

MENTAL HEALTH PRACTICE GUIDELINES FOR CHILD WELFARE



450 7th Avenue, Suite 1107
New York, NY 10123
Phone 212.947.7322
Fax 212.947.7400
www.thereachinstitute.org



1300 Dexter Avenue North, Floor 3
Seattle, WA 98109-3542
Phone 206.282.7300
Fax 866.282.3555
www.casey.org



The Annie E. Casey
Foundation

701 St. Paul Street
Baltimore, MD 21202
Phone 410.547.6600
Fax 410.547.6624
www.aecf.org

The enclosed guidelines are published in the following CWLA Journal:

Jensen, P. J., Hunter Romanelli, L., Pecora, P. J., & Ortiz, A. (2009).
Special Issue: Mental Health Practice Guidelines for Reform. *Child Welfare*, 88(1).

Table of Contents

Endorsing Organizations.....	3
CW-MH Best Practice Group.....	4
Guideline Development Process.....	5
Mental Health Interventions:	
Screening and Assessment Tools (4GL).....	6
Psychosocial Interventions (4GL).....	10
Psychopharmacological Interventions (9GL).....	12
Family Support:	
Parent Engagement (8GL).....	16
Youth Empowerment (7GL).....	20
References.....	24

Endorsing Organizations

The organizations listed below endorse the presented guidelines:

American College of Clinical Pharmacy (ACCP)

American Psychiatric Association (APA)

Annie E. Casey Foundation

Bazelon Center for Mental Health Law

Carter Center Mental Health Program

Casey Family Programs

California Institute of Mental Health (CIMH)

College of Psychiatric and Neurologic Pharmacists (CPNP)

Child Welfare League of America (CWLA)

Foster Family-based Treatment Association (FFTA)

National Foster Care Coalition (NFCC)

CW-MH (Child Welfare – Mental Health) Best Practice Group

Organizers:

Peter S. Jensen, M.D.
President and CEO
The REACH Institute (REsource for Advancing
Children's Health)

Peter J. Pecora, Ph.D.
Professor and Senior Director of Research
Casey Family Programs

Abel Ortiz
Senior Associate for Child Welfare and Mental
Health
Annie E. Casey Foundation

Lisa Hunter Romanelli, Ph.D.
Director of Programs
The REACH Institute (REsource for Advancing
Children's Health)

Lead Writer(s):

Jessica Mass Levitt, Ph.D.
Director of Evidence Based Screening and
Assessment Programs
Columbia University

Christopher Bellonci, M.D.
Medical Director and Senior Clinical Consultant
Walker School

Sandra J. Kaplan, M.D.
Director
North Shore University Hospital, Department of
Psychiatry

Susan P. Kemp, Ph.D.
Associate Director
University of Washington,

Kimberly E. Hoagwood, Ph.D.
Director, Division of Services Research
Columbia University, Department of Psychiatry

John Landsverk, Ph.D.
Child & Adolescent Services Research Center
Children's Hospital of San Diego

Members:

Kamala Allen
Program Dir., Children in Managed Care
Center of Health Care Strategies

Patsy Buida
Foster Care Specialist
Children's Bureau

Barbara Burns, Ph.D.
Director of Services Effectiveness Research Program
Professor of Medical Psychology
Duke University School of Medicine

Julie Collins
Director of Mental Health
Child Welfare League of America

M. Lynn Crismon, Ph.D., FCCP, BCPP
Dean ad interim
University of Texas College of Pharmacy

Leonard T. Gries, Ph.D.
Director of Mental Health Services
SCO Family of Services

Addie Hankins
Foster Parent/Kinship Advocate
Rose House Kinship Center

Robert L. Hartman MSW
Executive Vice President/COO
DePelchin Children's Center

Susan Ko, Ph.D.
Director of Service Systems Program
National Center for Child Traumatic Stress

Ron Prinz, Ph.D.
Carolina Distinguished Professor
University of South Carolina, Department of
Psychology

Miriam Saintil
Foster Care Alumni/Youth Advocate
SCO Family of Services

Corvette Smith
Foster Parent Advocate
Harlem Dowling- West Side Center

Wilfredo Soto
Foster Care Alumni/Youth Advocate
The Partnership for Kids

Casey Trupin, J.D.
Attorney
Columbia Legal Services

Eric Trupin, Ph.D.
Professor and Vice Chair,
Director, Div. of Behavioral Health and Justice Policy
University of Washington School of Medicine, Dept.
of Psychiatry and Behavioral Sciences

Best Practices for Mental Health in Child Welfare

Guideline Development Process

The enclosed guidelines and supporting rationale were developed from the October 2007 *Best Practices for Mental Health in Child Welfare Consensus Conference* sponsored by Casey Family Programs, the Annie E. Casey Foundation and the REACH Institute (REsource for Advancing Children's Health). The purpose of the conference was to develop best practice guidelines for addressing mental health in child welfare by focusing on five key areas – mental health screening and assessment, psychosocial interventions, psychopharmacological interventions, parent support and empowerment, and youth support and empowerment.

The Child Welfare-Mental Health (CW-MH) Best Practice Group, composed of leading child welfare and mental health researchers, policy makers and advocates, identified fellow experts in the fields of child welfare and mental health policy, practice and research as well as parent and youth advocates to invite to the conference. Approximately 100 individuals were invited and a total of 80 attended the conference.

In preparation for the conference, the steering committee commissioned child welfare or mental health researchers to write critical papers on the five key topic areas (mentioned previously) relevant to improving mental health for youth in child welfare. These papers included a systematic review of the literature and were presented at the conference to educate participants about the latest findings in the key topic areas.

During the two-day conference, the authors of each of the critical papers presented the key findings of their work. Following these presentations, conference participants were each assigned to one of five workgroups corresponding to the key topic areas mentioned previously. Each workgroup formulated preliminary guidelines in each of the five key areas, based on their synthesis of the evidence, expert consensus data, and clinical sensibility and feasibility.

Following the workgroup discussions, workgroup representatives presented their preliminary guidelines to conference participants for feedback. Workgroups were given the opportunity to revise and refine their guidelines based on this feedback. By the end of the two-day conference, each workgroup had a preliminary set of guidelines that had been reviewed by all conference participants. After the conference, several participants volunteered to further refine and develop rationale to support each of the guidelines with guidance from the CW-MH Best Practice Group and ultimate input from all consensus conference attendees.

Mental Health Interventions

SCREENING AND ASSESSMENT

Guideline 1. Stage 1 Screening for Emergent Risk

Within 72 hours of entry into foster care, medical personnel and/or caseworkers with specialized training screen children and adolescents to identify those who pose an immediate, acute risk of harm to themselves or others, of running away from placement, or of mental health or substance abuse service needs. In addition, the child's ability to function in relevant settings (e.g., school, home, peer groups, community) is evaluated and taken into consideration when deciding if further assessment or immediate intervention is warranted.

Rationale. Children entering the foster care system are likely to have elevated levels of distress which may be related to maltreatment, the child welfare investigation itself, and/or separation from their family. Therefore, it is important that an initial screening is conducted to gauge this level of acute distress, assess whether children pose a danger to themselves or others, and determine if immediate intervention is required. The screening procedure should include methods to check for acute problems such as suicidality, homicidality, runaway potential, psychotic symptoms, substance abuse and trauma, as well as other concerning behaviors that may occur as a result of exposure to maltreatment or being separated from family. The screening procedure should also identify the child's strengths and successful coping strategies and time should be devoted to supporting the child in utilizing these assets. If an acute risk is identified, the child should be immediately seen by a qualified mental health provider for further assessment and intervention services. The mental health provider should also coordinate with child welfare workers regarding decisions about the kind of placement that will best meet the child's needs and support the child during this difficult transition.

Although evidence based screening procedures and instruments have not yet been developed for the above stated purposes, potentially effective and feasible methods for providing screening as described above exists. Caseworkers should receive training in these methods.

Guideline 2. Stage 2 Screening for Ongoing Mental Health Service Needs

Within 30 days of entry into foster care, children and adolescents receive a second screening to more fully evaluate mental health and substance abuse service needs as well as the child's ability to function in relevant settings (e.g., school, home, peer groups, community). A feasible, evidence based screening instrument is used for the evaluation.

Rationale. The initial screening is meant to evaluate acute risk following entry into the foster care system. A second screening is important for evaluating overall functioning and identifying children who may have longer-term service needs. This screening should be brief, low in cost, simple, safe, and acceptable. It is important to note that positive screening results

are not intended to constitute a determination that a problem is actually present. It only indicates a need for a comprehensive assessment that will more fully assess specific problems and symptoms, establish a diagnosis, and link children with appropriate mental health or substance abuse services (see Guideline 3). Use of evidence-based mental health screening tools can improve the accuracy of screening evaluations and assist in making sure that children who do not have any risk of mental health or substance abuse problems are spared further assessment and those at risk are identified. Screening should be overseen by a mental health professional who may be assisted by caseworkers or other personnel who are trained in the administration and interpretation of screening instruments as well as in procedures for making appropriate referrals that link children with services. Current caregivers, and where feasible, caregivers of origin, should participate as informants about the child's past and present emotional and behavioral status. A mental health specialist should be responsible for integrating screening data and formulating recommendations about services, placement and programs needed.

Guideline 3. Comprehensive Assessment for Children with Positive Screening Results

Children in out-of-home care with a positive mental health screen are referred for an individualized, comprehensive mental health assessment using feasible, evidence based instruments. The comprehensive assessment is provided within 60 days of the positive screening, or sooner based on the severity of the child's needs as identified in the screening process.

Rationale. The comprehensive mental health assessment should provide a more in depth evaluation of mental health and substance abuse concerns as well as a broad assessment of psychosocial risk factors related to a child's environment. It should include a trauma assessment component as well as assessment of adaptive functioning. In addition, family or parent risk factors should be assessed, including: parent drug or alcohol abuse, parent severe mental illness, parent intellectual/cognitive impairment, parent physical impairment, impaired parenting skills (e.g. inappropriate or excessive discipline), monetary problems, and domestic violence. Finally, community risk factors should also be assessed, including: poverty, neighborhood safety and exposure to community violence, availability of appropriate adult role models, opportunities for appropriate extracurricular involvement, academic supports, positive peer influences, etc. All of these risk factors should be considered alongside the child, parent, family and community strengths and resources that are present.

Comprehensive mental health assessments should only be conducted by qualified mental health providers. In some cases, it may be possible to include the mental health provider as part of a larger multidisciplinary team that provides a comprehensive health assessment including medical, dental, and developmental evaluations. This approach provides coordinated care which can be more efficient, cost-effective, and successful (American Academy of Pediatrics, 2002).

Comprehensive assessments should include the opportunity for children to meet individually with the person conducting the evaluation and allow enough time for children to talk about their experiences and freely express any concerns and, when appropriate, any wishes about placement and visitation. Mental health professionals should obtain permission

and communicate these concerns and wishes to the child welfare worker involved so that they can be considered in any decision making processes. Because the child welfare system aims to keep families together and to reunify children with their families of origin as much as possible, families should be included in mental health evaluations and treatment, unless otherwise mandated by the courts.

The use of evidence based screening or assessment instruments is a key component of the evaluation as it helps to ensure accuracy in the identification of children in need of services. Instruments that have been shown to be valid and reliable in the child welfare system and as well as in other service settings are included in the tool kit.

Guideline 4. Ongoing Screening and Assessment for Mental Health Service Needs

Children in foster care are screened informally at each caseworker visit for indications that a mental health assessment might be needed. In addition, children are screened with a brief, valid, and reliable instrument at least once per year as well as when significant behavioral changes are observed, when significant environmental changes occur (e.g. change in placement or caretaking, participation in court proceedings, or other major events or disruptions for the child), and prior to leaving the system.

Rationale. Given the level of vulnerability of children in the child welfare system and the potential to be re-victimized/traumatized, children in the child welfare system should be periodically re-evaluated to ensure ongoing safety and well-being. Child welfare caseworkers should conduct informal screening during each visit with the child to determine if further assessment for service need is required. Child welfare workers should be trained in effective and feasible screening methods such as behavioral warning signs to prepare them to make observations and ask questions of the child, family, and any other key case participants that would provide the information needed to ascertain if further assessment is warranted.

Children who are receiving mental health services should be reassessed at regular intervals as part of their ongoing treatment. Children who are not receiving services, even if they do not appear to be in need, should also be reassessed regularly—no less than every 12 months – as part of their regular health care appointments if possible (see recommended developmental schedule: American Academy of Pediatrics, 2002) or as requested by the child or family (AACAP & CWLA, 2002). These screenings should utilize an evidence based screening instrument to increase the accuracy of the procedure.

In addition, children’s mental health is affected by changes in their environment. Therefore, children should be screened when significant environmental changes occur. For instance, changes in placement or caretaking, participation in court proceedings, or other major events or disruptions for the child may trigger mental health service needs. Importantly, changes in caretaker functioning or family of origin may also prompt mental health service need. Caseworkers should be aware of these environmental changes and conduct screenings as appropriate.

Finally, mental health should be reassessed when children are about to leave the system. Reasons for leaving the system include the termination of protective services, family reunification, or the transition to self-sufficiency. Children moving into self-sufficiency may still require assistance in dealing with issues related to their family and their individual

mental health needs. The system should assist those who need, or desire, further mental health services to obtain adequate referral and follow-up plans and assure continuity of care. Importantly, all parties involved in the child's care should be notified of any follow-up appointment and health records should be made available to the next provider or caregiver.

PSYCHOSOCIAL INTERVENTIONS

Guideline 1. Access to Evidence-Based Interventions

Child welfare agencies ensure that evidence-based interventions (EBIs) are available to clients when clinically indicated. In the absence of EBIs, agencies ensure the availability of promising interventions, and the adherence by mental health providers to an evidence based practice approach.

Rationale. This guideline underscores the importance of a solid commitment by delivery agencies to an evidence-based approach as the best way to improve the mental health care of clients from the child welfare system, but acknowledges that there are robust challenges to both identifying and fitting evidence-based psychosocial interventions in mental health and child welfare settings. The guideline is congruent with the well noted fact that it still takes years to spread scientifically proven practice into usual care settings, with some evidence that an average of 17 years is needed before research based medical treatments appear with regularity in clinical practice (Institute of Medicine, 2001). This guideline is consistent with the Institute of Medicine (IOM) definition of evidence-based practice as a combination of three factors: (1) best research evidence, (2) best clinical evidence, and (3) consistent with patient values. This definition builds on the foundation of scientific research while acknowledging the clinical experience of practitioners and the importance of family values in treatment decisions.

Guideline 2. Individualized and Strengths-Based Interventions

Psychosocial interventions provided to children and families are individualized and strengths-based. These interventions reflect the goals of the permanency plan, actively involve the current caregivers, and, when feasible, include the caregivers of origin at a clinically appropriate level.

Rationale. The principles of the “System of Care” are reflected in this guideline with the emphasis on individualized treatment planning that takes into account the strengths of the client and involves the caregivers in the development and choices of that treatment planning (Stroul & Friedman, 1986). The guideline is rooted in the special characteristics of the child welfare service system and uses the unique language of that system when it refers to the permanency plan. Also embedded in this guideline is the unique characteristic of the foster care where a child can have both a temporary caregiver while in the custody of the court and the permanent caregiver to whom the child will most likely be reunified after risks to child safety in the biological home have been resolved.

It should also be noted that Bickman’s well-designed Fort Bragg and Stark County, Ohio studies found no evidence for positive mental health clinical outcomes following the implementation of system of care models (Bickman, 1996a; 1996b; Bickman, et al., 1995; Bickman, Summerfelt, Firth, & Douglas, 1997). Those results underscore that positive clinical outcomes cannot be assumed when system of care principles drive the delivery of mental health care. Rather, these principles are values that are important to quality care but

need to be accompanied by clinical practice that is based on research evidence. Thus, guidelines 1 and 2 are should always be integrated in providing psychosocial interventions for children involved in the child welfare system.

Guideline 3. Collaboration with Mental Health Partners

Child welfare agencies collaborate with mental health partners to ensure that children and families receive high quality, individualized services delivered by practitioners adequately trained in EBIs.

Rationale. As noted in the introduction, while the child welfare system has two critical functions of protecting children (safety) and preserving families (permanence), the third mission element of child well-being has gathered increasing focus (Wulczyn, Barth, Yuan, Jones Harden, & Landsverk, 2005). Addressing the well-being of children requires services most often delivered by agencies outside of child welfare such as physical and mental health, developmental services, and education. Therefore referral of children and adolescents involved with child welfare to these other service delivery systems and use of their services is critical for addressing child well-being.

A study by Hurlburt and colleagues (2004) supports this guideline. The study found that increased coordination between the mental health and child welfare systems was associated with greater use by children at the highest level of need and with decreased racial/ethnic disparities in receipt of mental health care. These findings support the system of care values of collaboration between the two service systems and are promising in suggesting that explicit links might be programmatically targeted and result in both more efficient as well as more equitable mental health care.

Guideline 4. Outcome Tracking

Child welfare agencies collaborate with mental health partners to track outcomes (using multiple informants) of psychosocial interventions received by children and families. These outcomes include psychosocial functioning, placement stability, permanency and client satisfaction.

Rationale. There is a well known literature that has demonstrated the large gap between what is known from research studies about the effectiveness of psychosocial interventions and what is found in usual mental health practice where children involved with child welfare receive their care. This guideline underscores the need to monitor for beneficial changes in important outcomes even when evidence-based practices have been put in place. The guideline also emphasizes the need to assess a diverse set of outcomes. These include the two outcomes of psychosocial functioning and client satisfaction that are usual for mental health as well as two outcomes that are crucial for the child welfare mission, namely placement stability and permanency.

PSYCHOPHARMACOLOGICAL INTERVENTIONS

Guideline 1. Informed Consent

Informed consent is established when a clinician prescribes psychotropic medications. In establishing informed consent, information is given to the child, family (bio-parent, foster parent, or caregiver), and the caseworker/state-assigned decision maker about the treatment options (both medication and non-medication options), the risks/side effects and benefits of the medication, the targeted symptoms, and the course of treatment. Consent is obtained from a minor child's birth parent whose rights have not been terminated, unless there is a sufficient clinical basis for a legal override of parental objection. Clients 18 years of age and over must consent to treatment.

Rationale. Although there may be multiple means of addressing a psychiatric condition, the values of the child and family must be held primary in treatment decisions, unless it can be shown that those decisions would harm the child. This is the essence of informed consent. This guideline emphasizes the importance of informed consent in the psychopharmacologic treatment of children in the child welfare system and is consistent with the Institute of Medicine's definition of evidence-based practice that incorporates the clinical experience of the prescriber as well as the values and beliefs of the child and family.

The role of the prescriber is to provide the information necessary for the decision-maker to come to a decision about the care of their child. These decisions are usually guided by adult caretakers depending on the age and developmental abilities of the child and existing laws or statutes. If the child is in state custody, it is the responsibility of the state to make these decisions, but the child and parent should remain involved in the assessment and treatment of the mental health condition. This lays the ground work for familial support of continuing successful mental health treatment. Consistent with prior recommendations (AACAPP, 2008; AAP, 1995), efforts must be made to include the child as soon as possible through the assent process. This is particularly important for youth aging out of state custody who are required to act as the arbiter for their own care between the ages of 18 and 21, depending on state services.

Guideline 2. Access to and Documentation of Psychotropic Medication

Child welfare agencies ensure consistent access to prescribed psychotropic medications, and document the child's response to the medications, side effects, risks and benefits of the medications, and the timeframes for the expected response. This documentation follows the child throughout his or her stay in care.

Rationale. Continuity of care is a critical concern for children in the child welfare system. Due to lack of permanency in their lives, these children often receive care that lacks coordination and adequate integration. A single repository for medical information that can travel with the child between placements or is held in a single location (medical home model) despite where the child may be residing has been shown to improve outcomes for children in

the child welfare system (Leslie, Kelleher, Burns, Landsverk, & Rolls, 2003). The establishment of an ongoing source of health care has been identified as a federal priority, along with ensuring that “all children with special health care needs will receive regular ongoing comprehensive care within a medical home” (US Department of Health and Human Services and Health Resources and Services Administration, 1999).

Guideline 3. Ongoing Communication with Child and Caregivers

Prescribers have ongoing communication with the child and caregivers to monitor treatment response, side effects and potential adverse reactions, such as change in weight or metabolic parameters, cardiovascular symptoms, suicidality, or other outcomes as appropriate to the medications prescribed. In addition, the prescriber discusses with the child and family medication adherence and any medication changes in the context of a collaborative relationship.

Rationale. Psychotropic medications can be associated with significant side-effects that cannot be predicted in advance. In order to ensure that a child does not come to harm from a medication trial, frequent follow-up visits are necessary. Side-effects are most common in the initiation of a medication trial and close observation of the child/youth is particularly important during the first few months of medication treatment. Once it becomes clear the child is having a positive response to a medication trial without concerning side-effects and the child, parent and child welfare case worker feel the benefits of the medication outweigh the side effects observed or potential risks, the child can be considered to be in a maintenance phase of treatment which may require less frequent contact.

Guideline 4. Reliable and Valid Rating Scales

Reliable and valid clinical rating scales are used to quantify the response of the child’s target symptoms to medication. During the initial three months on a particular medication(s), visits should take place at least monthly or more frequently if the child’s condition is unstable. For children whose response to medication has stabilized, follow-up after the initial three months takes place on a quarterly basis, or more frequently if clinically required. If the youth’s condition becomes unstable, the prescriber is contacted immediately.

Rationale. Objective data helps in making informed choices. Whenever possible, rating scales or objective data-gathering methods help to inform diagnoses, treatment recommendations and whether treatments are working. It also allows data to be collected from multiple informants (e.g. teachers, caretakers, therapists). The more accurate the data, the better the outcome.

Guideline 5. Child Mental Health Training for Caseworkers

Agencies ensure that caseworkers receive training in common child mental health disorders, effective treatment options, child and adolescent development, and neuro-developmental effects of prenatal substance exposure.

Rationale. Children in foster care have significant, and often co-occurring, developmental, behavioral, and mental health problems (Leslie et al., 2005). For caseworkers to act in the role of ‘loco parentis’ for children in state custody, they must have a basic knowledge of normal development, the impact of parental substance use on development, and common mental health disorders. In addition, caseworkers need to be aware of evidence-based treatments for mental health disorders that incorporate an understanding of the unique histories and vulnerabilities of children in state custody. Caseworkers represent the front-line of intervention and, although not a substitute for formal mental health screening, they must serve as advocates to ensure children receive the mental health treatment they require. In order to achieve this goal they must be able to identify when a child’s behavior or development is atypical and in need of further assessment and/or treatment and assure that child is accessing efficacious treatments.

Guideline 6. Information for Children and Families

Children and families receive ongoing information on any diagnosed mental health problems, effective treatment options, and managing life with the condition.

Rationale. The role of the prescriber is as a consultant to the child, parents, caretakers and child welfare staff. It requires educating all involved parties in order for those parties to make the best possible decision with the available information. It is an evolutionary process, as more information becomes available our understanding of the underlying condition and its treatment may change. Ultimately, the child and their caretakers will be responsible for implementing treatment and effecting change in their lives. The prescriber’s role is to act as a catalyst towards that growth.

Guideline 7. Transition Planning

In advance of youth leaving care, agencies ensure an adequate clinical transition plan, including the identification of future prescribers and sources of payment.

Rationale: If the youth has been given adequate information about their mental health condition and provided a role in the decision-making regarding their treatment, it can be expected they will make safe and appropriate decisions about continuing their therapies (both medication and non-medication treatments). For youth transitioning out of care or aging out of the child welfare system it is imperative that sufficient information and resources be provided so they can serve as their own case managers and can continue to access effective treatments.

Guideline 8. Support for Birth Families

Child welfare agencies encourage, support, and monitor the mental health needs and access to psychotropic medications and other mental health services for birth families.

Rationale: 53% of children exiting foster care in 2006 were reunified with their biological parents or primary caretaker (Administration for Children and Families, 2008). In a national sample of children involved with child welfare, 40% of caregivers received a diagnosis of depression based on research diagnostic criteria, a rate which exceeds the rate of depression in the general population (16.6%) (Burns, 2007). Depressed parents have been found to be 3.45 times more likely to initiate physical abuse than their non-depressed counterparts. Substance abuse is also associated with both physical abuse and neglect (Chaffin, Kelleher, & Hollenberg, 1996). These statistics illustrate the importance of Guideline 8 and emphasize the need for parents to receive treatment for their mental health and substance abuse disorders in order to successfully reunify with their child(ren).

Guideline 9. Periodic Reviews of Psychotropic Medication Use Patterns

The agency periodically conducts reviews of patterns of psychotropic medication use within its caseload, on an aggregate- and provider-specific basis, and takes necessary action in response to findings of such reviews.

Rationale. The few studies available show rates of medication use for children in child welfare ranging from 13-37% (Raghavan et al., 2005; Zito et al., 2008), compared with approximately 4% in youth in the general population (Olfson, Marcus, & Weissman, 2002; Cox, Motheral, Henderson, & Mager, 2003). Although there is wide variability in the prescribing rates of psychotropic medications for children in the child welfare system, there does appear to be a significantly higher rate of psychotropic medication use for children in state custody compared to non-custodial children receiving Medicaid services or the general population of youth. In order to ensure that the use of psychotropic medication is both safe and appropriate states should monitor the use of these medications and be required to report the data to a national database.

Family Support

PARENT ENGAGEMENT

Guideline 1. Use of Peer (Adult) Family Mentors

Child welfare agencies should have on staff peer family mentors with experience working with different populations (for instance, birth, adoption, foster, kinship or youth) to advocate *with* and assist families in seeking care.

Rationale. Health services studies have shown that when peer mentors provide outreach, emotional/social support, or educational services, results include improved eating habits among women at risk for diabetes (Auslander, Haire-Joshu, Houston, Rhee, & Williams, 2002), decreased cocaine use (Egelko, Galanter, Dermatis, & DeMaio, 1998), improved health among persons with heart and lung disease or diabetes (Lorig, Ritter, & Gonzalez, 2003), reduced smoking among cancer survivors (Emmons et al., 2005), decreased high-risk behaviors associated with HIV exposure (Kegeles, Hays, & Coates, 1996; Wright, Gonzalez, Werner, Laughner, & Wallace, 1998), and improved usage of HIV medications (Broadhead et al., 2002; Lyon et al., 2003).

McKay and colleagues have found that the involvement of consumers and parents in preventive programs can reduce high-risk behaviors, improve health behaviors and family functioning, and increase service use (Atkins et al., 1998; McKay & Bannon, 2004; Lynn & McKay, 2001). In children's mental health, the use of professional family associates has been found to help families navigate the mental health system and reduce their obstacles to service use (Koroloff, Elliot, Korean, & Friesen, 1994).

Consequently, the use of peer family mentors working as staff in child welfare agencies is likely to alleviate workforce shortage issues and to bring the insights of experienced parents into the decision-making process. In addition, peer family mentors are able to provide direct family to family services which are likely to improve access, increase family engagement, and mitigate the distrust that often accompanies parent involvement in child welfare services.

Guideline 2. Training for Peer Family Mentors

Peer family mentors will be provided training, education and consultation on child and family mental health issues to assist them in their professional roles.

Rationale. As with all professional staff, peer family mentors will require ongoing training, consultation, and supervisory support in order to stay abreast of new evidence-based practices, to remain current with their skills, and to develop new skills (Jensen & Hoagwood, 2008). Programs and workshops to enhance the skills of peer family mentors are being disseminated through numerous organizations including family advocacy organizations, foundations, and not-for-profit entities.

Guideline 3. Agency Practices to Support Parents

Agencies will ensure that families experiencing removal of a child receive immediate orientation on their rights and responsibilities, preferably from a peer family mentor. Each family's understanding of these rights and responsibilities should be reassessed periodically by an agency staff member, preferably the peer family mentor.

Rationale. Involvement with child welfare services necessarily brings families into contact with a complicated array of service systems, including the legal system. Faced with these complex demands, parents and families in crisis are at high risk of failing to meet court and service system requirements. Peer advocates and mentors, such as the Parent Partners Program in California (Cohen & Canan, 2006), provide vital information and support to families as they come to terms with their child's removal from home, navigate related court proceedings, and work with child welfare and other services to address the issues that precipitated placement. Families have a vital role to play in ensuring their children get the help they need leading to their optimal mental health. Unless they are supported in understanding their rights and responsibilities it is hard for them to effectively do so.

Guideline 4. Comprehensive Family Assessments

Agencies will conduct a comprehensive family assessment in collaboration with the family to identify strengths, service needs, and necessary support services. In addition to child welfare staff, such assessments should involve the family as well as a peer family mentor as a member of the team. This plan should drive service delivery, and should be reviewed at regular intervals by child welfare staff, the family and the peer family mentor. It should be linked to a systematic tracking process so that agencies can be accountable for the provision of services identified in the service plan.

Rationale. Comprehensive family assessments, which "go beyond the investigation to permit the identification and provision of services that are specifically targeted to address the family's needs and problems and insure the child's safety, well-being, and permanency" (Schene, 2005, p. 2), are widely recognized as providing an essential foundation for effective child welfare practice. Developed and refined over the course of a family's involvement with child welfare services, such assessments ensure that service planning and delivery is maximally responsive to family strengths and needs. Since active family involvement and input is essential to developing valid assessments, careful attention to enhancing parents' engagement in ongoing planning processes is essential, including by way of support from peer mentors.

Guideline 5. Family Engagement Training for Child Welfare Staff

Agencies will ensure child welfare staff receives training on strategies for improving the engagement of families in services and improving the linkage of families to family support programs.

Rationale. Numerous studies have now documented how targeted programs aimed at improving the intake process can increase family retention in services, reduce no show rates, and improve family attitudes about services (McKay & Bannon, 2004; Swartz et al., 2007). Specific models to target first visit and ongoing retention in services have been developed and include approaches such as motivational interviewing (Miller & Rollnick, 2002), strategic family therapy (Satir, Banmen, Gerber, & Gomori, 1991), Functional Family Therapy (Sexton & Alexander, 2000), brief strategic family engagement (Santisebon et al., 1996) and engagement interventions (McKay et al., 2004). In child welfare, participatory decision-making meetings such as family group conferences and family team meetings offer a well-established strategy for engaging families. Research evidence shows meetings are particularly valuable in the initial phase of child welfare involvement (Crampton 2007). Linking evidence-informed engagement practices to delivery of evidence-based treatments is likely to improve the overall quality of services for children in the child welfare system with mental health problems.

Guideline 6. Referral to Substance Abuse and Mental Health Treatment when Needed

If parental substance abuse or mental health issues for the parent are identified in the family assessment, agencies will include in the comprehensive service plan appropriate linkage and referral to efficacious substance abuse or adult mental health treatment services operating in parallel with parenting and family intervention.

Rationale. Parental substance abuse and mental health problems impinge on parenting, family functioning, and child well-being. Parents who need substance abuse or mental health treatment should be able to readily obtain services that adequately address the problems. For those instances where the services are not available or accessible in the mental health and/or substance abuse treatment communities, best practice would be to coordinate with the relevant adult system to find workable solutions for the children and families.

Guideline 7. Early Assistance Services for Families.

Early assistance and differential response services to support families and divert them from entering the system will be made available whenever possible.

Rationale. Many states in the U.S., provinces in Canada, and some other countries are broadening the pathways for families who touch the child welfare system by invoking differential response services and options (Merkel-Holgun, Kaplan & Kwak, 2006). Differential response is an effort to divert some families away from an investigation oriented emphasis to a more service focus (Connolly, 2005) and can take various forms including diversion of lower-risk cases and offering of voluntary services to families in need. The differential response approach is also compatible with broader prevention strategies to reduce prevalence of child abuse and strengthen families (Sanders & Cann, 2002). By providing these prevention focused services to vulnerable families, providers and communities can assist with building the resiliency of the child and family to reduce stress and enhance coping

skills, thereby ensuring that families are able to advocate for their children receiving mental health services when they need them.

Guideline 8. Parent Involvement in Services

When possible, parents will be encouraged to be involved in mental and physical health promotion assessment, treatment, education, medical services, and other services as appropriate for their children.

Rationale. There are compelling reasons for involving parents in services. Families provide the primary social context in which children function, influence access to services, and shape attitudes toward service use that are critical to outcomes (McKay & Bannon, 2004). Parents' knowledge of their children, family circumstances, and cultural context is essential to valid assessments and appropriate intervention planning (Robertson, 2005). The importance of ongoing involvement of parents and kin in children's mental health interventions is underscored by research findings indicating not only that children's emotional and behavioral problems tend to escalate after they return home from foster care (Bellamy, in press; Lau et al., 2003; Taussig, Oyman, & Landsverk, 2001), but that the stress of re-establishing parenting with these children can lead to relapse for parents with substance abuse issues (Carlson et al., 2006). Anticipating and preventing these challenges necessarily means actively engaging parents while their children are still in care, to ensure that parents understand their children's evolving developmental needs and can learn and implement therapeutic strategies in the home setting (Landsverk, Davis, Ganger, Newton, & Johnson, 1996; Linares, Montalto, Li, & Oza, 2006; Lyons & Rogers, 2004).

Furthermore, although the empirical research base in child welfare is limited, several studies have shown that there are benefits when maltreating parents participate in mental health services with their children (for an overview see Runyon, Deblinger, Ryan, & Thakkar-Kolar, 2004), including lower rates of re-abuse (Chaffin et al., 2004). Even if reunification is unlikely, both recent research findings on youth transitioning out of foster care (Courtney et al., 2005; Pecora et al., 2005), and evidence regarding the cultural and social value of sustained parental and family connections for children of color (Jimenez, 2006) underscore the importance of ongoing family involvement to the longer term well-being of many children in care

YOUTH EMPOWERMENT

Guideline 1. Embed Youth Empowerment into the Mission of Child Welfare Agencies

Child welfare agencies and their partners (courts, mental health, education, health, etc.) incorporate the objective of empowering children and youth in their missions, values and practices in order to enhance the mental health and functioning of children and youth. To empower youth in child welfare settings, assessments of child and youth services need and the planning and implementation of these services are strengths-based and focus on engaging children and youth to enhance their mental health and functioning in multiple domains. These domains include school attendance and performance, employment education and experience, post high school educational and vocational training, preparation and attainment. In addition youth will be provided, while in care, with opportunities to enhance their peer and family relationships and recreational and spiritual participation and accomplishments (National Foster Youth Advisory Council Position Statements, n.d.).

Rationale. For youth in foster care, empowerment represents a vital process and outcome. The Foster Care Independence Act of 1999 recognized this in its requirement that youth in care be given the opportunity to participate in the development of their transition plans. The empowerment of youth in foster care involves them being given opportunities to test and assert themselves beyond the foster care system. It also requires that those who have agency caregiver roles have awareness of their responsibilities to contribute to youths' empowerment (Krebs & Pitcoff, 2006; Krebs & Pitcoff, 2004).

Guideline 2. Legal Advocates for Children and Youth

Courts and child welfare agencies ensure that in all legal proceedings every child and youth has a qualified legal advocate with training in child and youth mental health and domains of functioning. Consistent with their developmental capacities, all children and youth are informed about their legal proceedings and legal rights and are provided with opportunities to appear and be heard during their legal proceedings.

Rationale. Legal proceedings involving children and youth in foster care offer significant opportunities for youth empowerment, but involve complicated legal issues with life-altering outcomes. In order for youth to be empowered, to protect their legal rights (Kenny A. v. Perdue, 2005), and enhance their mental health, every child and youth needs an attorney with training in child and youth mental health issues and services (Keeping Children and Families Safe Act, 2003).

Significant benefits of having youth heard in court, include enhancement of youth's sense of control, understanding of the process, and the provision of additional information to the Court (Khoury, 2006). The importance of having youth in Court has been endorsed by the National Council of Juvenile and Family Court Judges (1995), the American Bar Association (1996), the National Association of Counsel for Children (1996), and the Pew Commission on Children in Foster Care (2004). Representation by an attorney and the opportunity to be

heard in court does not mean that a youth's stated wishes should or will override the legal standard. The Court's decision will always be guided by what is in the best interests of the child (National Foster Youth Advisory Council Position Statements, n.d.).

Guideline 3. Youth Advocate Involvement in Child Welfare Agencies

Child welfare agencies utilize youth and youth alumni in services planning and evaluation, staff development, and as providers of direct youth services. These youth advocates can help youth entering and those already in foster care to navigate the child welfare and mental health systems.

Rationale. Youth in child welfare face unique life circumstances that may be best understood by their peers who are dealing with similar issues or who experienced these issues in the past. By utilizing youth advocates, child welfare agencies offer youth in their care opportunities to make important connections with peers who can provide support, empathy and hope for the future.

Guideline 4. Multicultural Competence

Child welfare agencies exhibit multicultural competence by providing opportunities for youth empowerment and engagement in ethnic, cultural and religious activities and in the development of their personal identities consistent with the cultural traditions of their families and communities.

Rationale. Multicultural competence involves: (1) an ability to increase one's awareness about personal biases, assumptions, attitudes and worldviews, (2) specific knowledge of cultures, history, worldviews, languages, and diverse experiences, and (3) a repertoire of skills that allow one to effectively intervene in personal and professional domains (Jacoby, 1996). By demonstrating multicultural competence, especially in the areas of race, religion, gender and sexual orientation, and encouraging it in youth, child welfare agencies will contribute to the healthy development of youth in their care.

Guideline 5. Youth Understanding of Their Rights and Entitlements

Child welfare agencies and their partners strive to help children and youth understand, at their level of functioning, their rights, entitlements, and opportunities, by providing a range of communications, engagement, and support. These efforts include the provisions of information regarding access to services and assistance in completing applications for schools and employment opportunities, scholarships, legal documents, and references while in care and when exiting the system.

Rationale. The Casey Northwest and National Foster Care Alumni studies found that placement stability, educational supports, and employment experience were all associated with adult success (Pecora et al., 2003; Pecora et al., 2006). By helping youth to understand

their rights and entitlements and providing them with concrete assistance in accessing educational and employment opportunities, child welfare agencies can increase the likelihood of a successful transition to adulthood for these youth.

Guideline 6. Adequate Support for Youth Aging Out of Care

Child welfare agencies and their partners provide adequate support to youth who are aging out of or who have aged out of foster care, until at least age 21. These supports include focusing on accessing health and health insurance, housing, higher education and career development and the attaining of a permanent, significant connection to an adult.

Rationale. Providing ongoing supports to foster youth after age 18 is critical to ensuring positive outcomes. Youth remaining in state custody for an additional year after age 18 are more likely to advance their education, have stable housing, stay out of the juvenile justice system, receive independent living services, and have access to health and mental health services (Courtney et al., 2005). Given the significant medical and mental health needs of these youth, all states should extend Medicaid coverage for transitioning youth until age 21, as allowed by federal law (Medicaid Access, 2007). Independent living services should be provided to youth as early as age 13 and continued through their early-to-mid 20s (Eyster & Oldmixon, 2007). Strong, stable relationships also promote a sense of normalcy and security for youth. Those involved with foster care youth should ensure that these youth have a lifelong connection to a caring adult in their life (Eyster & Oldmixon, 2007).

Guideline 7. Accountability for Youth Empowerment Outcomes

The child welfare system is accountable for measurable outcomes related to youth empowerment.

Rationale. National, state and local data intended to measure the outcomes for children connected with the child welfare system should include data relating to youth empowerment. This could be accomplished by including in the Child and Family Services Review (CFSR), as well as state and local quality service reviews, measures of the rates of child welfare youth involvement with a youth advocate and engagement in a youth empowerment services such as those described by Kaplan, Skolnik & Turnbull (2009) in this special issue. The strong emphasis of the second CFSR round on the involvement of youth in the CFSR process at all levels and a toolkit to facilitate this process supports this guideline.

References

- American Academy of Child and Adolescent Psychiatry. (2008). *AACAP position statement on oversight of psychotropic medication use for children in state custody: A best principles guideline*. Retrieved October 8, 2008, from www.aacap.org
- American Academy of Child and Adolescent Psychiatry and Child Welfare League of America. (2002). *AACAP/CWLA policy statement on mental health and substance use screening and assessment of children in foster care*. Retrieved October 8, 2008, from www.aacap.org
- American Academy of Pediatrics. (1995). Informed consent, parental permission, and assent in pediatric practice. *Pediatrics*, *95*, 314–317.
- American Academy of Pediatrics. (2002). Health care of young children in foster care. *Pediatrics*, *109*, 536–541.
- American Bar Association. (1996, February 5). *Standards of practice for lawyers who represent children in abuse and neglect cases*. Chicago: Author.
- Atkins, M. S., McKay, M. M., Arvanitis, P., London, L., Madison, S., Costigan, C., Haney, P., Zevenbergen, A., Hess, L., Bennett, D., & Webster, D. (1998). An ecological model for school-based mental health services for urban low-income aggressive children. *The Journal of Behavioral Health Services Research*, *5*, 64–75.
- Auslander, W., Haire-Joshu, D., Houston, C., Rhee, C., & Williams J. H. (2002). A controlled evaluation of staging dietary patterns to reduce the risk of diabetes in African American women. *Diabetes Care*, *25*, 809–814.
- Bellamy, J. L. (2008). Behavioral problems following reunification of children in long-term foster care. *Children and Youth Services Review*, *30*(2), 216–228.

- Bickman, L. (1995). The Fort Bragg demonstration project: A managed continuum of care. *Child, Youth, and Family Services Quarterly, 18*, 2–5.
- Bickman, L., Heflinger, C. A., Lambert, E. W., & Summerfelt, W. T. (1996). The Fort Bragg managed care experiment: Short-term impact on psychopathology. *Journal of Child and Family Studies, 5*, 137–160.
- Bickman, L., Lambert, E. W., Summerfelt, W. T., & Heflinger, C. A. (1996). Rejoinder to questions about the Fort Bragg evaluation. *Journal of Child and Family Studies, 5*, 197–206.
- Bickman, L., Summerfelt, W. T., Firth, J., & Douglas, S. (1997). The Stark County evaluation project: Baseline results of a randomized experiment. In D. Northrup & C. Nixon (Eds.), *Evaluating mental health services: How do programs for children “work” in the real world?* (pp. 231–259). Newbury Park, CA: Sage Publications.
- Broadhead, R. S., Heckathorn, D. D., Altice, F. L., Hulst, Y., Carbone, M., Friedland, G. H., O’Connor, P. G., & Selwyn, P. A. (2002). Increasing drug users’ adherence to HIV treatment: Results of a peer-driven intervention feasibility study. *Social Science & Medicine, 55*, 235–246.
- Carlson, B., Matto, H., Smith, C., & Eversman, M. (2006). A pilot study of reunification following drug abuse treatment: Recovering the mother role. *Journal of Drug Issues, 22*, 878–902.
- Chaffin, M., Kelleher, K., & Hollenberg, J. (1996). Onset of physical abuse and neglect: Psychiatric, substance abuse, and social risk factors from prospective community data. *Child Abuse & Neglect, 20*, 191–203.
- Chaffin, M., Silovsky, J. F., Funderburk, B., Valle, L. A., Brestan, E. V., & Balachova, T.

- (2004). Parent-child interaction therapy with physically abusive parents: Efficacy for reducing future abuse reports. *Journal of Consulting and Clinical Psychology, 72*, 500–510.
- Cohen, E., & Canan, L. (2006). Closer to home: Parent mentors in child welfare. *Child Welfare, 85*, 867–884.
- Connolly, M. (2005). Differential response in child care and protection: Innovative approaches in family-centered practice. *Protecting Children, 20*, 8–21.
- Courtney, M. E., Dworksy, A., Terao, S., Bost, N., Cusick, G. R., Keller, T., & Havlicek, J. (2005). *Midwest evaluation of the adult functioning of former foster youth*. Chicago: Chapin Hall.
- Crampton, D. (2007). Family group decision-making: A promising practice in need of more programme theory and research. *Child and Family Social Work, 12*, 202–209.
- Cox, E., Motheral, B., Henderson, R., & Mager, D. (2003). Geographic variation in the prevalence of stimulant medication use among children 5 to 14 years old: Results from a commercially insured U.S. sample. *Pediatrics, 111*, 237–243.
- Egelko, S., Galanter, M., Dermatis, H., & DeMaio, C. (1998). Evaluation of a multisystems model for treating perinatal cocaine addiction: Meeting the needs of chemically dependent women. *Journal of Substance Abuse Treatment, 15*, 251–259.
- Emmons K. M., Puleo E., Park E., Gritz E. R., Butterfield R. M., Weeks J. C., Mertens, A., & Li, F. P. (2005). Peer-delivered smoking counseling for childhood cancer survivors increases rate of cessation: The partnership for health study. *Journal of Clinical Oncology, 23*, 6516–6523.

- Eyster, L., & Oldmixon, S. L. (2007). *State policies to help youth transition out of foster care*. Retrieved October 8, 2008, from www.nga.org/Files/pdf/0701YOUTH.pdf.
- Hurlburt, M. S., Leslie, L. K., Landsverk, J., Barth, R. P., Burns, B. J., Gibbons, R. D., Slymen, D. J., & Zhang, J. (2004). Contextual predictors of mental health service use among a cohort of children open to child welfare. *Archives of General Psychiatry*, *61*, 1217–1224.
- Institute of Medicine. (2001). *Crossing the quality chasm: A new health system for the 21st century*. Washington, DC: National Academy Press.
- Jacoby, B. (1996). *Service-learning in higher education: concepts and practices*. San-Francisco: Jossey-Bass.
- Jimenez, J. (2006). The history of child protection in the African American community: Implications for current child welfare policies. *Children and Youth Services Review*, *26*, 888–905.
- Kaplan, S. J., Skolnik, L., & Turnbull, A. (in press). Evidence for youth support, training, and empowerment. *Child Welfare*.
- Kegeles, S. M., Hays, R. B., & Coates, T. J. (1996). The empowerment project: A community-level HIV prevention intervention for young gay men. *American Journal of Public Health*, *86*, 1129–1136.
- Khoury, A. (2006, December). Seen and heard. *American Bar Association Child Law Practice*, *25*.
- Koroloff, N., Elliot, D. J., Koren, P. E., & Friesen, B. J. (1994). Linking low-income families to children's mental health services: An outcome study. *Journal of Emotional and Behavioral Disorders*, *4*, 2–11.

- Krebs, B., & Pitcoff, P. (2004). Reversing the failure of the foster care system. *Harvard Women's Law Journal*, 27, 357–366.
- Krebs, B., & Pitcoff, P. (2006). *Beyond the foster care system: The future for teens*. New Brunswick, NJ: Rutgers University Press.
- Landsverk, J., Davis, I., Ganger, W., Newton, R., & Johnson, I. (1996). Impact of psychosocial functioning on reunification from out-of-home placement. *Children and Youth Services Review*, 18, 447–462.
- Lau, A. S., Litrowik, A. J., Newton, R. R., & Landsverk, J. (2003). Going home: The complex effects of reunification on internalizing problems among children in foster care. *Journal of Abnormal Child Psychology*, 31, 345–358.
- Leslie, L. K., Kelleher, K. J., Burns, B. J., Landsverk, J., & Rolls, J. A. (2003). Foster care and Medicaid managed care. *Child Welfare*, 82, 367–392.
- Linares, O., Montalto, D., Li, M., & Oza, V. S. (2006). A promising parenting intervention in foster care. *Journal of Consulting and Clinical Psychology*, 74, 32–41.
- Lorig, K. R., Ritter, P. L., & Gonzalez, V. M. (2003). Hispanic chronic disease self-management: A randomized community-based outcome trial. *Nursing Research*, 52, 361–369.
- Lynn, C., & McKay, M. (2001). School social work: Promoting parent-school involvement through collaborative practice models. *School Social Work Journal*, 25, 1–14.
- Lyon, M. E., Trexler, C., Akpan-Townsend, C., Pao, M., Selden, K., Fletcher, J., Addlestone, I. C., & D'Angelo, L. J. (2003). A family group approach to increasing adherence to therapy in HIV-Infected youths: Results of a pilot project. *AIDS Patient Care and STDs*, 17, 299–308.

- Lyons, J. S., & Rogers, L. (2004). The U.S. child welfare system: A de facto public behavioral health care system. *Journal of the American Academy of Child and Adolescent Psychiatry, 43*, 971–973.
- McKay, M. M., & Bannon, W. M. Jr. (2004). Engaging families in child mental health services. *Child & Adolescent Psychiatric Clinics of North America, 13*, 905–921.
- McKay, M. M., Hibbert, R., Hoagwood, K., Rodrigues, J., Murray, L., Legerski, J., & Fernandez, D. (2004). Integrating evidence-based engagement interventions into “Real World” child mental health settings. *Brief Treatment and Crisis Interventions, 4*, 177–186.
- Merkel-Holgun, L., Kaplan, C., & Kwak, A. (2006). *National study on differential response in child welfare*. Washington, DC: American Humane Association and Child Welfare League of America.
- Miller, W. R., & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change* (2nd ed.). New York: Guilford Publications.
- National Association of Counsel for Children. (1996). *American Bar Association standards of practice for lawyers who represent children in abuse and neglect cases*. Denver, CO: Author.
- National Council of Juvenile and Family Court Judges. (1995, Spring). *Resources guidelines improving court practice, 69*.
- National Foster Youth Advisory Council. (n.d.). *Position statements*. Retrieved October 8, 2008, from www.cwla.org/programs/positiveyouth/nfyacstatements.htm.

- Olfson, M., Marcus, S. C., Weissman, M. M., & Jensen, P. S. (2002). National trends in the use of psychotropic medications by children. *Journal of the American Academy of Child & Adolescent Psychiatry, 41*, 514–521.
- Pecora, P. J., Kessler, R. C., Williams, J., O'Brien, K., Downs, A. C., English, D., Hiripi, E., White, C. R., Wiggins, T., & Holmes, K. E. (2005). *Improving family foster care: Findings from the Northwest Foster Care Alumni Study*. Seattle, WA: Casey Family Programs.
- Pecora, P. J., Williams, J., Kessler, R. C., Downs, A. C., O'Brien, K., Hiripi, E., & Morello, S. (2003). *Assessing the effects of foster care: Early results from the Casey National Alumni Study*. Seattle, WA: Casey Family Programs.
- Pecora, P. J., Williams, J., Kessler, R. C., Hiripi, E., O'Brien, K., Emerson, J., Herrick, M. A., & Torres, D. (2006). Assessing the educational achievements of adults who formerly were placed in family foster care. *Child and Family Social Work, 11*, 220–231.
- Pew Commission on Children in Foster Care. (2004, May 18). *Fostering the future: Safety, permanency and well-being for children in foster care*. Washington, DC: Author.
- Raghavan, R., Zima, B. T., Andersen, R. M., Leibowitz, A. A., Schuster, M. A., & Landsverk, J. (2005). Psychotropic medication use in a national probability sample of children in the child welfare system. *Journal of Child and Adolescent Psychopharmacology, 15*, 97–106.
- Robertson, A. (2005). Including parents, foster parents and parenting caregivers in the assessments and interventions of young children placed in the foster care system. *Children and Youth Services Review, 28*, 180–192.
- Runyon, M. K., Deblinger, E., Ryan, E. E., & Thakkar-Kolar, R. (2004). An overview of child physical abuse. *Trauma, Violence, & Abuse, 5*, 65–85.

- Sanders, M. R., & Cann, W. C. (2002). Promoting positive parenting as an abuse prevention strategy. In K. Browne, H. Hanks, P. Stratton, & C. Hamilton (Eds.), *Early prediction and prevention of child abuse: A handbook* (pp. 145–163). Chichester, UK: Wiley.
- Santisteban, D. A., Szapocznik, J., Perez-Vidal, A., Kuartines, W. M., Murray, E. J., & LaPerriere, A. (1996). Efficacy of intervention for engaging youth and families into treatment and some variables that may contribute to differential effectiveness. *Journal of Family Psychology, 10*, 35–44.
- Satir, V., Banmen, J., Gerber, J., & Gomori, M. (1991). *The Satir model: Family therapy and beyond*. Palo Alto, CA: Science and Behavior Books.
- Schene, P. (2005). *Comprehensive family assessments: Guidelines for child welfare*. Retrieved April, 6, 2008, from www.acf.hhs.gov/programs/cb/pubs/family_assessment/family_assessment.pdf.
- Sexton, T. L., & Alexander, J. F. (2000). Functional family therapy. *Juvenile Justice Bulletin, 3*–7.
- Stroul, B., & Friedman, R. (1986). *A system of care for children and youth with severe emotional disturbances* (Rev. ed.). Washington, DC: Georgetown University Child Development Center.
- Swartz, H. A., Zuckoff, A., Grote, N., Spielvogel, H. N., Bledsloe, S. E., Shear, M. K., & Frank, E. (2007). Engaging depressed patients in psychotherapy: Integrating techniques from motivational interviewing and ethnographic interviewing to improve treatment participation. *Professional Psychology: Research and Practice, 38*, 430–439.
- Taussig, H. N., Oyman, R. B., & Landsverk, J. (2001). Children who return home from foster care: A 6-year prospective study of behavioral health outcomes in adolescence.

Pediatrics, 108, e10.

U.S. Department of Health and Human Services, and Health Resources and Services

Administration. (1999). *Measuring success for healthy people 2010*. Washington, DC:

Author.

Wright, E. R., Gonzalez, C., Werner, J. N., Laughner, S. T., & Wallace, M. (1998). Indiana

Youth Access Project: A model for responding to the HIV risk behaviors of gay, lesbian, and bisexual youth in the heartland. *Journal of Adolescent Health*, 23, 83–95.

Wulczyn, F., Barth, R. P., Yuan, Y. T., Jones-Harden, B., & Landsverk, J. (2005). *Beyond*

common sense: Child welfare, child well-being, and the evidence for policy reform.

Piscataway, NJ: Aldine Transaction.

Zito, J. M., Safer, D. J., Sai, D., Gardner, J. F., Thomas, D., Coombes, P., Dubowski, M., &

Mendez-Lewis, M. (2008). Psychotropic medication patterns among youth in foster care.

Pediatrics, 121, e157–e163.