Phone: (888) 527-3828
E-mail: info@bsft-av.com
Web site: www.brief-strategic-family-therapy.com/bsft

Available Training:
Beginner, intermediate, and intensive trainings are available. Certification received after 12 days of training and 4-5 months of supervision. Training cost is based on training level: beginner - $7,500, intermediate - $15,000, and intensive - $22,500 per 30 training attendees. Certification costs $30,000 and supervision is $28,000 for five training attendees.

Additional Information:
An overview of the intervention can be found at www.ncjrs.gov/pdffiles1/ojjdp/179285.pdf

- **Functional Family Therapy (FFT)**

Contact Information:
Holly DeMaranville, FFT Communications Coordinator
Seattle, WA
Phone: (206) 369-5894
E-mail: hollyfft@comcast.net
Web site: www.fftinc.com

Available Training:
Trainings are available through beginning to advanced phases (1-3). Phase 1 costs $25,500, phase 2 costs $5,000, and phase 3 costs $2,000.

Additional Information:
An overview of the intervention can be found at www.ncjrs.gov/pdffiles1/ojjdp/184743.pdf

Guidelines for the Use of Psychotropic Medications with Children

Psychotropic Medication Utilization Parameters for Foster Children
Texas Department of State Health Services
www.dshs.state.tx.us/mhprograms/PsychotropicMedicationUtilizationParametersFosterChildren.pdf

Treatment Recommendations for the Use of Antipsychotic Medications for Aggressive Youth (TRAAY)
Journal of the American Academy of Child and Adolescent Psychiatry 2003; 42:145-61

Texas Children's Medication Algorithm Project (CMAP)
Major Depressive Disorder Algorithm
www.dshs.state.tx.us/mhprograms/mddpage.shtm

Attention Deficit Hyperactivity Disorder Algorithm
www.dshs.state.tx.us/mhprograms/adhdpage.shtm

Florida Best Practice Psychotherapeutic Medication Guidelines for Children and Adolescents-University of South Florida
http://flmedicaidbh.fmhi.usf.edu/recommended_child_guidelines.htm
Includes guidelines for ADHD, Bipolar, Chronic Impulsive Aggression, and Depression

American Academy of Child and Adolescent Psychiatrists (AACAP) Practice Parameters
http://www.aacap.org/cs/root/member_information/practice_information/practice_parameters/practice_parameters
Includes practice parameters for several mental health disorders including, ADHD, PTSD, Bipolar, Conduct Disorder, and Depression.

Comprehensive Interventions

- **Multidimensional Treatment Foster Care (MTFC)**

Contact Information:
TFC Consultations
Eugene, OR
Phone: (541) 343-2388
E-mail: renag@mtfc.com
Web site: www.mtfc.com

Available Training:
Quarterly 4-5 day trainings are held in Eugene, Oregon, with weekly phone consultation thereafter. During the first year of implementation, three implementation progress reviews and a program evaluation are completed.

Additional Information:
The cost of implementing MTFC is $750 for planning and preparation, $45,000 for the first year of implementation, and additional costs for travel and lodging. Ongoing costs should not exceed $10,000 per year.

- **Multisystemic Therapy (MST)**

Contact Information:
Marshall E. Swenson, M.S.W., M.B.A. Vice President, MST Services
Manager of New Program Development
MST Services
Mt. Pleasant, SC
Phone: (843) 284-2215
E-mail: marshall.swenson@mstservices.com
Web sites: www.mstservices.com
www.mstinstitute.org

Available Training:
Training is offered only to teams in agencies with a licensed MST treatment program. There are five-day orientations for clinical staff and two-day supervisor orientations. An advanced supervisor workshop is also offered. Training includes initial on-site training, quarterly on-site consultation, and weekly consultation calls.

Additional Information:
For information about the costs of training in MST, contact Marshall E. Swenson.

- **Wraparound**

Contact Information:
April Sather, MPH, Research Coordinator
Department of Psychiatry and Behavioral Sciences
Division of Public Behavioral Health and Justice Policy
University of Washington School of Medicine
Seattle, WA
Phone: (206) 685-2310
E-mail: sathea@u.washington.edu
Web site: www.rtc.pdx.edu/nwi

Available Training:
Training is available through consultants, which can be found on the Web site. A guide for choosing a consultant that will meet your needs is also available. Each trainer determines the training format.

Parent Engagement and Support Programs

- **Co-parenting**

Contact Information:
Oriana Linares, Ph.D., Associate Professor of Psychiatry
NYU Child Study Center
New York, NY
Phone: (212) 263-8847
E-mail: oriana.linares@med.nyu.edu

Available Training:
Dr. Linares conducts training using video tapes and role-plays. Training is $600 for one-half day, and is available at New York University or at agency sites within New York City.

- **Parents Anonymous®**

Contact Information:
Augusto Minakata, Senior Program Coordinator
Parents Anonymous® Inc.
Claremont, CA
Phone: (909) 621-6184 x218
E-mail: aminikata@parentsanonymous.org
Web site: www.parentsanonymous.org

Available Training:
An agency must be accredited before agency workers can be trained in Parents Anonymous (PA). To become accredited, please contact Parents Anonymous. After accreditation, there is a 2 ½ day training in a "train-the-trainer" model. The training is didactic and interactive, and includes role-plays, video clips, and discussions of different kinds of scenarios. Training is held for Parents Anonymous Group Facilitators, Parent Group Leaders, and Human Service Workers who will run the youth groups. After accreditation and initial training, there is ongoing evaluation through bi-annual, 1½ hour consultation calls. This is the Building Capacity for All Teleconference Series.

Additional Information:
The cost of training depends on the size of the organization being trained and how many PA groups the agency will open.

- **Parent Engagement and Self Advocacy (PESA) Program**

Contact Information:
Lisa Hunter Romanelli, Ph.D., Director of Programs
The REACH Institute
New York, NY
Phone: (212) 845-4603
E-mail: Lisa@thereachinstitute.org

Available Training:
Training for PESA group facilitators is available through the REACH Institute. Initial training is 40 hours, followed by bi-weekly consultation calls for one year. Training is provided at the REACH Institute or at agency sites.

- **Parent Mentoring Program**

Contact Information:
Ross Brown
DCFS
Vancouver, WA
Phone: (360) 993-7956
E-mail: rosb300@dshs.wa.gov

Available Training:
Training is currently available to in-state agencies. Training involves phone consultation to prospective agencies, then a two-day on-site training once foster parents have been identified. Service providers and foster parents are trained during this time. If you are located outside of Washington state, call Ross Brown or Peggy DeVoy for training options.

Additional Information:
Peggy DeVoy, the co-developer and co-coordinator, can be reached at (360) 993-7819 or Depe300@dshs.wa.gov

- **Shared Family Care**

Contact Information:
Saundra Marshall, Program Supervisor
FamiliesFirst, Inc.
Concord, CA
Phone: (925) 602-1750
E-mail: smarshall@familiesfirstinc.org
Web sites: www.familiesfirstinc.org/community_services_sharedfamily.html
http://aia.berkeley.edu/information_resources/shared_family_care.php

Available Training:
Training is provided on-site and occasional workshops are presented at regional conferences. Training, which is approximately one day, is conducted in Concord, CA. Participants learn program procedures and guidelines.

- **Powerful Families**

Contact Information:
Casey Life Skills Program
Seattle, WA
Phone: (206) 282-7300
Web site: www.casey.org

Available Training:
Training for individual agencies, not partnered with Casey Family Programs, is currently not available for Powerful Families. Casey Family Programs is not training the public on the use of Powerful Families, but rather they are training individuals at partner sites throughout 2009. If an agency would like to inquire about Powerful Families, its state or county would need to refer the agency to Casey Family Programs.

Youth Empowerment and Support Programs

- **California Youth Connection (CYC)**

Contact Information:
CYC Statewide Office
San Francisco, CA
Phone: (415) 442-5060 or (800) 397-8236
Web site: www.calyouthconn.org/site/cyc

- **Getting Beyond the System (GBS)**

Contact Information:
Youth Advocacy Center, Inc.
New York, NY
Phone: (212) 675-6181
E-mail: sross@youthadvocacycenter.org
Web site: www.youthadvocacycenter.org/model/beyond.html

Available Training:
The two-day GBS Philosophy and Approaches [Facilitator] Training Workshop costs $300 per attendee with 10% off for each additional attendee from the same organization. The workshop is held in New York City.

- **Foster Care Alumni of America (FCAA)**

Contact Information:
Foster Care Alumni of America
Alexandria, VA
Phone: (703) 299-6767 / (888)ALUMNI
E-mail: admin@fostercarealumni.org
Web site: www.fostercarealumni.org

- **Taking Control**

Contact Information:
The REACH Institute
New York, NY
Phone: (212) 845-4606
Web site: www.thereachinstitute.org

Additional Information:
The two-day training includes the participation of mental health clinicians and foster care alumni co-leader pairs.

- **Voices of Youth**

Contact Information:
Voices of Youth
New York City, NY
Phone: (212) 326-7000
E-mail: voy@unicef.org
Web site: www.unicef.org/voy/

- **Youth Communication**

Contact Information:
Youth Communication
NY Center, Inc.
New York, NY
Phone: (212) 279-0708
Web site: www.youthcomm.org

Youth Support: Academic Remediation Services

- **Foster Youth Services (FYS)**

Contact Information:
Jackie Wong, Foster Youth Services Program State Coordinator
Counseling, Student Support and Service-Learning Office
California Department of Education
Sacramento, CA
Phone: (916) 327-5930
E-mail: jawong@cde.ca.gov

Youth Support: Mentoring Programs

- **Adoption and Foster Care Mentoring**

Contact Information:
ACF Mentoring
Boston, MA
Phone: (617) 224-1300
Web site: www.afcmentoring.org

- **AmeriCorps Foster Mentoring Project (FYMP)**

Contact Information:
Sacramento, CA
Phone: (866) 325-3222
Web site: www.foundationccc.org/Home/tabid/36/Default.aspx

- **Fostering Healthy Connections**

Contact Information:
Kerrin Sweet, Foster Care Program Manager
Child Welfare League of America
Arlington, VA
Phone: (703) 412-2400
E-mail: ksweet@cwla.org
Web site: www.cwla.org/programs/fostercare/peermentoring.htm

- **New York City Administration for Children Services Mentoring Program**

Contact Information:
Administration for Children's Services (ACS)
ACS Mentoring Program, Office of Youth Development
New York, NY
Phone: (212) 341-0914
Web site: http://home2.nyc.gov/html/acs/html/become_mentor/referral_service.shtml

Youth Support: College Education Attainment Services

- **Casey Life Skills Program**

Contact Information:
Casey Life Skills Program
Seattle, WA
Phone: (206) 282-7300
E-mail: aclsa@casey.org
Web site: www.caseylifeskills.org

Additional Information:
For more information regarding training, visit www.caseylifeskills.org/pages/train/train_index.htm

- **Living Classrooms Foundation/UPS School to Career Partnership**

Contact Information:
Christine Truett
Living Classrooms
Baltimore, MD
Phone: (410) 685-0295
E-mail: christine@livingclassrooms.org
Web site: www.livingclassrooms.org

- **Chafee funded EVT (Education/Training Vouchers) Program**

Contact Information:
The Chafee Educational and Training Voucher (ETV) Program
National Foster Care Coalition
Washington, DC
Phone: (202) 756-4842
Web site: www.statevoucher.org

- **Orphan Foundation of America (OFA)**

Contact Information:
Orphan Foundation of America
Sterling, VA
Phone: (571) 203-0270
E-mail: scholarships@orphan.org
Web site: www.orphan.org

Youth Support: Employment Preparation Services

- **School-to-Career Partnership of United Parcel Service and the Annie E. Casey Foundation**

Contact Information:
The Annie E. Casey Foundation
Baltimore, MD
Phone: (410) 547-6600
E-mail: webmail@aecf.org
Web site: www.aecf.org/ChildFamilyServices/SchoolToCareer.aspx

- **Project H.O.P.E. Program**

Contact Information:
Thou M. Ny, Youth Employment Program Consultant
Alameda County Independent Living Skills Program
Oakland, CA
Phone: (510) 268-2843
E-mail: nyt@acgov.org
Web site: www.alamedacountyilsp.org/Services/Employment/HOPE/index.htm

- **Job Corps**

Contact Information:
U.S. Department of Labor
Washington, DC
Phone: (877) 889-5627
Web site: www.jobcorps.dol.gov

Other Tools

- **Organizational Social Context Measure**

Contact Information:
Dr. Anthony Hemmelgarn
Children's Mental Health Services Research Center
The University of Tennessee, College of Social Work
128 Henson Hall
Knoxville, TN 37996-3332
Phone: (865) 974-1707

Evidence-based Practice Needs Assessment

Agency: _____

Interviewer: _____

Respondent: ❑ Administrator ❑ Supervisor ❑ Caseworker
❑ Treatment Parent ❑ Birth Parent ❑ Youth

Date: _____

1. What is your understanding of evidence-based practice as it relates to treatment foster care?

_____
_____
_____
_____

2. Are you aware of any evidence-based practices currently implemented by this treatment foster care program?

❑ No (go to question 4)

❑ Yes (please name the specific evidence-based practices)

_____
_____
_____

3. For each practice listed in Question 2 ask:

a. What have been the advantages of this practice?

_____
_____
_____

b. What have been the disadvantages of this practice?

_____
_____
_____

4. In your opinion, what specific areas of this treatment foster care program need improvement based on:

a. Program outcomes?

b. Consumer feedback?

c. Foster Family-based Treatment Association (FFTA) Program Standards?

5. Do any of the evidence-based practices currently implemented in this treatment foster care program address these areas?

❑ No

❑ Yes

6. What (if any) evidence-based practices are available to address the areas of this program in need of improvement?

7. Which of the available evidence-based practices most closely match this program's organizational philosophy, needs and resources?

8. What are the potential advantages and disadvantages of implementing any of these evidence-based practices?

Evidence-based Practice Readiness Checklist

- ❑ Formed EBP implementation committee
- ❑ Conducted EBP needs assessment
- ❑ Analyzed results of needs assessment
- ❑ Assessed organizational factors that may impede EBP implementation
- ❑ Addressed any organizational barriers to EBP implementation
- ❑ Reviewed available EBP relevant to organizational/program needs
- ❑ Selected EBP to implement
- ❑ Spoke to other agencies that have implemented EBP to learn challenges
- ❑ Determined funding and staff resources needed to implement EBP
- ❑ Identified funding sources, if needed
- ❑ Discussed with staff members rationale for implementing EBP
- ❑ Met with EBP developers to determine any needed adaptations to the EBP
- ❑ Developed plan for monitoring and evaluating EBP implementation
- ❑ Scheduled EBP training
- ❑ Provided staff members with EBP training materials (i.e., manual, book, etc.) prior to scheduled training to allow time for becoming familiar with material
- ❑ Scheduled ongoing consultation in EBP (6 months – 1 year)

Evidence-based Practice Attitude Scale

The following questions ask about your feelings about using new types of therapy, interventions, or treatments. Manualized therapy refers to any intervention that has specific guidelines and/or components that are outlined in a manual and/or that are to be followed in a structured/predetermined way.

Fill in the circle indicating the extent to which you agree with each item using the following scale:

0	1	2	3	4
Not at all	To a Slight Extent	To a Moderate Extent	To a Great Extent	To a Very Great Extent

	0	1	2	3	4
1. I like to use new types of therapy/interventions to help my clients?	❍	❍	❍	❍	❍
2. I am willing to try new types of therapy/interventions even if I have to follow a treatment manual?	❍	❍	❍	❍	❍
3. I know better than academic researchers how to care for my clients?	❍	❍	❍	❍	❍
4. I am willing to use new and different types of therapy/interventions developed by researchers?	❍	❍	❍	❍	❍
5. Research based treatments/interventions are not clinically useful?	❍	❍	❍	❍	❍
6. Clinical experience is more important than using manualized therapy/treatment?	❍	❍	❍	❍	❍
7. I would not use manualized therapy/interventions?	❍	❍	❍	❍	❍
8. I would try a new therapy/intervention even if it were very different from what I am used to doing?	❍	❍	❍	❍	❍
For questions 9-15: If you have received training in a therapy or intervention that was new to you, how likely would you be to adopt it if:					
9. it was intuitively appealing?	❍	❍	❍	❍	❍
10. it "made sense" to you?	❍	❍	❍	❍	❍
11. it was required by your supervisor?	❍	❍	❍	❍	❍
12. it was required by your agency?	❍	❍	❍	❍	❍
13. it was required by your state?	❍	❍	❍	❍	❍
14. it was being used by colleagues who were happy with it?	❍	❍	❍	❍	❍
15. you felt you had enough training to use it correctly?	❍	❍	❍	❍	❍

For information about scoring the EBPAS, please contact: Gregory A. Aarons, Ph.D., Child & Adolescent Services Research Center, University of California, San Diego, 3020 Children's Way, MC-5033, San Diego, CA 92123-4282, email: gaarons@ucsd.edu

Summary of Evidence-based Practice Tools and Programs

TABLE 1

• **Screening and Assessment**

Measure	Developer	Description	Target Age
Child and Adolescent Functional Assessment Scale (CAFAS)	K. Hodges	Measures functional impairment	6-17
Child and Adolescent Needs and Strengths, Mental Health (CANS)	J. Lyons	Assesses strengths and mental health risk factors	0-5 / 5-18
Ohio Youth Problem, Functioning and Satisfaction Scales (OHIO Scales)	B. Ogles, K. Dowell, D. Hatfield, G. Melendez, et al.	Assesses problem severity, functioning, satisfaction, and hopefulness	5-18
Strengths and Difficulties Questionnaire (SDQ)	R. Goodman	Assesses positive and negative attributes on five scales (emotional, conduct, hyperactivity, peer problems, pro-social behavior)	4-10 / 11-17
Child Behavior Checklist (CBCL)	T. Achenbach	Measures social competence and behavioral functioning in four general domains (externalizing symptoms, general symptomatology, internalizing symptoms, and mood and anxiety symptoms)	1.5-18
Diagnostic Interview Schedule for Children (DISC)	D. Shaffer, P. Fisher, C.P. Lucas, M. Dulcan & M. Schwab-Stone	Assesses for most DSM-IV disorders	6-18 (Parent Ver.) 9-18 (Youth Ver.)
Diagnostic Interview Schedule for Children Predictive Scales (DPS)	C.P. Lucas, H. Zhang, P. Fisher, D. Shaffer, et al.	Assesses for most DSM-IV diagnoses	9-17
Behavior Assessment System for Children (BASC)	C. Reynolds R. Kamphaus	Measures emotions and behaviors	2-25
Child and Adolescent Level of Care Utilization System (CALOCUS)	American Association of Community Psychiatrists and the American Academy of Child and Adolescent Psychiatry	Determines the level of care of a child based on the child's clinical needs	6-18
CASII	M. Chenven, E. Dominguez, T. Fallon, K. Grimes, et al.	Measures a youth's strengths and needs	6-18

TABLE 2

• Evidence-based Psychosocial Interventions – PTSD and Abuse-Related Trauma

Intervention	Developer(s)	Description	Target Age	EBP Rating
Trauma-Focused CBT (TF-CBT)	J. Cohen, A. Mannarino & E. Deblinger	Treatment of behavioral and emotional symptoms related to past trauma; incorporates both parent and child during 12-16 sessions	4-18	Well Supported-Effective Practice
TF-CBT for Childhood Traumatic Grief	J. Cohen, A. Mannarino & K. Knudsen	Treatment of children suffering from traumatic grief; incorporates both parent and child during 12-16 sessions	4-18	Promising Practice
Abuse-Focused CBT (AF-CBT)	D. Kolko	Utilized in an outpatient setting for abusive parents and their children through 12-18 sessions	4-18	Promising Practice
Parent-Child Interaction Therapy (PCIT)	S. Eyberg, S. Boggs & J. Algina	Structured therapy for abusive parents and their children; 12-20 sessions	4-12	Well Supported-Effective Practice
Child-Parent Psychotherapy for Family Violence (CPP-FV)	A. Lieberman & P. Van Horn	For children who have witnessed violence or display violence-related symptoms; weekly sessions over 12 months	Up to 5	Promising Practice
Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)	R. DeRosa, M. Habib, D. Pelcovitz, J. Rathus, et al.	Group intervention for chronically traumatized youth; weekly sessions over a 16 week period	12-18	Emerging Practice

TABLE 2 **Continued**

- **Evidence-based Psychosocial Interventions – Disruptive Behavior Disorder**

Intervention	Developer(s)	Description	Target Age	EBP Rating
Parent Management Training	G. Patterson, R. Littman & W. Hinsey	Short-term treatment teaches parents behavioral management skills; session lengths vary	Under 5	Well Supported-Efficacious Practice
Incredible Years	C. Webster-Stratton	Support group based on parent management training and teaches behavior management skills to parents; 12 sessions	2-10	Well Supported-Efficacious Practice
Time Out plus Signal Seat	S. Hamilton & S. MacQuiddy	Self-instructive intervention using positive reinforcements and time-out utilizing a signal seat wired to produce noise if child leaves seat	2-7	Promising Practice
Project Keep	P. Chamberlain, S. Moreland & K. Reid	Support group for foster and kinship parents to increase parenting skills in working with children with significant behavioral problems (i.e., externalizing); 16 sessions	5-12	Promising Practice
Anger Coping	J. Lochman	School or clinic intervention intended to provide children with coping skills for challenging situations; 12-18 sessions	8-12	Well Supported-Efficacious Practice
Problem Solving Skills Training (PSST)	A. Kazdin	Individual child and parent therapy implementing cognitive problem-solving skills to improve behavioral problems; 12-20 sessions	6-14	Promising Practice
Assertiveness Training	W. Huey & R. Rank	Training teaches effective relationship skills; 8-10 sessions	12-18	Promising Practice
Anger Control Training with Stress Inoculation	K. Schlichter & J. Horan	Anger management skills and coping skills with stress inoculation component; 10 sessions	12-18	Promising Practice
Rational Emotive Behavior Therapy (REBT)	A. Ellis	Incorporates cognitive and moral reasoning components to improve moral reasoning and judgment skills	12-18	Promising Practice

TABLE 2 Continued

• Evidence-based Psychosocial Interventions – Depression

Intervention	Developer(s)	Description	Target Age	EBP Rating
Coping with Depression (CWD-A)	P. Lewinsohn, G. Clarke, H. Hops & J. Andrews	Intervention explores techniques for use in combating depression; 16 sessions	Adolescents	Promising Practice
Interpersonal Therapy for Adolescents	L. Mufson, D. Moreau, M. Weissman & G. Klerman	Brief individual or group treatments used to target and resolve the interpersonal issues contributing to depression; 12 sessions	Adolescents	Well Supported-Efficacious Practice
Self-Control Therapy	K. Stark, W. Reynolds & N. Kaslow	Brief treatment teaches cognitive and behavioral techniques to help reduce symptomology; 12 sessions	School and Adolescents	Emerging Practice
Enhanced Self-Control Therapy	K. Stark, L. Rouse & R. Livingston	Uses an increased number of sessions and family meetings; up to 24 sessions	School and Adolescents	Emerging Practice
Relaxation Therapy	W. Reynolds & K. Coats	Utilizes relaxation techniques to reduce stress, muscle tension and depression; 10 sessions	Adolescents	Emerging Practice
Cognitive Behavioral Therapy (CBT)	A. Beck	Cognitive and behavioral techniques to help reduce symptomology; 12-16 sessions	Adolescents	Promising Practice

• Evidence-based Psychosocial Interventions – Substance Abuse

Brief Interventions	Varies based on intervention	Varies based on intervention (i.e., health education programs)	Varies	Emerging Practice
Cognitive Behavioral Therapy (CBT) for Substance Abuse	H. Waldron, N. Slesnick, J. Brody, C. Turner, et al.	Cognitive and behavioral techniques to help reduce substance use; ranges from 5 to 12 sessions	13-25	Promising Practice
Brief Strategic Family Therapy (BSFT)	J. Szapocznik, W. Kurtines, F. Foote, A. Perez-Vidal, et al.	Family therapy focused on children with emotional and behavioral problems and families with problematic relations	6-17	Well Supported-Efficacious Practice
Functional Family Therapy (FFT)	T. Sexton & J. Alexander	Family therapy for use with children presenting with disruptive behavioral disorders and/or substance abuse	11-18	Well Supported-Efficacious Practice

TABLE 5

- **Youth Empowerment Programs – General Empowerment Programs**

Program	Leadership/Developer	Description	Ages	EBP Rating
California Youth Connection (CYC)	T. Hightower, *President*	Guided by youth in care to promote alumni policy, development, and legislative change	14-24	NA
Foster Care Alumni of America (FCAA)	W. Stanton, *Chair, Board of Directors*	Brings the voices of foster care alumni to public policy and program design	18 and older	NA
Voices of Youth	United Nations Childrens Fund	Includes youth in all aspects of child welfare practice and policy development and operation	10 and older	NA
Youth Communication	K. Hefner, *Publisher/ Executive Director*	Provides reading and writing skills through training in journalism and publications	14-19	NA
The 'Taking Control' Program	M. Habib, S. Sunday, A. Turnbull, V. Labuna, et al.	Educates foster care youth, in a group setting, on various skills and topics, such as coping skills, interpersonal skills, and mental health	12-18	Emerging Practice
The 'Getting Beyond the System' (GBS) Model	B. Krebs & P. Pitcoff, *Co-Founders*	Strengths-based self-advocacy training program teaches skills for the improvement of intellectual, career, and lifelong learning	14-24	Emerging Practice

- **Youth Empowerment Programs – Academic Remediation Services**

Foster Youth Services (FYS) Program	Federal Government	Provides academic remediation services including tutoring and vocational training for the improvement of educational performance and achievement	Up to 18	NA

- **Youth Empowerment Programs – Mentoring Programs**

New York City Administration for Children's Services (ACS) Mentoring Program	NYC Children's Services	Matches mentors with youth aging out of foster care to help youth develop practical independent living skills	14-21	NA
AmeriCorps Foster Youth Mentoring Project (FYMP)	Chancellor's Office of the California Community Colleges	AmeriCorps students from state colleges mentor foster care youth	14-18	NA
Adoption and Foster Care Mentoring	M. French, *Executive Director*	Identifies, trains, and supervises mentor-mentee relationships, both one-on-one and in groups	7-14	NA
Fostering Healthy Connections	Child Welfare League of America (CWLA)	Support foster care alumni ages 21 and younger in mentor-mentee relationships with current foster care youth	Up to 21	NA

TABLE 5 Continued

• Youth Empowerment Programs – College Education Attainment Services

Program	Leadership/Developer	Description	Ages	EBP Rating
General College and Vocational Preparation Programs: *Casey Life Skills*	Casey Family Programs	Service high school students through preparatory services and apprenticeship or internship attainment	8 and older	NA
Scholarship Programs: *The Living Classroom*	J. Bond, *President and CEO*	Involves collaboration with state-foundations to offer scholarships to foster care youth	16-19	NA
Community Collaborations: *Washington State Puget Sound Pathways Network (PATHNET)*	Federal Government	Public school and community college collaborations provide high school mentoring, career counseling, and tutoring opportunities to foster care youth prior to and during college admission	18 and older	NA
Orphan Foundation of America (OFA)	J. Rivers, *Founder*	Provides college scholarships, online mentoring, internships and other supports to college students while administering several state Chafee Educational and Training Voucher (ETV) programs	Under 25	NA

• Youth Empowerment Programs - Employment Preparation Services

School-to-Career Partnership of United Parcel Service (UPS) and the Annie E. Casey Foundation	Annie E. Casey Foundation	Provides business-training opportunities along with transportation assistance	Up to 21	NA
Project H.O.P.E.	Federal Government	Collaboration of youth advocacy programs and the Alameda County Independent Living Skills Program in Alameda County, California to provide foster care youth with career and education, opportunities.	16-18	NA
Job Corps Programs	Federal Government	Federal programs which provide education and training services focused on employment, education, and military attainment	16-24	NA

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