Practice Parameter for the Assessment and Management of Youth Involved With the Child Welfare System

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This Practice Parameter presents principles for the mental health assessment and management of youth involved with the child welfare system. Important definitions, background, history, epidemiology, mental health care use, and functional outcomes are described. Practical guidance regarding child welfare-related considerations for evaluation and management are discussed.

Key Words: practice parameters, practice guidelines, child and adolescent psychiatry, foster care, child welfare

J Am Acad Child Adolesc Psychiatry 2015;54(6):502–517.

This Practice Parameter provides an introduction to the knowledge, skills, and attitudes important for effective mental health assessment and management of children and adolescents involved with the child welfare system. Child and adolescent psychiatrists and other professional and community stakeholders play an important role in the lives of these youth. Work in the child welfare system requires clinicians to use the full range of their professional expertise in assessment and treatment, child development, systems of care, cultural competence, and youth and family engagement. Understanding youth, family, and systems concerns will facilitate effective interaction with youth, families of origin, foster families, caregiver staff at out-of-home placements, prospective adoptive families, child welfare personnel, child advocates, additional child-serving agencies, the education system, courts, other health care providers, and other stakeholders.

In this Parameter, the terms "*child*" and "*youth*" are used interchangeably, except where otherwise specified. The term "*family*" is used in a broad sense to include relatives, close family friends, and nontraditional families, and the term "*caregiver*" includes family and, when specified, other childcare providers in out-of-home placements.

METHODOLOGY

The list of references for this Parameter was developed by systematically searching different electronic databases: Cochrane, PubMed, PsycINFO, Social Services Abstracts, and Social Work Abstracts. The search was conducted in February 2012. There were no limits set for age or date. The search was limited to American studies and the English language. The search used only controlled vocabulary terms (i.e., medical subject headings [MeSH] for PubMed and thesaurus terms for PsycINFO, and Social Services Abstracts). In the case of PubMed, a clinical queries filter was applied with a narrow scope to capture specific results.

Child welfare was combined with a range of subjects to thoroughly encompass the topic. Because foster care is a key component of child welfare, the term was used synonymously in the search. A sample search strategy for PubMed followed this pattern: (child welfare [MeSH] OR foster home care [MeSH]) AND child abuse (MeSH). The combination search terms included *adoption, child abuse, child advocacy, child behavior disorders, child care, child custody, child development, child health services, child rearing, developmental disabilities, group homes, mental disorders, mental health, Munchausen syndrome by proxy,* and *parenting*. This resulted in 2,635 PubMed references. A similar combination of search terms was repeated in PsycINFO (2,172 references), Social Services Abstracts (1,791), and Social Work Abstracts (166). This resulted in 6,729 unduplicated references. Abstracts and/or titles of all 6,729 references were reviewed. The search was augmented by a review of articles nominated by expert reviewers and further search of article reference lists, relevant books, and pertinent Web sites. A total of 314 articles were selected for full-text review based on their relevance to the topics addressed in this Parameter. The most pertinent of these 314 articles were selected for inclusion in the reference list for this Parameter.

DEFINITIONS

Clinicians working with youth involved with the child welfare system should be familiar with some commonly used child welfare system terms. These terms are defined broadly because laws and procedures vary in different jurisdictions. Many of these definitions are informed by the Child Welfare Information Gateway glossary.[1]

- *Child Welfare System.* A group of services designed to promote the well-being of children by ensuring safety, achieving permanency, and strengthening families to care for their children successfully. The child welfare system is not a single entity and involves many organizations. Some child welfare services are provided by state and local departments of social services, whereas others are contracted

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to private child welfare agencies and child service providers.

- *Child Maltreatment.* There is no single accepted definition of child maltreatment. Each state provides its own definitions of maltreatment within civil and criminal statutes. The Federal Child Abuse Prevention and Treatment Act reads "child abuse and neglect means, at a minimum, any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation, or an act or failure to act which presents an imminent risk or serious harm." In addition to physical, emotional, and sexual abuse or neglect, child maltreatment can encompass a broader array of exposures such as a child's experience of domestic violence or parental substance abuse. Any form of child maltreatment can lead to traumatic responses.
- *Child Protective Services (CPS).* The social service agency that receives reports, conducts investigations and assessments, and provides initial intervention and treatment services to children and families when child maltreatment is suspected to have occurred. This umbrella term refers to any state or county social service agency that responds to and investigates reports of possible child abuse and makes a disposition based on the findings.
- *Foster Care.* A service for children who cannot live with their custodial parents or guardians for some period; sometimes this is termed *out-of-home care.* The range of placements can include kinship care, nonrelative foster care, treatment or therapeutic foster care, group home, residential group care, secure residential treatment, and supervised independent living. Foster care is intended to be short term, with a focus on returning children home as soon as possible or providing them with permanent families through adoption or guardianship.
- *Child Welfare Worker.* The person who is responsible for the case management of the youth in question. The worker coordinates services to the child and family including referrals to appropriate agencies and services and monitors the youth's placement. The child welfare worker also prepares documentation for the courts and represents social services in any juvenile court proceedings.
- *Dependency Court.* The portion of juvenile court presiding over child welfare matters.
- *Dependent Child.* A child placed in the custody of a child welfare system by dependency court, typically because of maltreatment by caregivers. During dependency, the youth might remain at home with court oversight or be placed in out-of-home care. A court plan will be generated. The plan will indicate when the child can be reunified if the youth was placed in out-of-home care and under what circumstances the case can be dismissed from dependency court.
- *Permanency.* A concept based on the value that youth grow up best in a family environment that is durable, nurturing, and stable. This is supported by policies and practices in the dependency court and foster care systems. Permanent placements include return to the biological family, adoption, and legal guardianship.
- *Kinship Care.* Placements of children with relatives or close family friends, also known as *fictive kin.* Kin are preferred for children removed from their birth parents because it maintains the children's connections with their families. Kinship care can be informal (e.g., the family makes the decision for youth to live with kin) or formal (e.g., the state removes a youth from parental custody and places the youth with kin). The latter involves training, licensure, and more resource support.
- *Guardianship.* Caregivers can assume legal guardianship of a child in out-of-home care without termination of parental rights. Guardianship removes the youth from the child welfare system, allows the guardian or caregiver to make important decisions on behalf of the youth, and establishes a long-term caregiver for the youth. Relative caregivers who wish to provide a permanent home for a child and maintain relationships with extended family members most frequently use guardianship.
- *Treatment (Therapeutic) Foster Care.* Family foster care designed for children with severe emotional and behavioral problems. It provides additional support, including supplemental finances, supervision, and training. Treatment foster care standards vary in different jurisdictions.
- *Court-Appointed Special Advocate (CASA).* A person, usually a volunteer, appointed by the court who seeks to ensure that the needs and interests of a child in dependency court proceedings are protected. The CASA is a party to the case and advocates for safety, permanency, and well-being. CASAs are given certain powers and can speak on the youth's behalf in court. They cannot consent for treatment but can function as an educational surrogate for special education purposes, if specifically tasked.
- *Guardian ad Litem.* A lawyer or layperson appointed by the court to handle the affairs, act, or speak on behalf of someone involved with the court. In dependency court, this typically involves representing the youth's best interests in maltreatment cases. It can involve different additional roles, including independent investigator, advocate, advisor, or guardian for the child. A layperson who serves in this role is sometimes known as a CASA. Not all cases will have a guardian ad litem appointed. It is up to the individual bench officer to decide whether to do so.

BACKGROUND

The child welfare system is a group of services designed to promote the well-being of children by ensuring safety, achieving permanency, and strengthening families to care for their children successfully.[2] Significant numbers of youth and families have contact with the child welfare system, with considerable social and fiscal consequences. In 2011, approximately 681,000 children were confirmed to be victims of maltreatment, and approximately 400,000 youth resided in foster care daily.[3] The total annual cost of child abuse and neglect has been estimated to be $80.2 billion.[4]

Child and adolescent psychiatrists and other mental health professionals can play an important role in the lives of many youth in foster care. Upward of 80% of youth involved with the child welfare system have developmental, behavioral, or

emotional concerns requiring mental health treatment.[5-8] Compared with other Medicaid-eligible youth, youth placed in foster care have 5 to 8 times the rate of mental health service use, 8 to 12 times greater mental health expenditures, and 2 to 8 times the rates of various psychotropic prescribing practices (e.g., any psychotropic medication, antipsychotic medication, and polypharmacy).[7,9-18]

Increasing attention has focused on the high rates of psychotropic prescribing to youth in foster care. Wide geographic variations in prescribing rates suggest psychotropic medications can be over- and under-prescribed, and that factors other than clinical need influence prescribing practices.[19-22] Foster youth have higher rates of mental health disorders, which could be due in part to the effects of maltreatment, trauma, removal from home and family, multiple placements, disrupted attachments, poverty, gestational exposures, and genetic vulnerability. In addition to higher rates of mental health disorders, factors potentially contributing to appropriately higher rates of prescribing include gaining access to Medicaid insurance, systematic screening and assessment, and child welfare advocacy for indicated treatments. Although higher rates of mental health disorders support higher psychotropic prescribing rates, it is not clear whether the current magnitude of higher prescribing is appropriate. Factors contributing to potentially inappropriate psychotropic prescribing can include insufficient time and information for clinicians to properly evaluate and reassess, limited support for collaboration among providers and stakeholders, under-recognition of trauma etiology in case formulation of complex presenting problems, limited access to effective and specifically targeted psychosocial treatments, clinician workforce insufficiently trained in effective psychosocial and psychopharmacologic treatments, poor continuity of care, limited integration of care, ineffective advocacy, unrealistic hope that medication will stabilize a complex psychosocial situation, lack of commitment to indicated parent skills training (especially when permanency is unclear), lack of commitment to or confidence in psychotherapy for complex problems, and responding to behavioral crises and urgent requests with pharmacologic interventions. Addressing many of these concerns will require reorganizing the mental health and child welfare systems and how they interface. This restructuring goes beyond the scope of this Practice Parameter but provides opportunities for public policy advocacy.

Although there is no definitive evidence to determine the appropriateness of higher rates of psychotropic prescribing to youth involved with the child welfare system, various stakeholders are concerned. In a survey of state child welfare agencies, the US Government Accountability Office found that 15 states identified the overprescribing of psychiatric medication to youth involved with the child welfare system as one of the most important emerging issues facing their child welfare system.[23] One study of child welfare and mental health professionals' view of the quality of psychiatric services received by consumers of the child welfare system showed concerns about the overuse of psychotropic medications and overmedication of youth. The overuse was attributed in part to a lack of clinical feedback from child welfare partners to psychiatrists.[24] A survey of 47 states and the District of Columbia on psychotropic medication oversight in foster care found that more than half the states rated their level of concern about psychotropic medication use as "high." Most of these states reported an increasing trend in the use of psychotropic medications, specifically increased use of antipsychotics, antidepressants, and attention-deficit/hyperactivity disorder medications, increased polypharmacy, increased medication use in young children, and increased reliance on pro re nata medications in residential facilities.[16]

As a result of these concerns, different guidelines and protocols for the oversight of psychiatric medication use in the child welfare system have been developed and catalogued.[16,17,25] In 2005, the American Academy of Child and Adolescent Psychiatry (AACAP) published a Position Statement on Oversight of Psychotropic Medication Use for Children in State Custody: A Best Principles Guideline,[26] which is a set of oversight recommendations for child welfare jurisdictions and state agencies. In summary, the position statement *minimal standards* call for jurisdictions to:

- Identify the parties empowered to consent for treatment of youth in state custody in a timely fashion
- Obtain assent from minor youth for psychiatric medication when possible
- Establish guidelines for the use of psychiatric medications for youth in state custody

Recommended standards include:

- Providing psychoeducational materials to facilitate the consent process
- Maintaining an ongoing medical record with medical and psychiatric history
- Establishing a child psychiatry consultation program for:
  - Persons who are responsible for consenting to psychiatric medication treatment
  - Physicians working with youth involved with the child welfare system
  - Face-to-face evaluations of youth at the request of child welfare stakeholders who have concerns about a specific youth's psychiatric medication regimen

Ideal standards include:

- Establishing training requirements for child welfare workers, court personnel, and/or foster parents to promote more effective advocacy for youth in their custody regarding behavioral health care, psychiatric medications, and monitoring
- Establishing programs administered by child psychiatrists to oversee and evaluate the use of medications for youth in state custody at the individual youth and population levels
- Creating a Web site to provide stakeholders easy access to pertinent policies and procedures governing the use of psychiatric medications and useful information about child psychiatric diagnoses and psychotropic medications

In 2011, the US Government Accountability Office recommended that the US Department of Health and Human

Services, the federal agency overseeing child welfare, endorse further guidance to states on best practices for oversight of psychotropic prescribing to youth involved in the child welfare system. The US Department of Health and Human Services agreed with this recommendation.[18] In a survey of key informants from child welfare and affiliated agencies in 47 states and the District of Columbia,[16] four fifths of states had or were developing a written policy or guideline regarding psychotropic medication use. Two thirds of states had adopted at least 1 "red flag" marker signaling a need for heightened scrutiny (the nature of which varied across states). The most commonly used red flags were use of psychotropic medications in young children (defined variously as 3–6 years old), endorsed by nearly one half of states; use of multiple concurrent psychotropic medications (defined variously as 3–5 medications), endorsed by two fifths of states; and use of multiple medications within the same class for longer than 30 days, endorsed by two fifths of states. Dosage exceeding maximum recommendations (e.g., manufacturer, professional, federal, or state) and medications inconsistent with current recommendations (e.g., professional or state guidelines) were endorsed as red flags by more than one fourth of states. These state actions were congruent with the 2012 federal guidelines pertaining to oversight of psychotropic medication for children in foster care (https://www.acf.hhs.gov/sites/default/files/cb/im1203.pdf), which identified 3 potentially problematic psychotropic prescribing practices, designated as *too many* (polypharmacy), *too much* (dosages exceeding recommendations), and *too young* (prescribing to young children).

HISTORY

In 1909, the first White House Conference on the Care of Dependent Children recommended that children be placed with selected local foster families, rather than the previous practice of using orphanages. The child welfare system has always been dynamic, constantly modified by state and federal legislation, state and federal agency oversight, and locally adopted court rules. As a result, no uniform national system exists. Each state and county can have different systems of care for child welfare, governed by federal and state law, and informed by locally developed policy and practice.

The potential conflict between parents' rights to raise their children without government interference and children's rights to be raised free from maltreatment is a societal dilemma. Debate continues over the relation between the rights of parents and the best interests of the child, including safety and developmental needs. When considering the rights and interests of the state, parents, caregivers, or youth, differences of opinion can arise. More than 50 years ago, the courts did not recognize that a child in state custody had any rights. Over the years, dependency court principles shifted first to the "tender years" concept, which acknowledged the developmental needs of young children, and then in the 1970s to the concept of "the best interests of the child." All states have statutes requiring that the child's best interests be considered in at least some aspect of child welfare decision making, but application of this concept varies significantly. No standard definition exists for "best interests of the child," but the term generally refers to the primacy of the child's safety and well-being.

The history of foster care in the United States includes examples in which the rights of parents in certain ethnic and racial groups have been inappropriately overridden. For example, American Indian youth have been, and continue to be, removed from their families at high rates. As a result, the Indian Child Welfare Act of 1978 mandates that, if possible, a tribal court will hear all child welfare cases involving American Indian children. The Indian Child Welfare Act also sets specific guidelines for the placement of American Indian children into foster care to preserve the child's cultural identity.

The Social Security Act of 1935 first established national standards for child welfare in the United States and provides federal grants to states for child welfare services. The Child Abuse Prevention and Treatment Act (PL 108-6), originally enacted in 1974 and most recently amended in 2010, provides funding in support of prevention, assessment, investigation, prosecution, and treatment activity for child maltreatment. It identifies the federal role in supporting child welfare research, evaluation, and data collection.

The Adoption Assistance and Child Welfare Act of 1980 (PL 96-272) created the Title IV-E program, which establishes court review of the status of a foster child at least every 6 months, stipulates that the child be placed in the least restrictive setting, and requires "reasonable efforts" be made to prevent removal. When youth are removed, PL 96-272 encourages reunification of youth with their parent(s) or legal guardian and requires determination of a youth's permanent placement within 18 months of entry into foster care. The act also provides financial assistance for adoptive parents.

The Multiethnic Placement Act of 1994 (PL 103-382) prohibits delaying, denying, or otherwise discriminating when making a foster or adoption placement decision or allowing a person to become a foster or adoptive parent based on the parent's or child's race, color, or national origin. At the same time, the act allows agencies to consider the cultural, ethnic, or racial background of a child and the capacity of a foster or adoptive parent to meet the cultural needs of a child. The Multiethnic Placement Act requires states to develop plans for the recruitment of foster and adoptive families that reflect the ethnic and racial diversity of the children needing family homes.

The 1997 Adoption and Safe Families Act (PL 105-89) modifies the Title IV-E program to clearly establish 3 national goals for child welfare: safety, permanency, and youth well-being. PL 105-89 also provides supports for adoptions and other permanency and incentives for completed adoptions and specifies that case planning include "concurrent planning" and "safety of the child."

The Foster Care Independence Act (John H. Chafee Foster Care Independence Program) was signed into law in 1999 and provides states with more funding and greater flexibility in carrying out programs designed to help youth transition from foster care to self-sufficiency. Chief provisions of this

law are an expansion of a state's ability to provide services for youth up to 21 years of age, including housing assistance and Medicaid eligibility. The act also expands opportunities for providing education, training, and employment services and financial support to foster youth preparing to live on their own.

The Fostering Connections to Success and Increasing Adoptions Act of 2008 (PL 110-351) provides options for states to provide new supports for kinship care, family connections, and older youth, including those transitioning into adulthood and out of the child welfare system. PL 110-351 improves educational stability and opportunities, provides incentives and assistance for adoption, and affords Indian tribes direct access to federal resources. The law also requires states to ensure coordination of health services, including mental health and dental services, for children in foster care and to develop monitoring and oversight plans for all prescription medications, including psychotropic medications.

The Child and Family Services Improvement and Innovation Act (PL 112-34), signed into law in 2011, requires states to develop plans for oversight and coordination of health care services for foster youth. It specifically requires states to outline the monitoring and treatments of emotional trauma associated with a child's maltreatment and removal from a home and to develop protocols for the appropriate use and monitoring of psychotropic medications. The law calls for states to describe activities to shorten the time youth younger than 5 years are without a permanent family and to identify which populations are at greatest risk of maltreatment and how services are targeted to the highest-risk populations. The law also requires peer-to-peer mentoring and support groups for parents and services and activities designed to facilitate visitation of children by parents and siblings.

Although not specifically relating to child welfare, the Affordable Care Act of 2010 (PL 111-148) allows youth aging out of the foster care system to remain eligible for Medicaid until 26 years of age, beginning in 2014.

PRINCIPLES

Principle 1. Clinicians should understand the child welfare process and how youth and family may interface with the child welfare system

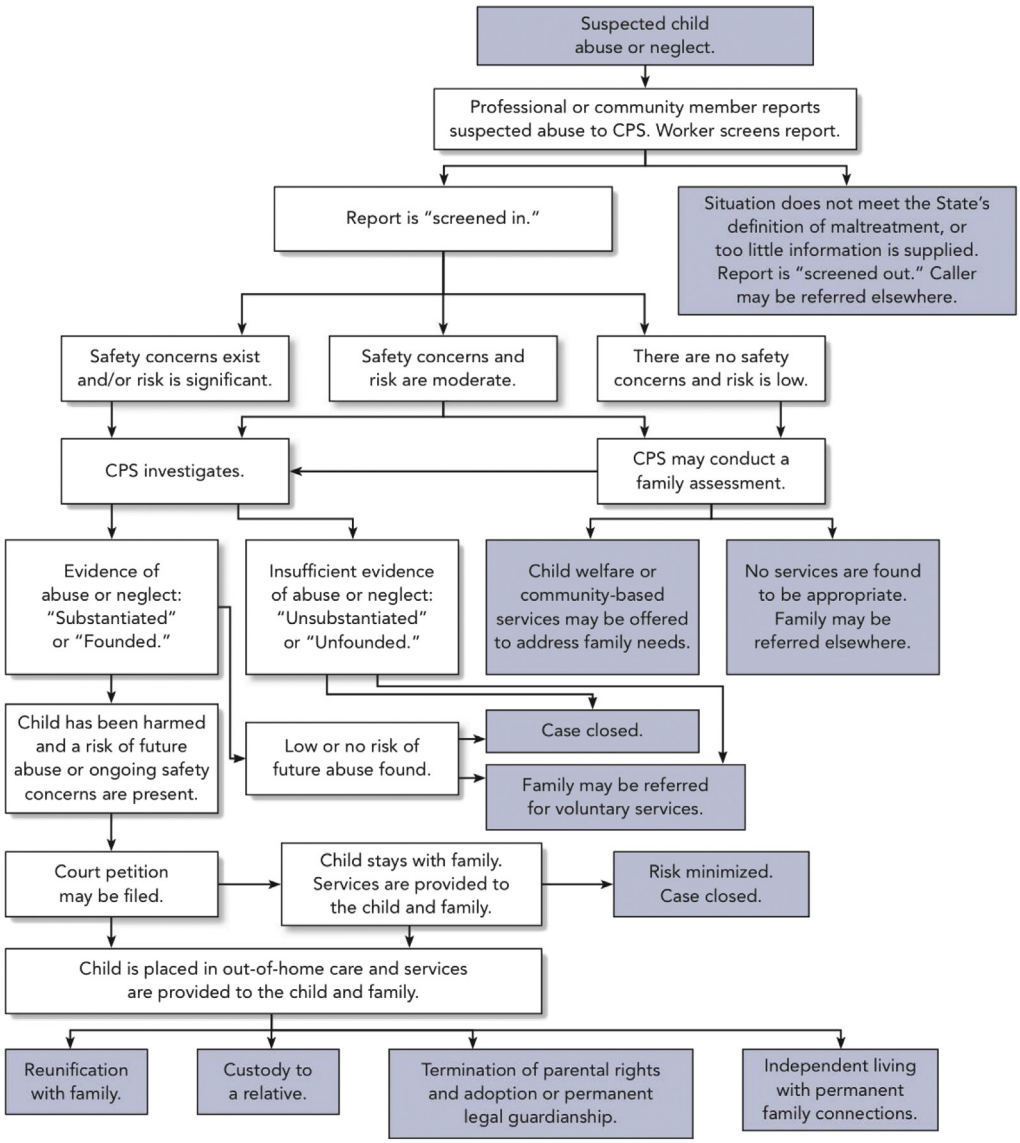
Involvement with the child welfare system (Figure 1) typically begins with a report of suspected maltreatment to the CPS, although there are other pathways to entry, such as parents voluntarily seeking child-rearing support. CPS personnel review the report and decide whether sufficient information exists to open a case based on the state's definition of maltreatment or risk. For those cases that do not meet the criteria for investigation, the reporter and/or family might be referred to community-based organizations for voluntary services. In lower-risk situations, some jurisdictions offer a more flexible and engaging family assessment response to guide families to services. Typically, cases are not formally opened in a family assessment response. Other terms for family assessment response, or similar services, include alternative response, differential response, multitrack response or dual-track response.

Situations meeting local CPS criteria for safety and/or risk concerns will be assigned to an "urgent" or "regular" response. The time frames depend on risk level and state and federal regulations and might be modified according to local rules or specific situations. At the end of the investigation, CPS personnel typically determine whether maltreatment allegations are "substantiated" or "unsubstantiated." Some states have additional categories, such as "unable to determine." For cases of substantiated maltreatment, the 2011 national frequencies of the types of maltreatment were 78.5% for neglect, 17.6% for physical abuse, 9.1% for sexual abuse, 9.0% for psychological maltreatment, and 2.2% for medical neglect (note: percentages add up to >100% because a youth can experience >1 type of maltreatment).[3]

Depending on the level of assessed risk, the case could be closed, referred to voluntary services, or referred to dependency court oversight through the filing of a dependency petition. Additional options exist in some jurisdictions. When allegations of maltreatment are substantiated, the CPS immediately decides whether the child is safe to remain at home or should be taken into CPS custody. Each open case is reviewed in dependency court. A child made dependent by the court can be "placed" at home or in out-of-home care. When placed in out-of-home care, the CPS prioritizes placing youth in kinship care, when possible, to maintain a youth's family connections. When more formal placements are used, child welfare workers seek the least restrictive setting. On a given day in 2011, youth in out-of-home placements were placed mainly in nonrelative foster care (47%) and relatives' homes (27%). The remaining youth were in institutions (9%), group homes (6%), trial home visits (5%), pre-adoptive homes (4%), or supervised independent living (1%) or were runaways (1%).[27]

Youth in dependency court will have a permanency plan, which specifies the plan for the youth's exit from the child welfare system, and a service plan. Depending on the jurisdiction and characteristics of the situation, youth might be assigned a CASA or guardian ad litem to represent the youth's best interests in dependency court. The CPS develops a service plan after assessing a youth's and family's strengths and needs. Service plans typically address basic needs (e.g., housing, food), barriers to effective parenting (e.g., substance use, parenting skills), and the youth's medical, emotional, and behavioral needs. The child welfare worker supports and monitors progress and reviews the case status at regularly scheduled court hearings. When the court determines that the service plan has been successfully completed, it dismisses the petition. In situations in which families do not make sufficient progress despite "reasonable efforts" made to support them, each jurisdiction has statutes providing for the termination of parental rights by a court. Termination of parental rights can be voluntary or involuntary. When considering involuntary termination of parental rights, most jurisdictions require the court to determine whether the parent is unfit by clear and convincing evidence and whether termination is in the child's best interests. Termination of parental rights ends the

FIGURE 1 Flowchart of how the child welfare system works. Note: CPS = child protective services. This material is made available from the Child Welfare Information Gateway and can be freely reproduced and distributed (https://www.childwelfare.gov/pubPDFs/cpswork.pdf#page=9%26view=Appendix).



legal parent–child relationship. At that point, the preferred permanent plan is adoption. Under child welfare principles, family settings are preferred over long-term group or residential placements because family settings offer youth an opportunity for enduring and nurturing attachments, a sense of belonging, long-term commitment, and a shared future. In some cases, intermediary solutions such as guardianship can become the permanent plan.

Some child welfare systems use structured decision making in their determination and decision processes. In this approach, fundamental child welfare objectives, values, and problems are defined and analyzed from multiple stakeholder perspectives to develop clearly defined decision-making criteria. Jurisdictions using structured decision making seek to promote consistent, transparent, and objective decision making at key points of the child welfare process and produce positive outcomes for youth and families.

Nationally, the most common type of exit from the child welfare system in 2010 was reunification with parents or primary caregivers (52%), which occurred more than twice as often as adoption (20%), the next most frequent exit category. The remaining most prevalent permanencies were emancipation (11%), living with other relatives (8%), and guardianship (6%). For youth exiting foster care, the mean and median lengths of stay of children in foster care were 21.1 and 13.2 months, respectively, with the lengths in months distributed as shorter than 1 (12%), 1 to 5 (15%), 6 to 11 (19%), 12 to 17 (15%), 18 to 23 (10%), 24 to 29 (7%), 30 to 35 (5%), 36 to 59 (9%), and longer than 60 (7%).[27]

Principle 2. Clinicians should be familiar with child welfare system core values and principles

Child welfare systems value and prioritize a family's right to raise their children and the principle that youth are usually best raised by their families. It is considered to be in a youth's best interest to be raised by his or her own family, unless there are compelling reasons to terminate parental rights. Child welfare systems share core values and principles with other child-serving organizations. In 1986, Stroul and Friedman[28] described core concepts of a system of care for youth with serious emotional disturbance. These core concepts are sometimes referred to as the Child and Adolescent Service System Program principles. These principles specify that services should be centered on the child, focused on the family, based on strengths, culturally competent, and provided in the least restrictive appropriate setting. In addition, the system should involve youth and families as full partners, include a comprehensive array of services, individualize services to each youth and family, stress early identification and intervention, and coordinate among service providers and systems. Identifying and highlighting family voice and choice will make it more likely that service planning will emphasize family values, priorities, and culture.

Child welfare systems value strengths-based approaches and resilience orientations. Masten[29] defined resilience as a class of phenomena characterized by good outcomes despite serious threats to adaptation or development and emphasized that resilience is a common, rather than extraordinary, characteristic of individuals. Resilience highlights the tendency of a human being toward typical development, rather than assuming inevitable pathology. A resilience orientation portends a strengths-based approach that identifies and enhances protective factors in a youth's ecology. The Center for Study of Social Policy's Strengthening Families framework organizes and addresses protective factors around parental resilience, social connections, knowledge of parenting and child development, concrete support in times of need, and social and emotional competence of children.[30]

Clinicians using a culturally informed approach attempt to understand youth and families in the context of their culture. Some minority groups, including African Americans and American Indians, are overrepresented at each decision point of the child welfare system.[31,32] At the same time, youth of color in foster care are underrepresented in accessing mental health services.[33,34] Lesbian, gay, bisexual, transgender, and questioning their gender identity or sexual orientation (LGBTQ) youth also are overrepresented in the child welfare system. In addition to the maltreatment, traumas, disrupted attachments, and losses experienced by other youth in the child welfare system, LGBTQ youth in foster care face additional challenges. These include homophobia or transphobia and the need to assess safety in their schools, social networks, communities, and homes to decide whether, and to whom, to disclose their LGBTQ identity.[35] Clinicians should be aware of and responsive to a youth's and family's culture, ethnicity, race, language, sexual orientation, gender identity, and spirituality. Provider sensitivity to cultural differences will facilitate engagement with youth and families, enhance the quality of services, and promote culturally acceptable decision making. Clinicians should elicit and attempt to understand a youth's and/or family's perspective and explanatory model of behavioral health concerns and child welfare system involvement. This will help facilitate culturally appropriate treatment planning. A diverse provider workforce inclusive of providers from the cultures of the families being served will improve cultural literacy and fit. When placed in out-of-home care, a youth's cultural identity should be promoted and nurtured. Readers are referred to the Practice Parameter for Cultural Competence in Child and Adolescent Psychiatric Practice[36] and the Practice Parameter on Gay, Lesbian, or Bisexual Sexual Orientation, Gender Nonconformity, and Gender Discordance in Children and Adolescents[37] for more information.

Many stakeholders endorse a trauma-informed approach; however, there is no single accepted definition of trauma-informed care. The term generally refers to an organizational approach and commitment to recognizing the manifestations of trauma in youth, caregivers, care providers, and stakeholders and to addressing trauma effects. Trauma awareness will permeate all aspects of organizational functioning, including incorporating trauma knowledge into policies and addressing the impact of vicarious and/or secondary trauma on clinicians and other stakeholders. In addition, trauma-informed service systems routinely screen for trauma exposure and symptoms, support youth and families in understanding traumatic experiences, emphasize safety and resiliency, and stress Child and Adolescent Service System Program principles. Clinicians should have specific training on the impact of maltreatment and other forms of trauma and recognizing trauma responses, including complex trauma responses. The National Child Traumatic Stress Network Web site provides a Child Welfare Trauma Training Toolkit[38] for teaching basic knowledge, skills, and values for working with youth in the child welfare system who have experienced traumatic stress. Clinicians sufficiently trained in, and committed to, trauma-informed approaches are better poised to advocate for the integration of this orientation with day-to-day practice and to advocate for the types of public health policies and clinical practice needed to provide good care.

Principle 3. Clinicians should be aware of a referred child's current legal status, including who has the authority to give consent for evaluation and treatment

Every child and adolescent in foster care has a representative of the state's child welfare agency responsible for managing his or her case. Consent should be addressed before the first appointment. Each specific step in the child welfare process (e.g., placed but not in court dependency, legal guardianship, shared social services/juvenile justice custody, etc.) has different implications for consent, release of information, and treatment. The child's biological parents might retain

certain rights and, in some circumstances, courts require their consent for evaluation and/or treatment. The individual with physical custody of the child might not be able to provide consent because legal custody and/or authority for consent might rest with a child welfare agency, biological parent, or some other party such as the court or a state-appointed consent agent. Most jurisdictions also have specific laws and procedures for prescribing psychiatric medications to youth involved with dependency court. Psychiatric medications should not be prescribed without first obtaining consent from the designated consenting authority, although exceptions can apply in emergencies. Questions about a child's legal status and requests for consent for evaluation and treatment, informed consent, release of information, and coordination of treatment should be directed to the child welfare worker.

Principle 4. Before accepting a referral, the clinician should clarify the circumstances and goals of the referral and the limits of which services can and cannot be provided

Multiple individuals (e.g., parent, child welfare worker, judge) can refer a youth who is involved in the child welfare system for a psychiatric assessment. Clinicians should understand the reason and timing for a referral to psychiatry. Child psychiatry services in the child welfare system include:

- *Assessment.* Multiple guidelines and federal statutes call for early universal mental health screening of all youth entering the child welfare system, followed by a more comprehensive mental health evaluation for youth who screen positively.[39-41] Screenings and evaluations must include assessments of trauma exposure and trauma-related symptoms using assessment techniques with adequate reliability and validity.
- *Treatment and Teamwork.* As indicated, clinicians can provide ongoing psychiatric care to youth involved with the child welfare system. When providing clinical care, clinicians join the child and family team. Child and family teams are family members; their community supporters; and other stakeholders who come together to keep children safe and promote children's permanency and well-being. Receiving feedback from other team members, coordinating care, providing psychoeducation when appropriate, and communicating with other stakeholders can improve outcomes. The camaraderie of a team with strengths-based and solution-focused approaches is likely to buffer some challenges and enhance a clinician's capacity to work with youth involved with the child welfare system. Mental health clinicians working with youth in the child welfare system should coordinate care with caregivers, primary care providers, educators, and other stakeholders. Some youth might be involved with other pediatric providers, other mental health providers, special education services, and/or the juvenile justice system.
- *Level-of-Care Recommendations.* Clinicians are sometimes asked to provide a recommendation for the level of mental health care and/or treatment intensity to address a youth's mental health needs. This could be for a youth a clinician is working with or a specific role in system-of-care oversight for multiple youth. For all youth, but especially for those with a history of maltreatment, clinicians must carefully consider the effects of more restrictive placements and interventions, including seclusion and restraint.
- *Consultation.* Child welfare agencies and departments increasingly turn to mental health clinicians to provide consultation and/or evaluations for youth in state care and their families. In various child welfare systems, child and adolescent mental health clinicians consult with and/or oversee aspects of the child welfare system. They can provide consultation to child welfare agency personnel and treating clinicians, case-specific and/or systemic oversight of psychotropic medication use, and education for stakeholders.[25]
- *Psychiatric Medication Consent and Oversight.* Some jurisdictions place psychiatric medication consent for youth in foster care within a central or regional authority made up of expert clinicians. Review and consultation can accompany the psychotropic medication consent. Some jurisdictions monitor child welfare psychotropic medications with specific programs. Examples of programs include second opinions, tracking compliance with pertinent policies, and/or expert review of behavioral health care.
- *Forensic Assessment.* It is critical that clinicians understand the distinction between therapeutic and forensic roles when working with dependency court and the differences between a fact witness and an expert witness. Some professional organizations have ethical guidelines addressing the distinction between clinical and forensic activities. Clinicians must be aware there is no known method to determine the veracity of a child's statements, so care must be taken to not overstate one's opinion. For more information and guidance, readers are referred to the AACAP Practice Parameter for Child and Adolescent Forensic Evaluations.[42]
- *System Advocacy.* Clinicians should advocate for the development of systems that facilitate and promote effective behavioral health care and for the safety, permanency, and well-being of youth involved with the child welfare system.

Principle 5. Clinicians should communicate with the referral source and the child welfare worker to obtain the information needed to proceed with the evaluation

Before the initial appointment, the clinician should communicate with the person making the referral to ensure that relevant information arrives before or at the time of the initial appointment. The clinician should ask that the youth be accompanied to the appointment by persons familiar with the youth and the youth's recent functioning and by whom the youth feels supported. Clinicians should proceed only when there is sufficient information and access to persons with suitable familiarity with the youth. Sources of additional information that the child welfare worker can provide include dependency court documents; court evaluations; initial and subsequent pediatric, developmental, trauma,

mental health, and substance use screens required by most states; pediatric evaluations after initial placement required by most states; previous behavioral health evaluations and treatment notes; school evaluations and notes; and evaluations and documents from juvenile court. Federal legislation provides for additional sources of information. The Fostering Connections to Success and Increasing Adoptions Act of 2008 directs states to develop plans to oversee and coordinate health care services and establish a medical home with prescription medication oversight. The Child and Family Services Improvement and Innovation Act of 2011 requires states to develop plans for oversight and coordination of health care services for foster youth.

Principle 6. Clinicians should involve biological and foster family members in assessment and/or treatment

Building on family strengths as levers for change and affirming parental voice and choice will promote engagement, motivation, and positive outcomes. Most jurisdictions specify that if families can be made safe, then parents must be given back their fundamental right to raise their children, and that it is in a child's best interest to be raised by his or her family unless there are convincing reasons to terminate parental rights. The most common permanency for youth in foster care is reunification with their families.[27] Some states specifically encourage biological family involvement in mental health treatment. Thus, families should be involved in treatment unless persuasive reasons exist not to involve them.

In mental health assessment and planning, caregivers—whether biological or foster parents or caregiver staff in other out-of-home placements—can provide information regarding a youth's functioning and caregiver concerns and will be instrumental in implementing treatment plans. Biological and foster families and caregiver staff benefit from education regarding the mental health assessment of the youth's strengths and needs. It might be appropriate to involve siblings or other biological family members in assessment and/or treatment.

After immediate safety concerns are addressed, some child welfare systems use a family group decision-making process. In this approach, which might be known by other names, independent, trained facilitators engage and empower families and their supporters to collaborate with child welfare agency and non-agency personnel to make decisions and to develop plans to promote youth safety, permanency, and well-being.

Principle 7. Clinicians should be aware of special considerations in the evaluation and management of youth involved with the child welfare system

Evaluations should consider the youth's developmental stage and associated common health, developmental, and mental health issues. Evaluators should consider the history of maltreatment and trauma, the complexity of maltreatment and trauma responses, the effects of separation from family, the effects of disrupted attachments, the effects of separation from other community and school supports, the youth's developmental trajectory, current youth functioning, and risk and protective factors in the youth's ecology. The history obtained from informants should include the specific circumstances surrounding the youth's entry into care, the number of placements, the circumstances and qualities of each placement, reasons for transition from one placement to another, youth response to transitions, and current and longitudinal contact with parents, siblings, and extended family. The child welfare worker usually provides much of the information, with input from other informants, including biological and foster parents when available. Clinicians might hear multiple and sometimes disparate perspectives from various stakeholders. This requires sensitivity to all perspectives and a level of comfort with ambiguity and lack of certainty. Descriptions of current youth functioning also can vary, based on the reporter's relationship to the youth. Given the potential multiple viewpoints, motivations, and interests, collecting information from multiple collateral contacts and domains is essential. Areas for special consideration in the evaluation and management of youth involved with the child welfare system include:

- *Establishing Trust.* Trust is a critical component of the therapeutic relationship. Youth with a history of maltreatment, trauma, and disrupted attachments should not be expected to trust unfamiliar clinicians. Caution in developing new relationships is appropriate and respecting and speaking to a youth's caution can help develop the therapeutic relationship. Clinicians can promote engagement through open and authentic communication and developing youth-identified treatment goals. Techniques facilitating the building of an alliance include attending to nonverbal cues, active listening, validation, warmth, empathy, acceptance, and a nonjudgmental stance.
- *Youth Experience of Child Welfare System Involvement.* In addition to the facts of a youths' history, clinicians should attend to the youth's perceptions, reactions, emotions, and cognitions related to the experience of being involved with the child welfare system. This can include exploring the youth's beliefs and feelings regarding why the child welfare system is involved, why they are placed in out-of-home care, views of the child welfare system, desired outcomes, and how helpful or unhelpful the youth's experience has been. Evaluators should consider typical manifestations of grief, loss, and trauma in children and adolescents and the potential range of reactions to separation from attachment figures. Youth might feel ambivalent about separation from parents who have maltreated them.
- *Typical Development and Attachment and Disruption.* Knowledge of normative child and adolescent development, parent–child attachment, and specific trauma-focused training will enhance clinician recognition of the diverse and complex effects of maltreatment, trauma, separation, out-of-home placement, and other aspects of child welfare system involvement. During an initial assessment, the clinician should consider whether, and to

what extent, a youth's symptoms are related to a long-standing concern, problems with attachment, separation from caregivers, separation from familiar ecology, grief and loss, out-of-home placement, and/or maltreatment and trauma. Clinicians can provide important information to other stakeholders on the potential effects of these factors.

- *Trauma.* Clinicians should recognize that maltreatment and trauma can be complex and chronic, leading to a confusing clinical presentation that might be difficult to differentiate from other mental health conditions. Readers are referred to the AACAP Practice Parameter for the Assessment and Treatment of Children and Adolescents with Posttraumatic Stress Disorder (PTSD)[43] for more information on the effects and manifestations of trauma. This Parameter acknowledges that youth with a history of trauma can present with emotional, physical, and/or interpersonal dysregulation but not meet full criteria for a diagnosis of PTSD, but recommends considering trauma effects in the differential diagnoses of other psychiatric disorders. The PTSD Practice Parameter also discusses the potential for other psychiatric disorders and physical conditions to mimic PTSD. The trauma histories of youth involved with the child welfare system will generally include abuse and/or neglect and the traumatic stress of removing youth from their primary caregivers and familiar social ecology.
- *Adjustment to Placement.* An individual youth's adjustment to placement depends on numerous factors. The factors include pre-removal functioning, individual youth characteristics, the circumstances of removal, the stability and supportiveness of the current placement, access and connections to support from previous ecologies, and the youth's perceptions of current circumstances.
- *Collaboration.* Clinicians assessing and managing youth involved with the child welfare system must collaborate and coordinate with medical providers and stakeholders from other child-serving systems. The provision of health care and coordination of health care services is mandated by federal child welfare guidelines. Youth involved with the foster care system should have a primary care provider. In addition to mental health concerns, youth in foster care face medical challenges at significantly higher rates than other children, sometimes as a consequence of the circumstances that led to their removal from their home and sometimes exacerbated by their experiences in foster care.[44]
- *Functioning in Multiple Domains.* Information on academic, social, behavioral, and emotional functioning in school and comparing school with home functioning will inform assessment and treatment planning. Youth involved with the child welfare system are at increased risk for involvement in other child-serving systems, such as juvenile justice or special education. Clinicians must understand the youth's status in these other systems and collaborate with providers and stakeholders to coordinate care and receive feedback on youth functioning and response to services. Clinicians also should attend to youth functioning in multiple domains (such as school, peers, home, and community) because prior disruptions place the youth at greater risk for problems in these domains, and problems in one of these domains can disrupt the current placement. Emerging evidence indicates that youth problem behaviors place foster youth at risk for disrupted placement, and that multiple placements increase the likelihood of youth disruptive behavior.[45,46]
- *Movement in the Child Welfare System.* Clinicians must understand the youth's status in the child welfare system, promote youth understanding of the process, and address issues associated with movement through the child welfare system. Clinicians often will work with more than 1 placement and system of care. Permanency plans can change as the child's and family's circumstances change. Clinicians who elect to work with youth in the child welfare system must be willing to accept that placement decisions ultimately rest with dependency court judges and hearing commissioners. However, clinicians can effectively advocate for youth involved with the child welfare system by working as a member of the child and family team and presenting clear reasoning for their recommendations. Clinicians should advocate for consistency, stable and nurturing placements, clinically appropriate transitions, minimal disruptions, maintenance of supportive relationships and familiar settings, permanency, and well-being. Clinicians also must consider and address a youth's development and transition to adulthood.
- *Clinician Self-Awareness.* The circumstances surrounding youth involved with the child welfare system (such as abuse, neglect, family functioning, child-rearing beliefs, and disrupted attachments) can give rise to strong emotions and differences of opinion; clinicians should be conscious of transference and countertransference issues.

Principle 8. Clinicians should maintain high standards of record keeping with due attention to youth outcomes and confidentiality

The content of medical records and specific feedback and written reports to child welfare workers should be thoughtfully considered. Documentation should add value to the understanding of the child's situation and inform the work and decision making of other stakeholders. Mental health clinicians have a unique status and influence that has the potential to greatly affect the dependency court process. Clinical documents should be clear and unambiguous so they are not misunderstood or misinterpreted in adversarial legal proceedings.

Clinicians must pay particular attention to record keeping and be aware of the possible tensions between the need for detailed records and confidentiality issues or privacy concerns that can arise for youth involved with the child welfare system. On the one hand, continuity of a child's treatment can rely heavily on the accuracy and details of records passed from one clinician to another. On the other hand, clinician copies of medical records provided to child welfare workers and other stakeholders will be read by many different individuals. During active CPS investigations in

most states, all records might be subject to disclosure. Clinicians must be mindful that their records can become part of court proceedings, including the prosecution of an alleged maltreating parent, without the knowledge or consent of the patient or the clinician. Clinicians should clearly attribute sources of information and indicate when information is obtained second or third hand so that hearsay does not appear to be fact.

Suspicions of maltreatment can arise in the course of evaluation or treatment. Professionals who work with youth in foster care must remember that although a child can have an open child welfare care case and/or reside in out-of-home care, any new suspicion of abuse or neglect must be reported.

Principle 9. Clinicians should be familiar with common problems presenting in youth involved with the child welfare system

Studies using different methods of population ascertainment and assessment have consistently found that, compared with the general population, youth involved with the child welfare system have significantly higher rates of developmental, physical, emotional, behavioral, and substance use disorders. In preschool-age children in the child welfare system, 30% to 65% have developmental and/or behavioral health concerns.[47-50] Fifty percent to 80% of youth in foster care have behavioral health concerns with high rates of comorbidity, including elevated rates of depression, anxiety, posttraumatic stress, disruptive behavior, attention-deficit/hyperactivity disorder, learning problems, substance use disorders, and suicide attempts.[6,51-56] Children who remain with their family of origin or are placed with kin also have high rates of developmental and behavioral health concerns.[6,48,57-59] In adulthood, elevated physical, mental health, and substance use risks persist, in addition to increased rates of low academic achievement, unemployment, low income, disability, poverty, lack of health insurance, homelessness, and engagement in illegal behavior.[56,60-65]

Despite guidelines for screening and evaluating youth entering the child welfare system for behavioral health needs, well-documented high rates of behavioral health needs and multiple reports of disproportionately high rates of mental health use, and expenditures by youth involved with the child welfare system, significant unmet or underserved behavioral health needs exist. The National Surveys of Child and Adolescent Well-Being (NSCAW), 2 national longitudinal studies of youth and families referred to the child welfare system, provide valuable information regarding behavioral health needs and underuse of services. In the second NSCAW, it was found that in a subgroup of 12- to 36-month-olds with mental health needs, only 2.2% received any type of mental health service. The percentage increased to 19.2% when parent skills training was included.[66] In the first NSCAW, in children younger than 6 years with developmental and behavioral needs, fewer than 25% were receiving services. Remaining in the biological home and being younger than 3 years were factors associated with underuse of services.[48] For youth 2 to 14 years of age, only approximately 25% of youth with strong evidence of clinical need received any care in the previous 12 months. Severity of need and living outside the biological home increased the likelihood of receiving specialty mental health care for all ages. Of school-age children, African Americans were less likely to receive services, whereas adolescents who had a parent with a severe mental illness were more likely to receive mental health care.[6] An evaluation of a subset of youth 2 to 15 years of age who had been in out-of-home care for approximately 12 months showed that approximately 25% of youth with high rates of mental health needs had not received mental health services. Severity of need, older age, and history of sexual abuse were associated with accessing mental health services, whereas history of neglect and African-American ethnicity were associated with decreased use of services.[58] Thus, additional advocacy is needed to ensure that youth who are known to be at risk of being underserved—including African-American youth, young children, youth remaining at home or placed in kinship care, and victims of neglect—receive the help they need.

Given that 50% to 80% of all youth in the child welfare system have behavioral health treatment needs and only 19% to 50% of youth in need of mental health services receive services,[6,66,67] clinicians should advocate for appropriate mental health screening and evaluation in their local child welfare system and in primary care settings. Multiple guidelines[39-41,68] and the Fostering Connections to Success and Increasing Adoptions Act (PL 110-351) call for youth in foster placement to receive initial and follow-up mental health screenings. Screenings should include assessment of exposure to trauma and related symptoms. The use of validated, developmentally appropriate, and feasible instruments for screening and assessment is recommended.[69] Guidelines generally call for initial screening within 24 to 72 hours of entering foster care by trained personnel. Initial screening should focus on identifying youth at high risk for safety concerns, running away from placement, and in need of mental health or substance abuse services. Initial and subsequent screenings also should determine whether further assessment or immediate intervention is needed. One recent guideline calls for a second and more complete screen within 30 days to evaluate mental health and substance use service needs and assess functioning in multiple relevant domains, such as school and community.[41] Within 60 days, or sooner as indicated, youth who screen positively should receive an individualized, comprehensive mental health evaluation. The mental health evaluation will help inform treatment and permanency planning. Ongoing screening should include informal screening during each child welfare worker visit. More formalized screening using standardized instruments should occur at least annually and whenever there is a change in functioning or environment. Youth should be screened before exiting the child welfare system. Given their increased risk to have unmet behavioral health needs, youth remaining at home or placed with kin should receive similar screenings and evaluations. Collaborating with primary care and other health care providers and advocating for universal behavioral health care screenings in

primary care settings also will help identify behavioral health needs.

Principle 10. Clinicians should be knowledgeable about evidence-based psychosocial interventions for youth involved with the child welfare system

Clinicians should follow professional practice guidelines for the assessment and treatment of identified psychiatric disorders in children and adolescents involved with the child welfare system.

There have been several recent reviews of the effectiveness of various psychosocial interventions for youth involved with the child welfare system and youth who have been maltreated.[55,70-76] The review formats vary, and different rating criteria lead to differences in the ratings of individual treatments, but all the reviews are informative. Some of these reviews include discussion of the definition of evidence-based practice, dissemination of evidence-based and expert consensus best practices, and various barriers to dissemination. Some "best" and "most promising" practices are described below but represent only a portion of empirically supported treatments for youth involved with the child welfare system. At the same time, the range and effectiveness of treatments must be enhanced.

Parent–Child Interaction Therapy (PCIT) is an evidence-based treatment for disruptive behavior disorders that focuses on improving the quality of the parent–child relationship and changing parent–child interaction patterns. The 2 main components of the skills training are organized around child-directed interactions and parent-directed interactions. Live coaching is provided. PCIT was originally developed for children 2 to 7 years old with disruptive behavior. It has been adapted for physically abusive parents and their children up to 12 years of age and supplemented with an additional motivational enhancement module. In 1 trial, at a median follow-up of 850 days, families receiving the child welfare-adapted PCIT had a re-report rate of 19% for physical abuse compared with 49% for the standard community control group.[77] In a subsequent study, trained community providers were used, and the study design dismantled the motivational enhancement versus services as usual orientation module and PCIT versus usual parent training. A significant decrease in future child welfare reports was found for caregivers receiving combined motivation enhancement orientation and PCIT, which was synergistic.[78]

Alternatives for Families: Cognitive-behavioral therapy (formerly abuse-focused cognitive-behavioral therapy) is an evidence-based treatment for improving relationships between children and caregivers in families involved in physical coercion or force and chronic conflict or hostility. The treatment emphasizes intra- and interpersonal skills training to decrease individual youth, parent, and family risk factors for, and the consequences of, physical abuse or coercive behavior. This therapy is comprised of 2 components: individual child and parent cognitive-behavioral therapy (CBT) and family therapy. After comparing the separate components with treatment as usual, at 1-year follow-up, individual CBT and family therapy were associated with improved child-to-parent violence and child externalizing behavior, parent distress and abuse risk, and family conflict and cohesion. Abuse recidivism rates were 5% for individual CBT, 6% for family therapy, and 30% for treatment as usual.[79]

Trauma-focused cognitive-behavioral therapy is an evidence-based treatment originally developed for posttraumatic stress symptoms resulting from childhood sexual abuse, which has been applied to posttraumatic stress symptoms related to other traumas. Individual youth and parallel non-offending parent sessions are provided initially and progress to conjoint sessions. The treatment uses psychoeducation, parent management skills, relaxation, affective modulation skills, cognitive coping, trauma narrative, exposure, and enhancing personal safety. Youth treated with trauma-focused CBT compared with youth receiving alternative treatments showed greater decreases in posttraumatic stress, depressive, anxiety, and behavioral symptoms, and caregivers reported less abuse-specific parental distress.[80-82]

Multidimensional treatment foster care (MTFC) is an evidence-based, intensive, community-based treatment originally developed for youth involved with the juvenile justice system, which has been adapted for multiple populations, including youth involved with the child welfare system in need of out-of-home placement. MTFC provides behavioral parent training and intensive support for MTFC foster parents, family therapy for the biological family, skills training and supportive therapy for youth, and school-based behavioral interventions and academic support. An adaptation of MTFC for child welfare—Keeping Foster Parents Trained and Supported—was evaluated in a randomized controlled trial and found to decrease child behavior problems, increase reunification with biological families, and decrease foster home disruptions.[83,84] MTFC has been adapted for preschoolers involved with the child welfare system (MTFC-P) and also is called Early Intervention Foster Care. Early Intervention Foster Care has been shown to increase the likelihood of permanent placements (90% compared with 64% for regular foster care control)[84] and alter cortisol activity to more closely resemble that of non-maltreated community comparison youth.[85]

Multisystemic therapy is an empirically supported, intensive, community-based treatment originally developed for youth involved with the juvenile justice system, which has been adapted for multiple populations, including physically abused youth and their families. In 1 trial with 16-month follow-up, multisystemic therapy for child abuse and neglect was more effective than enhanced outpatient services in decreasing youth mental health symptoms, parent psychiatric distress, parenting behaviors associated with maltreatment, youth out-of-home placements, and changes in youth placement. Youth receiving multisystemic therapy for child abuse and neglect were less likely to be re-abused, but base rates were low and the difference did not reach statistical significance.[86]

In addition to being knowledgeable about effective treatments, clinicians should be aware of interventions with risk of harm. The AACAP Policy Statement on

Coercive Interventions for Reactive Attachment Disorder highlights the danger, lack of evidence of effectiveness, violation of fundamental human rights, and growing number of deaths associated with so-called "rebirthing techniques" or "holding therapy" and calls for the cessation of these interventions.[87]

Principle 11. Clinicians should be familiar with regulations and procedures for prescribing psychiatric medications to youth involved with the child welfare system and should follow evidence-based and best prescribing practices

The authority to consent to psychiatric medications varies by jurisdiction and the youth's status in the child welfare process. The authority to consent can reside with a youth, biological parents, child welfare agency, court, or other party, and there might be further oversight by another state-supported agency with expertise in mental health treatment and psychopharmacology. Clinicians need to be aware of the local laws and standards before prescribing medication. In addition to obtaining proper legal consent, clinicians should obtain youth assent if youth do not have authority to consent for themselves. In developmentally appropriate language, the clinician should discuss the clinician's findings, the role of medication in the treatment of the youth's symptoms, potential positive and negative effects of the medication including how medication could help, and alternative treatment options. The clinician also should address any questions and concerns the youth might have. Many youth believe they have little control or influence over child welfare decisions.[88-90] Involving a youth in the decision to try medication affirms the youth's role in his or her treatment and can enhance engagement in the trial and treatment in general. Youth-oriented toolkits can assist older youth in mental health and psychiatric medication decision making.[91] The youth's caregivers should be involved in a similar manner, when appropriate.

Requests for psychiatric medication prescriptions might present as urgent or an emergency, but before prescribing, clinicians need sufficient information to support psychiatric evaluation and treatment planning. Clinicians also should determine whether there are appropriate levels of structure, supervision, and stability in a youth's current living situation to manage psychiatric medications. Psychotropic medication is just one element of a comprehensive plan and must be coordinated and integrated with psychosocial interventions. Evidence-based treatments for youth often require the participation of caregivers, especially when addressing youth disruptive behavior. If youth placement is transitory, including when permanency has not been achieved, foster parents or kinship caregivers might be less likely to participate in parent skills training. Clinicians can play an important role in advancing the importance of psychosocial interventions as first-line treatments or in coordination with the initiation of psychotropic medications. Failure to provide effective psychosocial treatments can lead to an inappropriate emphasis on prescribing psychotropic medications. Clinicians are referred to the AACAP Practice Parameter on the Use of Psychiatric Medications for Children and Adolescents[92] for general prescribing principles and should be aware of "red flag" monitoring in their state. Psychotropic prescribing should be based on the best available evidence of safety and efficacy and should be coordinated with a youth's primary care providers.

PARAMETER LIMITATIONS

AACAP Practice Parameters are developed to assist clinicians in psychiatric decision making. These Parameters are not intended to define the sole standard of care. As such, the Parameters should not be deemed inclusive of all proper methods of care or exclusive of other methods of care directed at obtaining the desired results. The ultimate judgment regarding the care of a particular patient must be made by the clinician in light of all the circumstances presented by the patient and his or her family, the diagnostic and treatment options available, and available resources. &

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The AACAP Practice Parameters are developed by the AACAP CQI in accordance with American Medical Association policy. Parameter development is an iterative process among the primary author(s), the CQI, topic experts, and representatives from multiple constituent groups, including the AACAP membership, relevant AACAP committees, the AACAP Assembly of Regional Organizations, and the AACAP Council. Details of the Parameter development process can be accessed on the AACAP Web site. Responsibility for Parameter content and review rests with the author(s), the CQI, the CQI Consensus Group, and the AACAP Council.

AACAP develops patient-oriented and clinician-oriented Practice Parameters. Patient-oriented Parameters provide recommendations to guide clinicians toward best assessment and treatment practices. Recommendations are based on the critical appraisal of empirical evidence (when available) and clinical consensus (when not) and are graded according to the strength of the empirical and clinical support. Clinician-oriented Parameters provide clinicians with the information (stated as principles) needed to develop practice-based skills. Although empirical evidence might be available to support certain principles, principles are based primarily on clinical consensus. This Parameter is a clinician-oriented Parameter.

The primary intended audience for the AACAP Practice Parameters is child and adolescent psychiatrists; however, the information contained therein also might be useful for other medical and mental health clinicians.

The authors acknowledge the following experts for their contributions to this Parameter: Emilie Becker, MD, Marilyn Benoit, MD, Joan Daughton, MD, Michael Naylor, MD, Lesley Siegel, MD, Enrico Suardi, MD, Laurel K. Leslie, MD, Peter Pecora, PhD, the Child Welfare League of America, and Angela Lee, MSW, MLS. An earlier draft of the Parameter was reviewed by the following experts: Christine Davidson, PhD, Ronald Davidson, PhD, April Fields, MD, J. Matthew Orr, PhD, Guy Palmes, MD, Alvin Rosenfeld, MD, Alan Rushton, PhD, Moira Szilagyi, MD, and Jill Welte, LCSW.

Jennifer Medicus served as the AACAP staff liaison for the CQI.

This Practice Parameter was reviewed at the Member Forum at the AACAP Annual Meeting in October 2012. An earlier draft of the Parameter was reviewed at the Member Forum at the AACAP Annual Meeting in October 2009.

From April 2014 to September 2014, this Parameter was reviewed by a consensus group convened by the CQI. Consensus group members and their constituent groups were Heather J. Walter, MD, MPH, co-chair; Oscar G.

Bukstein, MD, MPH, Saundra Stock, MD, and Carol Rockhill, MD (CQI); Laurel K. Leslie, MD, and Michael Naylor, MD (topic experts); Judith A. Cohen, MD, and Jeanette M. Scheid, MD, PhD (AACAP Child Maltreatment and Violence Committee); Elise Leonard, MD (AACAP Assembly of Regional Organizations); and Aradhana "Bela" Sood, MD, and Warren Y.K. Ng, MD (AACAP Council).

This Practice Parameter was approved by the AACAP Council on January 21, 2015.

This Practice Parameter is available on the Internet (http://www.aacap.org).

Disclosures: Terry Lee, MD, George Fouras, MD, and Rachel Brown, MBBS, MPhil, have no financial relationships to disclose. Oscar Bukstein, MD, MPH, co-chair, has intellectual property with Routledge Press. Heather Walter, MD, MPH, co-chair, has no financial relationships to disclose.

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0890-8567/$36.00/©2015 American Academy of Child and Adolescent Psychiatry

http://dx.doi.org/10.1016/j.jaac.2015.03.005

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