Mental Health Care for Children and Adolescents in Foster Care: Review of Research Literature

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Introduction

In Fall 2005, Casey Family Programs requested a review of the professional literature to answer questions regarding the mental health needs of children in foster care. The review was to include studies on the provision of mental health care, the evidence base for mental health care, and related legal actions (e.g., class action suits) taken on behalf of these children. This overview briefly summarizes the major findings gleaned from the literature, and it outlines the challenges and implications for those steps that have the potential to improve mental health care for these "high risk" youth.

Need for Mental Health Care

The research literature here, which is based on studies across several states plus one nationally representative survey, the National Survey of Child and Adolescent Well-Being [NSCAW] (Leslie, Hurlburt, Landsverk, Barth, & Slymen, 2004; Burns et al., 2004)], suggests that between one-half and three-fourths of the children entering foster care exhibit behavior or social competency problems that warrant mental health care. There is also evidence that this high rate of need may be anticipated as well for children who are served by child welfare while remaining in their biological homes. This rate of mental health problems is significantly higher than that which would be expected in community populations although it is more comparable to that of children living below poverty level within these communities. Furthermore, these service needs range across a number of domains, rather than being concentrated in broad behavior problems alone. A noteworthy finding is the high rate of developmental problems in children entering foster care prior to the age of seven. In addition, some evidence suggests that the rate of developmental problems may be somewhat lower in children who end up in kinship care compared to children who are placed in non-relative foster care although this relationship remains open to further, more definitive research. Finally, psychosocial functioning of the children in foster care may not only affect their long-term functioning outcomes, but also decisions regarding their continuity in or exit from living in foster

care. For example, children with poorly treated mental health disorders may be less likely to be reunified or adopted.

Below is the first of a series of text boxes that summarizes this review's recommendations based on the implications of the review for policy and services.

Recommendation: Increase Access to Care

- Inform child welfare workers (CWW) about the importance of early identification and treatment.
- Institute a standard protocol for screening and assessment to identify the need for mental health care upon the child's entry into the child welfare system.
- Educate CWWs about local resources and create a liaison with mental health providers to facilitate rapid referrals into mental health services.
- Monitor referrals and follow-up with foster parents to ensure that youth receive services.

Use of Mental Health Care

Multiple local area studies across multiple states together with early data from the NSCAW national study indicate that youth in the child welfare system use mental health services at very high rates across all age groups, with the highest rates in late adolescents who had been in out-of-home care for an average of six years. Studies using Medicaid data confirm that this much higher rate for children in foster care is in contrast to the relatively low rates seen children served by Aid to Families with Dependent Children (AFDC).

The findings from the NSCAW study indicate that, despite these high rates in comparison with community studies, three out of four youth in child welfare who meet a stringent criterion for need were not receiving mental health care within 12 months after a child abuse and neglect investigation. More encouraging are the results of the Casey Northwest Alumni study indicating that, over time, 80% do receive some mental health services (Pecora et al., 2005). This finding needs to be understood in light of national data from NSCAW.

There is growing recent evidence that both clinical and nonclinical factors affect mental health referral and utilization patterns for children in foster care. The nonclinical factors implicated are type of maltreatment, racial/ethnic background, age, and type of placement. The recent review of the race/ethnicity factor by Garland, Landsverk, and Lau (2003) suggests that this nonclinical factor consistently predicts lower use of mental health care for African American youth. Evidence from a national study suggests that coordination between child welfare and mental health agencies may increase the effect of clinical factors in the use of mental health care and may decrease nonclinical factors such as race/ethnicity (Hurlburt et al., 2004).

Among youth in foster care who utilize “usual care” mental health services, the great majority receive outpatient treatment, a small number is admitted to hospitals, and many others are placed in group homes or residential treatment centers. While it may be helpful to obtain, at a minimum, a diagnostic assessment and long-term psychotherapy with a trusted professional who can offer support about a troubling life history, there are more effective treatment approaches today. Research suggests that there are effective brief clinic-based and group-based models for children needing diagnostic-specific interventions. Research on more comprehensive interventions for youth with more complex needs suggests that there longer-term and intensive interventions that offer alternatives to institutional care for many youth in foster care.

Recommendation: Move Beyond Usual Outpatient and Institutional Care

- Examine the evidence base for interventions to treat common clinical conditions and more complex conditions experienced by youth in foster care.
- Assess the availability of evidence-based interventions at the local level and national level to assure relevance and explore adaptations needed for youth in foster care.
- Identify possible evidence-based interventions to meet mental health needs at the local level.

Evidence-Based Interventions and Promising Practices

Children in foster care frequently experience several specific conditions that require targeted treatment. The most prevalent conditions include PTSD and abuse-related trauma, disruptive behavior disorders (including ADHD), depression, and substance abuse. There is a strong evidence base for treating each of these conditions with interventions that are largely behavioral or cognitive-behavioral and that address symptoms, behavior, and functioning. Examples of such interventions include Trauma-Focused Cognitive Behavior Therapy, the Incredible Years, Parent-Child Interaction Therapy, and cognitive behavior therapy for depression. Such interventions tend to be relatively brief, and most are more effective when a caregiver is actively involved. A number are directed at the caregiver only, particularly when the focus is on managing the child's disruptive behavior. In fact, dropping a child off at a clinic for individual therapy for most of these conditions is of very limited value. Note: A caution about rapidly endorsing evidence-based treatment. At present, these interventions are not uniformly available across the country.

Youth with complex combinations of mental health conditions and the functional impairment associated with long-term risks, such as multiple episodes and types of maltreatment, other trauma (e.g., domestic violence and loss), and instability of placements, will benefit from intensive home and community-based services. Children in foster care often move on to "deep end" services in institutional settings because of the failure to manage their behavior in the community. The benefit of care in institutional settings is not well substantiated and may even be deleterious due to close association with deviant peers, the risk of contagion, loss of contact with family and peers, and other factors (Schaefer & Swanson, 1988; Dishion, McCord, & Poulin, 1999).

Few recent studies have examined the effectiveness of group care models. There are alternatives to the care and treatment of these youth today. Increasing the availability of intensive home- and community-based services while youth are in

foster care could benefit the children and prevent further movement away from family and community. Those alternatives that could more effectively address the needs of such youth tend to be intensive interventions that are long–term in nature. Major examples include intensive case management and home-based interventions (e.g., multisystemic therapy, treatment foster care, crisis services, respite care, mentoring, and several types of family therapy) in addition to special education services in school or recreational and work opportunities in the community. The critical challenge to creating such a continuum of care is to engage the relevant other providers (e.g., schools, juvenile justice, Medicaid) in a joint endeavor.

Evidence-based interventions have been identified that have the potential to address the mental health needs of youth in foster care, but they are delivered largely by the mental health system. What may be more innovative is the provision of specific mental health interventions within the child welfare system, and several important studies are underway to test their applicability. Of real promise is the statewide implementation of Parent-Child Interaction Therapy in an experimental design in Oklahoma. A second important study will test the potential to adapt treatment foster care principles and approaches to foster care parents (personal communication, Patti Chamberlain, January 15, 2006). A third significant initiative sponsored by the National Child Traumatic Stress Training Center will train clinicians in 12 sites across the country to provide Trauma-focused Cognitive Behavior Therapy (for child sexual and/or physical abuse). Another new initiative will field-test rapid but more thorough mental heath references and training for both parents and foster parents to better access effective mental health services (http://www.kidsmentalhealth.org/Caseyproject.html). Further, other studies are examining strategies for the dissemination of diagnostic-specific interventions and the lessons learned from them will also be applicable to increasing the availability of evidence-based practices for maltreated youth in child welfare.

Recommendation: Increase the Use of Evidence-Based Interventions in Child Welfare

- Track the progress of dissemination studies of mental health interventions in foster care and clinical interventions relevant to the needs of these children to determine readiness for large scale adoption.
- Learn from the challenges of intervention, adoption, and dissemination efforts (e.g., stakeholder buy-in, the importance of policy and organizational factors, and factors contributing to sustainability) prior to making policy decisions.
- Consider additional interventions for implementation within child welfare, in contrast to those typically provided in the mental health system.
- For evidence-based interventions that require the expertise and resources of the mental health system, develop a partnership between mental health and child welfare with clearly explicated roles of each system, preferably with joint child welfare and mental health and/or Medicaid funding.

Legal Interventions

Legal interventions through court actions with consent decrees and settlements have become a frequent method for addressing problems in the foster care system. A recent study (Kosanovich & Joseph, 2005) found that, within the past decade, “there has been child welfare class action litigation in 32 states, with consent decrees or settlement agreements in 30 of these (pg. 2).” Currently, 21 states operate “under court consent decrees, settlement agreements or are under pending litigation brought against public child welfare agencies (pg. 6).”

While the litigation cases have addressed a wide range of child welfare issues, the study investigators found that 20 of the 35 decrees have addressed service provision, including 12 decrees explicitly dealing with mental health care. We would note that 6 decrees addressed substance abuse problems and 7 decrees among the 35 addressed the more generic treatment needs of children in foster care.

Limiting the number of decrees to those dealing with the narrow definition of failure to provide treatment for the mental health needs of children in foster care may underestimate the scope of this issue within the decrees. Many other issues may be indirectly linked to provision of mental health care, such as training of caseworkers and foster parents, education and independent living services for children in foster care, parent-child visitation, minimizing disrupted placements and reduction in number of placements, residential facility placement, and support and supervision of foster parents. These latter issues may be especially linked to mental health care because of the high prevalence of externalizing problems seen in children who are involved in foster care and the findings that externalizing problems are best addressed through parent-mediated interventions.

Finally, we would suggest that foundations such as the Casey Family Programs have a vital role to play in efforts to improve mental health care for children in child welfare, and we offer a small number of modest recommendations.

Recommendation: Use Evidence to Improve Practice and Policies in Child Welfare

- Consider the unique leverage points that Casey Family Programs can use to assist initiatives to improve mental health care for children in foster care through increased use of very promising interventions.
- Use the unique experience of Casey Family Programs to initiate and support partnership dialogue between the child welfare system and the mental health service system around efforts to integrate evidence-based interventions into services for children in foster care.
- Provide leadership to the child welfare community as it works to improve service delivery through the use of evidence about interventions that show great promise for improving well-being outcomes for children in foster care.

Summary

This report has focused on the rapidly expanding research literature related to the mental health care of children in foster care. Great needs for mental health care have been demonstrated in these children, and many efficacious interventions that can be beneficial for children in foster care have been reviewed. Despite the challenges of integrating the best interventions into the child welfare and mental health service systems, which provide care for this population, there is enormous promise in the robust efforts currently underway. Considerable focus and research resources are being expended by federal agencies, including the National Institutes of Health and the Administration for Children and Families. Foundations such as the Casey Family Programs have an important role to play in these efforts to improve mental health care for children in foster care.

Mental Health Care for Children and Adolescents in Foster Care: Review of Research Literature

Overview

This report was written in response to a request from Casey Family Programs for a review of the literature on the mental health needs of children and adolescents in foster care and on the treatment interventions for addressing these needs. Casey Family Programs provided the following six questions to guide the review.

- What mental health treatment needs have been identified?
- What treatment interventions have been tried?
- What are the promising practice models?
- What interventions have been proven effective through evaluation and research?
- How many studies have been done?
- How many lawsuits have been filed because of the failure to meet the mental health needs of foster youth?

Encompassing these six questions, the review is organized in five sections: 1) the need for mental health care, 2) the use of mental health care, 3) evidence-based interventions and promising practices, 4) system-level legal interventions addressing mental health care, and 5) recommendations.

I. NEED FOR MENTAL HEALTH CARE

This report is based on a comprehensive but not exhaustive literature review. It is comprehensive in that it covers most major issues involved in the provision of mental health care for children and adolescents who experience foster care. It is not exhaustive because it relies heavily on recent reviews with some updating but without a thorough searching of extant literature. In particular, the sections on need for and use of mental health care rely heavily on two review papers published within the past three years: Landsverk, Garland, and Leslie (2002), “Mental Health Services for Children Reported to Child Protective Services,” and Landsverk (2005),

Improving the Quality of Mental Health and Substance Abuse Treatment Services for Children Involved in Child Welfare.. In addition, the chapter “Evidence-based Mental Health Interventions for Children in Child Welfare” in *Beyond Common Sense: Child Welfare, Child Well-Being, and the Evidence for Policy Reform* by Wulczyn, Barth, Yuan, Jones-Harden, and Landsverk (2005) informs the section on effective research-based treatments and promising practices.

Reliable estimates, using standardized measures, of the need for mental health care have become increasingly available over the past 15 years, both for community populations and for the specialized population of children and adolescents who have been involved with foster care (see Costello, Burns, Angold, and Leaf, 1993, for a cogent discussion of four ways to estimate the need for mental health services). From community studies, general estimates of this need range from 10 to 22% (Gould, Wunsch-Hitzig, & Dohrenwend, 1981; Offord et al., 1987; Costello et al., 1988; Zahner, Pawelkiewicz, Defrancesco, & Adnopoz, 1992). Most recent meta-analytic and epidemiological studies have narrowed the estimate for the prevalence of psychiatric disorders among community youth to a range of 5-8% for serious emotional disturbance, both psychiatric diagnosis and moderate to severe levels of impairment (Friedman, Katz-Leavy, Manderscheid, & Sondheimer, 1996; Costello, 1999), and approximately 20% for any diagnosis with functional impairment (Costello et al., 1996; Shaffer, Fisher, Lucas, Dulcan, & Schwab-Stone, 2000).

All early studies that provide estimates from standardized measures for youth in the child welfare system have focused on those placed in foster care. These studies have shown that youth in foster care exhibit problems that require a mental health assessment and/or intervention at a significantly higher rate than what would be expected from either normative data or from community studies. ***Based on the studies briefly reviewed below, this rate is likely to be five times greater compared to community-based youth who are not involved in the child welfare system.***

Pilowsky (1995) completed a review of studies published from 1974 through 1994 that supports this conclusion, with the special note that externalizing disorders

in particular may be more prevalent in the foster care population. Studies published since the Pilowsky review confirm this widely accepted conclusion. In the state of Washington, Trupin, Tarico, Low, Jemelka, and McClellan (1993) compared children receiving protective services from child welfare with a criterion group of children in the state's most intensive mental health treatment programs and found that 72% of the children in child welfare exhibited profiles of severe emotional disturbance indistinguishable from the criterion group. In a Tennessee study of children over the age of 4 years entering state custody, of whom 64% were under the supervision of child welfare, Glisson (1994, 1996) found that 52% were in the clinical range of the Child Behavior Checklist as determined by both the parent and teacher informant, with 82% scoring in the clinical range of at least one of the three scales of internalizing, externalizing, and total behavior problems. In another Tennessee study of children in custody, Heflinger, Simpkins, and Combs-Orme (2000) found elevated rates of aggressive, delinquent, and withdrawn behavior.

An important adjunct to the estimates based on standardized behavior or diagnostic measures are studies that estimate problems in developmental functioning. For example, in a study of 272 children entering foster care in Connecticut before the age of 8 years, Horwitz, Simms, and Farrington (1994) found that 53% showed developmental delays as determined by either the Connecticut Infant/Toddler Developmental Assessment or the Battelle Developmental Inventory.

A number of recent studies have been conducted with children entering foster care or having resided in foster care in California. Urquiza, Wirtz, Peterson, and Singer (1994) conducted a comprehensive screening and evaluation of 167 children between the ages of 1 and 10 years who were made dependents of the juvenile court in Sacramento for reasons of child abuse and neglect. The researchers found that 68% of the children displayed significant problems in one of four psychosocial domains, as operationalized by a score 1.5 standard deviations below national norms on one or more of four standardized assessment instruments.

Halfon, Mendonca, and Berkowitz (1995) reported on 213 young children with a mean age of 3 years who were referred to a comprehensive health clinic after

entering foster care in Oakland; the authors found that over 80% had developmental, emotional, or behavior problems. They also found that children who were placed after 2 years of age exhibited a higher rate of these problems than children placed at an earlier age.

Clausen, Landsverk, Ganger, Chadwick, and Litrownik (1998) examined 140 children between the ages of 4 and 16 years entering foster care in three California counties; they found that 54.4% met clinical or borderline criteria on one or more of the narrow-band, broad-band, or total behavior problem scales of the Achenbach Child Behavior Checklist, Parent Report Form, and that 62.6% met clinical or borderline criteria on one or more of the narrow-band and social competency scales as well. Only 23.0% were determined to fall in the nonclinical or borderline range on both the behavior problem and social competency dimensions.

Landsverk, Litrownik, Newton, Ganger, and Remmer (1996) conducted a study in San Diego County comparing children entering kinship care with children entering non-relative foster care through the Parent Report Form of the Achenbach Child Behavior Checklist. For children between the ages of 4 and 16 years, the investigators determined that 43.2% in the kinship group and 51.9% in the non-relative foster care group were in the borderline or clinical range on total behavior problems. In the same study, they found that 60% of the children under age of 6.5 years and residing in kinship care were in the questionable or abnormal range on the Denver Developmental Screening Test, Version Two (DDST II), as compared to 72% of the same-age children residing in non-relative foster placements. A more recent study of 791 consecutive children in San Diego County entering the emergency shelter/receiving facility found that 61.2%% were in the questionable or abnormal range (currently termed the “suspect range”) on the DDST II (Leslie, Gordon, Ganger, & Gist, 2002). Over two-thirds of these children (69%%) received a developmental evaluation using the Bayley Scales of Infant Development II (Bayley-II), with 34% scoring more than two standard deviations below the standard score on at least one component of the Bayley II. Comparable with the findings from the earlier study, children entering non-relative foster care placement were more likely to

score in the suspect range (67%) as compared to children ending up in kinship care (56%) or reunited with their biological parents (58%).

Two separate studies conducted in San Diego have used the NIMH Diagnostic Interview Schedule for Children (DISC) for estimating rate of psychiatric disorder based on separate versions of the Diagnostic and Statistical Manual. In a study from the early 1990s, Madsen (1992) used the Diagnostic Interview Schedule for Children (DISC), Version 3.2, with 59 children between the ages of 11 and 16 years in the early months of foster care; they found that 60% met criteria for one or more DSM III-R diagnoses as determined by reports from either the parent or the youth. In a more recent study conducted from 1997 through 1999 in San Diego, Garland et al. (2000) reported on estimates for selected diagnoses using Version IV of the DISC (Shaffer et al., 2000) with weighted samples drawn from five different sectors of care, including 426 youth between the ages of 6 and 18 years who had been declared dependents of the court. Two out of every five of these youth (41.8%) met the criteria for one or more DSM IV diagnoses with at least a moderate level of diagnostic-specific functional impairment. The largest proportion met the criteria for disruptive disorders, with 22.2% meeting the criteria for oppositional defiant disorder, 16.1% for conduct disorder, and 20.8% for attention-deficit with hyperactivity disorder. Considerably smaller proportions met the criteria for mood disorders (5.2%) and anxiety disorders (8.6%). In the same study, Aarons, Brown, Hough, Garland, and Wood (2001) reported that 19.2% of the adolescents aged 13-18 years who were in child welfare custody met the criteria for a lifetime substance-use disorder and 11.0% had met those criteria during the past year.

In a study of 406 17-year-old youths in foster care in Missouri, McMillen et al. (2004) reported that 37% had met DSM-IV criteria for a psychiatric diagnosis in the past year and 61% had met similar criteria for a lifetime disorder, with the highest rates for disruptive disorders (CD and ODD), major depression, and ADHD. An important new study from the Casey Family Programs interviewed 479 young adults between the ages of 20 and 33 who had been placed in family foster care in Oregon and Washington between 1988 and 1998 (Pecora et al., 2005). Using the Composite International Diagnostic Interview (CIDI), the study estimated that 54.4% had met

criteria for a DSM diagnosis within the previous year as compared to 22.1% for the general population in the same age group. The highest rates were for PTSD (25.2%) and major depression (20.1%).

While not the primary focus of this report, we would note that a limited but growing empirical base suggests that estimates of need for mental health care may be almost as high for youth involved with the child welfare system who remain with their biological parents as for youth placed in foster care. For example, in a re-analysis of the Great Smoky Mountains study data , Farmer et al. (2001) compared three subgroups of children (age 9, 11, or 13 years at baseline) who were randomly selected into their community sample: (1) children who had ever been in foster care (N=132), (2) children who had been in contact with child welfare but who had never been placed in out-of-home care (N=234), and (3) children living in poverty with no known contact with child welfare (N=413). More than three out of four of these children met the criteria for either a DSM III-R diagnosis, functional impairment, or both, using the Child and Adolescent Psychiatric Assessment (CAPA) measurement, with only small differences between the three groups (78% for the foster care group, 80% for the child welfare contact group, and 74% for the poverty group). These data suggest that children provided services by child welfare while remaining in their biological home may evidence equally high rates of mental health problems as those observed in children placed in foster care.

The National Survey of Child and Adolescent Well-Being [NSCAW] is providing the first nationally representative data on psychosocial functioning for children involved in child welfare. In a study of mental health service use, Burns et al.(2004) reported that “nearly half (47.9%) of the youths aged 2 to 14 years (N=3,803) with completed child welfare investigations had clinically significant emotional or behavioral problems (pg. 960)” as measured by the Achenbach CBCL. However, these rates varied dramatically by placement setting, from a low of 39.3% for youth in kinship foster care to a high of 88.6% for youth in group home or residential treatment settings. In a separate NSCAW-based paper, Leslie et al. (2004) reported that almost half (46.8%) of youth age 2 to 14 years who resided in

foster care had clinically significant emotional or behavior problems as measured by the CBCL.

Finally, two of the studies reviewed reported findings that suggest that decisions about reunification may be affected by the psychosocial functioning of the child in foster care. Horwitz, Simms, and Farrington (1994) found that children with developmental problems were almost two times more likely to remain in foster care than be reunified. Landsverk, Davis, Ganger, Newton, and Johnson (1996) found that children with significant behavior problems, especially externalizing problems, were one-half as likely to be reunified with their birth parent within 18 months of foster care entry as were those without significant behavior problems.

Summary

The research literature based on studies across several states and a nationally representative survey suggests that between one-half and three-fourths of the children entering foster care exhibit behavior or social competency problems warranting mental health services. Preliminary evidence indicates that this high rate may also be anticipated for children served by child welfare but who remain in their biological homes. The rate of problems is significantly higher than would be expected in community populations, although more comparable with that of children living below poverty level within these communities. Furthermore, these needs range across a number of domains, rather than being concentrated in only broad behavior problems. A noteworthy finding is the high rate of developmental problems in children entering foster care prior to the age of 7 years. In addition, evidence suggests that the rate of problems may be somewhat lower in children who end up in kinship care as compared to children who are placed in non-relative foster care. Finally, psychosocial functioning of the children in foster care may not only affect their long-term functioning outcomes but also decisions regarding their continuity in or exit from foster care.

II. USE OF MENTAL HEALTH CARE

Since 1988, a growing body of studies has examined the use of mental health care services for this special population. This section discusses findings from seven studies that provide estimates of service use in six states, namely, California, Tennessee, Washington, Pennsylvania, North Carolina, and Missouri. These rates are compared to rates found in community samples. Early published findings from the NSCAW study are also reviewed for the first national estimates of use of mental health care by youth in foster care.

Use of Mental Health Care

Estimates regarding rates of mental health service use are difficult to ascertain given the variations in definitions of mental health services, which range from the traditional outpatient and inpatient modalities to the less traditional services such as case management and therapeutic group homes. Despite these definitional variations, a number of community studies using survey reports by parents and youth have estimated that between 4 to 12% of children in community samples have received mental health services (Offord et al., 1987; Zahner et al., 1992; Koot & Verhulst, 1992).

Three studies of mental health service use by children in foster care used Medicaid program claims data from the late 1980s and 1990s, one from California , one from the state of Washington, and one from Pennsylvania. The Medicaid data from these three states are especially relevant because they have made all children in foster care categorically eligible for the Medicaid program regardless of the eligibility status of their biological parents. In the California study conducted by Halfon, Berkowitz, and Klee (1992a, 1992b), Medi-Cal data (the name for the Medicaid program in California) were examined for all paid claims involving children under 18 years of age in the fee-for-service program in 1988. Rates of health care utilization and associated costs were compared between the 50,634 children identified in foster care and the 1,291,814 eligible children. While the children in

foster care represented less than 4% of the population of Medi-Cal eligible users, they represented 41% of the users of reimbursed mental health services and incurred 43% of all mental health expenditures. This over-representation among mental health service users held for all age groups within the foster care population, ranging from rates of 31% for children under the age of 6 years and 32% for children between the ages of 6 and 11 years, to 49% for all users between the ages of 12 and 17 years. The investigators further determined that children in foster care had an age-adjusted rate of mental health service utilization that was 15 times the overall Medi-Cal population that served as the reference group. The investigators found that this pattern of greater utilization was also true across many different types of mental health services, with children in foster care accounting for 53% of all psychologist visits, 47% of psychiatry visits, 43% of public hospital inpatient hospitalizations, and 27% of all psychiatric inpatient hospitalizations.

The second study (Takayama, Bergman, & Connell, 1994) using Medicaid claims form data compared the health care utilization rates of 1,631 children in foster care with those of a sample of 5,316 children from the population of children who were AFDC recipients but not in foster care in 1990 This research focused on children under the age of 8 years in Washington state, making it less inclusive than the California study. Despite the younger age cohort studied, the findings were comparable to those reported by Halfon and colleagues for California, with 25% of the children in Washington foster care using mental health services as compared to only 3% of the AFDC comparison group children. When the diagnoses were examined for high-cost children, those whose 1990 health care expenditures exceeded $10,000, (8% of foster children and 0.4% of AFDC children), the prominent diagnoses for the children in foster care were mental disorders and neurological conditions.

The third study (Harman, Childs, & Kelleher, 2000) compared use and costs of mental health services between children in foster care and children identified under the Supplemental Security Income (SSI) program (children qualify for SSI if there is a medically determinable physical or mental impairment that results in

marked and severe functional limitations) in western Pennsylvania. This research team found that:

> children in foster care were 3 to 10 times more likely to receive a mental health diagnosis, had 6.5 times more mental health claims, were 7.5 times more likely to be hospitalized for a mental health condition, and had mental health expenditures that were 11.5 times greater ($2082 vs. $181) than children in the Aid to Families With Dependent Children (AFDC) program. Overall, utilization rates, expenditures, and prevalence of psychiatric conditions for children in foster care were comparable with those of children with disabilities (p. 1114).

Further insight into the use of mental health services by children in foster care is provided by two additional studies within two separate states that shared important design features. The investigations in Tennessee (Glisson, 1994, 1996) and in San Diego County, California (Garland, Landsverk, Hough, & Ellis-Macleod, 1996; Landsverk et al., 1996; Leslie et al., 2000) both studied children entering foster care and both used the Achenbach Child Behavior Checklist to determine the need for mental health services.

The San Diego County study examined the need for mental health services in a cohort of 662 children between the ages of 2 and 17 years at the first out-of-home interview (approximately 5 to 8 months after entry into foster care). Need for services was determined by a behavior problems score above the borderline cut point on the Parent Report Form of the Child Behavior Checklist (Achenbach, 1991). Mental health service utilization was based on reports by the substitute parent regarding any service use for help with behavioral, social, school, or other adjustment problems. In addition, the type of provider and frequency of visits were elicited from the same informant. The study found that 56% of these children had used mental health services within the period between entry into foster care and the first interview. The proportion using mental health services ranged from 21% of the children age 2 to 3 years, 41% of the children age 4 to 5 years, 61% of the children age 6 to 7 years, and over 70% for children and adolescents over the age of 7 years. These rates contrast sharply with the less than 10% of the same children for whom

there was evidence of mental health care utilization prior to entry into out-of-home placement (Blumberg, Landsverk, Ellis-MacLeod, Ganger, & Culver, 1996). By far, the largest proportion (60%) were being seen by a clinical psychologist. The frequency of outpatient visits for all subjects receiving services (except those in residential care) was relatively high with an estimated mean of 15.4 visits in 6 months. This suggests that the majority of subjects who received outpatient services were in some type of ongoing treatment as opposed to an initial evaluation.

The Tennessee study followed a cohort of 600 children between the ages of 5 to 18 years who were randomly selected from approximately 2,000 children who entered state custody in 24 Tennessee counties over the course of one year. Two-thirds of the sample children were placed in the custody of the child welfare system. The social workers for all of the 600 sample children reported that 14% had been referred for mental health treatment after being placed in custody. No information was included on the actual utilization of services.

A study of 17-year-old youths in out-of-home care in Missouri for an average of six years reported especially high rates of both outpatient and inpatient mental health services (McMillen et al., 2004). McMillen and his colleagues reported that 66% of the 406 youth were receiving some form of mental health services at the time of the baseline interview, 83% reported mental health care within the past 12 months, and 94% had received mental health services within their lifetime. Use of group home or psychiatric inpatient care was reported at very high levels, with 15% having been in inpatient settings within the past 12 months (42% lifetime), and 60% in group home care during the same time period (77% lifetime). This study also reported that 3% of the youth had been in residential drug or alcohol treatment within the past 12 months (8% lifetime). Comparably high rates (84% to 96%) of access to “therapeutic services and supports” have been reported by Pecora and colleagues (2005) for young adults age 20-33 years who had experienced an episode of family foster care during their youth.

A North Carolina survey study generated estimates about the use of mental health services for children in both in-home and out-of-home settings. Farmer et al. (2001) in a re-analysis of North Carolina community youth in the Great Smoky

Mountain study (described in the prior section) found that 90% of youth reported use of mental health services in both the group who had experienced foster care and the group who had had contact with child welfare but had not entered foster care. This was significantly higher than the 70% rate of use reported by youth living in families with incomes below the poverty line.

National estimates of mental health service use for children involved with child welfare have now been published from the NSCAW study. Burns(2004) examined the use of specialty mental health services among children involved with child welfare in both in-home and out-of-home settings and found that youth with mental health needs (defined by a clinical range score on the Child Behavior Checklist) were much more likely to receive mental health services than lower-scoring youth, but that only one-fourth of such youth received any specialty mental health care during the 12 months surrounding early involvement with the child welfare service system. Leslie et al. (2004) examined an additional NSCAW cohort that had been in out-of-home care for at least 12 months and found that over half of the children age 2-15 years had received an outpatient mental health service since the time of investigation leading to placement in foster care.

Factors Associated with Use of Mental Health Care

The studies discussed above also examined factors that were associated with receipt of mental health care for youth residing in foster care. This report will selectively review the most recent findings, especially those based on the NSCAW study. Two published papers from the NSCAW national study both examined clinical and nonclinical factors in reported use of mental health services. Examining mental health care within 12 months of child abuse and neglect investigation, Burns and her colleagues (2004) found that clinical need was related strongly (odds ratio = 2.7-3.5) to receipt of mental health care across all age groups. Nonclinical factors were moderated by age, with sexual abuse (versus neglect) associated with increased use of mental health services among very young children (age 2-5 years). For 6-10-year-olds, African American race and living at home reduced the likelihood of care, while children aged 11 to 15 years were less likely to receive care if they were living

at home instead of out-of-home. Leslie and colleagues (2004) reported use of mental health services within the past 12 months for youth in out-of-home placement during that same period; they found that clinical need, older age, and history of sexual abuse all predicted use of services, while African American children were significantly less likely to have received care.

A very recent paper suggests that the geographic context may shape the relationship between predictors and use of mental health care. Hurlburt et al. (2004) used the NSCAW survey with child welfare participants from 92 geographic areas (97 counties) to examine how patterns of specialty mental health service use might vary as a function of the degree of coordination between local child welfare and mental health agencies. After controlling for the usual predictors of use, including need as measured by the Achenbach CBCL, age, type of placement, and race/ethnicity, the investigators found that increased coordination between child welfare and mental health agencies was associated with stronger relationships between need and service use and decreased differences in rates of service use between Caucasian and African American children. This is the first evidence that "increases in interagency coordination may lead to more efficient allocation of service resources to children with the greatest levels of need and to decreased racial/ethnic disparities." (Hurlburt et al., p. 1184).

Summary

Multiple local area studies across multiple states together with early data from the NSCAW national study demonstrate very high rates of use of mental health services by children in child welfare across all age groups, with the highest rates shown in older adolescents who had been in out-of-home care for an average of 6 years. The studies using Medicaid data confirmed this much higher rate for children in foster care, in contrast to the relatively low rates seen in children served by AFDC. The rates of mental health service usage observed in the North Carolina study were considerably higher than rates observed in the other states but that study did indicate that children in both in-home and out-of-home settings were significantly more likely to receive mental health services than children in families with incomes

below the poverty line. The findings from the NSCAW study indicated that despite these high rates in comparison with community studies, three out of four youth in child welfare who meet a stringent criterion for need were not receiving mental health care within 12 months after a child abuse and neglect investigation. There is growing recent evidence that both clinical and nonclinical factors affect mental health referral and utilization patterns for children in foster care. The nonclinical factors implicated are type of maltreatment, racial/ethnic background, age, and type of placement. The recent review of the race/ethnicity factor by Garland, Landsverk, and Lau (2003) suggests that this nonclinical factor consistently predicts lower use of mental health care for African American youth. Evidence from a national study suggests that coordination between child welfare and mental health agencies may increase the effect of clinical factors and decrease nonclinical factors such as race/ethnicity in use of mental health care (Hurlburt et al., 2004).

III. EVIDENCE-BASED INTERVENTIONS AND PROMISING PRACTICES

The prior sections of this report have used results from a growing body of empirical research to demonstrate the substantial evidence for a high level of need for mental health services and a high rate of use of mental health services for children reported to child protective services, especially in the out-of-home setting of foster care. A reasonable question to ask is whether the use of mental health services ameliorates the mental health problems of this high-risk group. Unfortunately, few studies have been conducted that provide an answer to this question. We do not know enough about whether these services are effective in reducing behavioral and emotional symptoms or enhancing functional outcomes in children reported to child protective services. On a more positive note, children involved with child welfare have been included with other children in studies of selected interventions (e.g., cognitive behavioral therapy for sexual abuse treatment, or treatment foster care). Emerging efforts to focus the development of interventions

on children in foster care (Fisher & Chamberlain, 2000) are encouraging and could be increased.

However, other bodies of research suggest there may not be measurable positive effects of “usual care” mental health services delivered in the type of community settings to which children reported to child protective services are referred. We briefly discuss the overall research findings in order to introduce the issue of a gap between what is known from tightly controlled efficacy studies and the treatment services that children receive in community-based settings.

A large body of efficacy trial research supports the conclusion that psychotherapeutic interventions can produce large improvements in children’s symptoms and functioning in non-child-welfare settings. (Similar evidence exists for the efficacy of psychotropic medications for certain conditions such as attention deficit hyperactivity disorder (ADHD), but that research will not be addressed here.) Evidence to support this claim comes both from meta-analytic studies that review a broad range of psychotherapeutic interventions in the research literature and from criterion-based reviews of interventions for specific kinds of mental health disorders.

Extensive meta-analytic reviews of clinical trial studies (Casey & Berman, 1985; Weisz, Weiss, Alicke, & Klotz, 1987; Kazdin, Bass, Ayers, & Rodgers, 1990; Weisz, Weiss, & Donenberg, 1992; Weisz, Weiss, Han, Granger, & Morton, 1995; Kazdin & Weisz, 1998), conducted by different investigators and using somewhat different review methodologies, have examined the effects of psychotherapeutic interventions on symptoms and functioning across a large number of published studies. Uniformly, these reports have concluded that psychotherapies for children result in improved clinical outcomes. Depending upon the meta-analytic methodology employed (weighted or unweighted least squares), the average treatment effect size (defined as the difference between treatment and control groups, after treatment or at follow-up, divided by the standard deviation of the outcome measure) falls between .5 and .8. These effects are similar to those reported in the meta-analytic literature on adult psychotherapeutic outcomes (Weisz et al., 1992; Weisz et al., 1995). The conclusions of these meta-analyses remain true, even when subjected to extensive re-analyses. For example, the positive

effects of psychotherapy exist across years within the same meta-analyses and in meta-analyses spanning different years. Outcomes are more positive for domains related to the target of the intervention but are not due to the use of outcome measures that are unnecessarily close to the actual treatment process. Effects of treatment are not limited to immediate post-treatment improvements but remain relatively constant across follow-up periods of a year or more. Positive outcomes appear across different problem categories and across different kinds of potential outcome measures, including parental report and child self-report (Casey & Berman, 1985; Kazdin et al., 1990; Weisz et al., 1995). The conclusions of meta-analytic studies are thus quite robust.

Whereas meta-analytic studies and review papers typically examine the impact of psychotherapies generally or a class of treatments (e.g., Baer & Nietzel, 1991; Grossman & Hughes, 1992), alternative methods have been established to determine whether specific psychotherapeutic interventions result in improved outcomes for children. These methods involve establishing a set of criteria for deciding whether sufficient evidence exists to label a psychotherapeutic treatment as empirically supported (Task Force on Promotion and Dissemination of Psychological Procedures Division of Clinical Psychology, 1995; e.g., Chambless & Hollon, 1998). In a series of recent reviews, a number of different psychosocial interventions fulfilled the criteria for either “probably efficacious” or ”well-established” (Chambless et al., 1996; Birmaher, Ryan, Williamson, Brent, & Kaufman, 1996; Rogers, 1998; Ollendick & King, 1998; Pelham, Wheeler, & Chronis, 1998; Brestan & Eyberg, 1998; Kazdin & Weisz, 1998; Kaslow & Thompson, 1998; American Academy of Child and Adolescent Psychiatry, 1998), including treatments for depression and conduct disorders, two of the most common problems presenting for care in public mental health service systems (Rosenblatt, Rosenblatt, & Biggs, 2000). Therefore, from both the meta-analytic perspective and the criterion-based perspective, relatively clear evidence exists that psychosocial interventions can result in moderate to large improvements in client outcomes both at the close of treatment and over follow-ups of one year or more.

In contrast to the strong evidence demonstrating the efficacy of psychotherapeutic interventions generally, and of specific treatments in particular, evidence supporting the effectiveness of mental health treatment ***delivered in community settings*** is quite weak. In a meta-analytic review of studies that compared children receiving treatment in a community setting with children receiving no treatment, Weisz, Donenberg, Han, and Weiss (1995) identified nine studies sufficiently well designed for some conclusions to be drawn. Across the nine studies reviewed, effect sizes for treatment relative to a no-treatment control ranged from -.4 to +.29, with an overall mean effect size of .01. Not surprisingly, this was not significantly different from zero and amounted to no clinically important impact. A closer review of the studies included in this meta-analysis reveals that a number of studies provided relatively good tests of the impact of care delivered in community treatment settings (e.g., Levitt, Beiser, & Robertson, 1959; Jacob, Magnussen, & Kemler, 1972). The studies generally compared children receiving no treatment to children receiving extensive treatment. Tests were conducted to confirm the comparability of groups at baseline, and in some cases quite large sample sizes were employed. An alternative view is that most of these studies were conducted decades ago, did not utilize a controlled research design, and may not reflect community care in the 21st century.

Over all, there is little evidence to suggest that measurable benefit in lowered mental health symptom levels or increased functioning can be expected from the receipt of "usual" mental health care in public mental health community settings that serve children and adolescents who experience foster care. This has led to a sharp focus on bringing therapeutic interventions into these settings that have better potential for addressing the mental health problems of this clientele. A selective review of these evidence-based interventions and promising practices is provided in Section Three, which is directed toward the Casey Family Programs' questions about what mental health interventions have been evaluated. In the language of this era with its focus on evidence-based medicine and evidence-based interventions, the field is directed toward treatments/interventions that have been tested empirically, usually in randomized clinical trials (RCTs), and have been shown to

demonstrate greater benefit (improved outcomes) for youth receiving the treatment tested versus usual care or an alternative intervention.

In this section, three major questions are examined. "What is evidence?" explores the criteria for evidence and how these vary as multiple professional organizations have become engaged in examining evidence. Second, the question "What is the evidence?" is pursued. To do so, the evidence for four of the most common disorders (i.e., PTSD and abuse-related trauma, disruptive behavior disorders, depression, and substance abuse) is presented. Then, since many youth placed in foster care experience multiple disorders and difficulty functioning at home, at school, and/or in the community, intensive home and community-based services, which are applicable to these higher-risk youth are described and reviewed. The third question asks about the status of evidence-based interventions in the practice community, and it addresses the spread (or availability) of such interventions and relevant experience with them in the foster care population.

What Is Evidence?

The expectation that evidence even existed for child mental health interventions was low until the extant scientific literature was pulled together for the Surgeon General's Report on Mental Health in 1999 (U.S. Department of Health and Human Services, 1999). The surprising finding was that significant evidence existed for the treatment of a number of common childhood disorders, even when stringent criteria were applied. Since then, further treatment development research has strengthened the potential to intervene effectively for trauma/PTSD, disruptive behavior disorders, and depression, conditions that occur frequently in the foster care population and in the general population, as well as interventions for more complex or persistent conditions that are also common among youth in foster care.

Prior to 1999 and during the years since, multiple organizations have become engaged in defining criteria for evidence and categorizing interventions on the basis of "well established" at the highest level to "concerning treatment" (meaning potentially harmful). The proliferation of criteria and lists of evidence-based practices may have created confusion around understanding what works (i.e., is effective) and

does not work for youth with emotional and behavioral problems. A number of registries, including those created by the federal government, vary in the quality of evidence required, from multiple controlled trials to self-nominated “promising practices” with some indication of benefit from uncontrolled studies. These registries and reports offer additional information from federal and state agencies and independent research organizations beyond the scope of what we have presented in this report (see Appendix A for a listing of these resources and registries).

For this review, we have adopted a conservative approach by including those interventions that (1) merit the highest standards of evidence while also commenting upon several that may be deleterious or dangerous; (2) address the range of common conditions, as the evidence permits; and (3) identify developmental, or at least age-appropriate, interventions as feasible for pre-school, school age, and adolescent youth. The major criteria relied upon here are those proposed by the Division of Clinical Psychology of the American Psychological Association (Lonigan, Elbert, & Johnson, 1998; Chambless & Hollon, 1998). To be identified as “well established,” the following criteria were applied:

- At least two controlled group design studies or a large series of single-case design studies
- Minimum of two investigators
- Use of a treatment manual
- Uniform therapist training and adherence
- True clinical samples of youth
- Tests of clinical significance of outcomes
- Functioning outcomes plus symptoms
- Long-term outcomes beyond termination

The major difference in the second level standard, “probably efficacious,” is that a single investigator has conducted controlled studies on the intervention, in contrast to the two or more controlled studies required for “well established.” These criteria represent a high standard and are relatively easy to apply to the scientific literature on diagnostic-specific psychosocial interventions. The APA standards have not been applied officially in the recent published literature either to

diagnostic-specific interventions or to intensive home- and community-based services. However, we have applied these standards for this report.

What Is the Evidence for Interventions Addressing PTSD and Abuse-Related Trauma, Disruptive Disorders, Depression, and Substance Abuse?

PTSD and abuse-related trauma

Child abuse and neglect constitute the principal reason for children being placed in foster care. Children who suffer from abuse and neglect often exhibit physical, emotional, behavioral, and other symptoms (see Curie, 2002, for a developmental review). Young children (up to age 5 years) are likely to experience generalized fear that can manifest in various ways such as heightened arousal, nightmares, clinging to caregivers, and/or a startle response to loud or unusual noises. In school-aged children (6-11 years), general fearfulness may be accompanied by guilt, aggression, social withdrawal, and loss of concentration. For adolescents (age 12 to 18 years), symptoms may also include a decline in school performance, rebellion at home or school, eating disturbances, and trauma-driven acting out such as early sexual activity and other types of risk-taking. These symptoms are in line with those associated with post-traumatic stress disorder (PTSD) as defined by the DSM-IV (American Psychiatric Association, 1994). As such, treatments provided to children with histories of abuse focus largely on relieving PTSD symptoms. The effectiveness of these treatments has been examined in recent reviews, and the findings will be presented in this section.

Four reviews of treatment for child abuse and neglect have been completed in the last three years (Saunders, Berliner, & Hanson, 2002; Kolko & Swenson, 2002; Chadwick Center for Children and Families, 2004; Chaffin & Friedrich, 2004). The criteria used in these reviews to determine which treatments are effective broadly follow the guidelines on “what is evidence” discussed earlier. The method for each

review is described briefly below to provide context for the main findings on which interventions are best supported.

The primary aim of one review done by the Office for Victims of Crime [(OVC] (Saunders et al., 2002) was to identify the treatments with the strongest research evidence. A secondary aim was to more generally review and document the research base for common treatments for children with abuse histories. These goals necessitated a very comprehensive and specific set of criteria for classifying interventions according to the type and quantity of evidence collected. The criteria that were used (shown in Appendix B) prioritized experimental control up to the top category ("well-established"), which requires evidence from RCTs. The full list of treatments reviewed and the findings on their research support can be viewed at the OVC website (http://www.musc.edu/cvc/guide1.htm).

The aim of the Kauffman report (Chadwick Center for Children and Families, 2004) was also to identify the leading interventions for children with abuse histories. The OVC findings were reviewed, and a simplified classification scheme was applied, which resulted in three interventions being labeled "best practices." The Kauffman guidelines also prioritized level of experimental control as the top marker for reliable evidence. However, because the goals did not include review of a wide array of common treatments as in the OVC report, fewer criteria were needed. To be classified as a leading intervention, a treatment had to demonstrate a sound theoretical basis and have a manual, acceptance in clinical settings, and at least one RCT. The final report can be accessed through the Chadwick Center for Children and Families website at http://www.chadwickcenter.com/kauffman.htm.

The remaining two published reviews took a slightly different approach (Kolko & Swenson, 2002; Chaffin & Friedrich, 2004). Their aim was to present the most rigorously researched and the most commonly provided interventions organized by type of trauma history (e.g., physical abuse, sexual abuse, neglect). Although specific criteria for classifying treatments in terms of research support were not presented, the authors were more supportive of treatments that had been subjected to controlled research from which positive findings emerged.

In addition to these four reviews, the National Child Traumatic Stress Network (NCTSN) has compiled a list of treatments for child trauma, classified according to the OVC guidelines. The NCTSN intervention list differs from that of the OVC report because it includes treatment for all types of trauma, not just abuse and neglect. The NCTSN list is available on the Internet at http://www.nctsnet.org and is slightly more up-to-date than the other reviews presented here. That website also includes a fact sheet for each treatment, which presents a summary of the treatment model and the research that has been conducted on its effectiveness.

Despite the fact that these reviews did not use identical criteria to classify treatments in terms of their research support, each one prioritized experimental control, and their results do converge to reveal a degree of expert consensus on the leading candidates in the field. Three clear frontrunners emerged as the most well-supported interventions for children with histories of abuse. These interventions have been subjected to rigorous analysis in the form of RCTs. Each intervention is described below, and the evidence for their effectiveness is briefly reviewed. Table 1 provides summary information for each treatment, including citations to controlled treatment studies. Information on training materials and dissemination can be found in the NCTSN fact sheets for all of the following treatments with the exception of Project 12-Ways/Safe Care for Child Neglect.

Table 1. Well-established and probably efficacious interventions for child trauma

Intervention	Target Population	Controlled Studies (RCT* or quasi-experimental)	Main findings
Trauma Focused CBT	Children (4-18 years) with emotional and behavioral disturbance related to traumatic events, even if there is no PTSD diagnosis	RCTs Cohen & Mannarino (1996) Cohen & Mannarino (1997) Cohen & Mannarino (1998) Cohen, Mannarino, & Knudsen (2005) Cohen, Deblinger, Mannarino, & Steer (2004) Deblinger, Lippman, & Steer (1996) Deblinger, Steer, & Lippman (1999) Deblinger, Stauffer, & Steer (2001)	• Improvement in child PTSD, depression, anxiety, behavior problems, sexualized behaviors, and feelings of shame and mistrust • Decreased parental depression and emotional distress about the child's abuse • Improvement in parental child support and parenting practices
Abuse-Focused CBT	Physically abusive parents and their children	RCTs Kolko (1996a) Kolko (1996b)	• Decreased parent use of physical discipline • Decreased parent anger problems • Decreased child behavior problems • Decreased child aggression towards parent • Decreased family conflict
Parent-Child Interaction Therapy	Physically abusive parents and their children age 4-12	RCTs Chaffin et al. (2004)	• Decreased parent physical abuse • Reduced negative parent-child

	years	 Quasi-experimental Eyberg, Boggs, & Algina (1995) Borrego, Urquiza, Rasmussen, & Zebell (1999) Eyberg et al. (2001) Boggs et al. (2004) Timmer, Urquiza, Zebell, & McGrath (2005)	interactions • Maintenance of effects at long-term follow-up (3 to 6 years after treatment)
Child-Parent Psychotherapy for Family Violence	Children up to age 5 years who have witnessed traumatizing domestic violence	RCTs Toth, Maughan, Manly, Spagnola, & Cichetti (2002) Cicchetti, Rogosch, & Toth (2000) Lieberman, Van Horn, & Ghosh Ippen (2004) Lieberman, Weston, & Pawl (1991)	• Decreased PTSD symptoms • Decreased behavior problems • Decreased maternal avoidance
CB Intervention for Trauma in Schools (CBITS)	Children age 10-15 years who have witnessed traumatic events	RCTs Stein et al. (2003) Quasi-experimental	• Improvement in PTSD and depressive symptoms • Maintained improvements at 6-month follow-up

		Kataoka et al. (2003)	
TF-CBT for Childhood Traumatic Grief	Children who have experienced both trauma and loss of a loved one	Quasi-experimental Cohen, Mannarino, & Knudsen (2004) Cohen, Goodman, Brown, & Mannarino (2004)	• Improvement in PTSD, grief depression, anxiety, and behavior problems in children • Improvement in PTSD and depression in parents
Project 12-Ways/Safe Care for Child Neglect	Children who have suffered neglect	Quasi-experimental Gershater-Molko, Lutzker, & Wesch, (2002) Lutzker & Rice (1987) Taban & Lutzker (2001) Lutzker, Bigelow, Doctor, & Kessler (1998)	• Improved assertion skills • Improved job skills • Improved home management skills

*RCT = Randomized clinical trial

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

TF-CBT addresses behavioral and emotional symptoms as well as the negative thought patterns associated with childhood trauma. Treatment is targeted at both the parent and the child. A PTSD diagnosis is not necessary; rather, the child must exhibit behavioral or emotional problems related to a past trauma experience. The model is clinic-based and short-term (results are expected within 12-16 weeks). Some of the essential components of TF-CBT include:

- Establishing and maintaining a therapeutic relationship with child and parent
- Emotion regulation skills
- Connecting thoughts, feelings, and behaviors associated with the trauma
- Stress management skills
- Parenting skills training
- Personal safety skills training
- Coping with future trauma reminders

TF-CBT has been the focus of several RCTs. It has been compared to non-directive play therapy and supportive therapies in children aged 3 to 14 years who have been subjected to multiple types of trauma (Deblinger et al., 1996; Cohen & Mannarino, 1996; Cohen & Mannarino, 1997; Cohen & Mannarino, 1998; Deblinger et al., 1999; Deblinger et al., 2001; Cohen et al., 2004; e.g., Cohen et al., 2004; Cohen et al., 2005). TF-CBT has been linked to improvements in PTSD symptoms, depression, anxiety, behavioral problems, and feelings of shame and mistrust. Moreover, these improvements have been maintained following treatment completion (Deblinger et al., 1999). When parents are also involved in TF-CBT, research has shown that the positive effects for children increase (Deblinger et al., 1996). This occurs through improvement of parental depression, support of the child, emotional distress about the child's abuse, and parenting practices.

Abuse-Focused Cognitive Behavioral Therapy for Child Physical Abuse (AF-CBT)

AF-CBT was developed by Kolko and is fully described in Kolko and Swenson (2002). AF-CBT is delivered in an outpatient setting to physically abusive parents and their school-age children. Treatment is brief (12-18 hours) and can be applied in either the clinic or the home. The model incorporates aspects of learning/behavioral theory, family systems, and cognitive therapy. Individual child and parent characteristics are targeted as well as the larger family context. Both risks and sequelae associated with abuse are addressed (e.g., parenting skills and beliefs, child behavioral and emotional problems). Some essential components of AF-CBT are presented below. These interventions can be directed at the child, the parent, or both.

- Instruction in specific interpersonal skills
- Instruction in specific intrapersonal skills (e.g., cognitive, affective)
- Promoting prosocial behavior
- Discouraging coercive/aggressive behavior at both individual and family levels
- Coping skills
- Relaxation training
- Anger management

AF-CBT has been compared to family therapy and routine community services (see Chalk & King, 1998, and Kolko & Swenson, 2002 for review). AF-CBT led to decreases in parental anger and use of physical discipline and force (Kolko, 1996a, 1996b). These changes occurred more quickly than similar changes seen in family therapy and to a greater degree than seen in routine community services. Over the follow-up period, both AF-CBT and family therapy were superior to routine community services on decreasing child-to-parent aggression, child behavior problems, and parental child abuse potential, psychological distress, and drug use. Families in these two conditions demonstrated more cohesion and less conflict.

Parent-Child Interaction Therapy (PCIT)

PCIT is a highly structured treatment model involving both parent and child. Originally developed for children with behavioral problems, PCIT has been adapted for physically abusive parents with children age 4 to 12 years. Treatment is brief (12-20 sessions) and involves live-coached sessions where the parent/caregiver learns skills while engaging in specific play with the child. The overarching goal of PCIT is to change negative parent-child patterns. The time in each session is usually divided between relationship-enhancing, positive discipline, and compliance skills. Specific parent and child behaviors are tracked and charted on a graph during each session, and the therapist provides feedback to the parent on his or her mastery of the skills. Some of the specific components of treatment include:

- Relationship-enhancing skills
- Positive discipline and compliance skills
- Homework sessions of 5-10 minutes daily to reinforce skills taught in session
- Parenting skills
- Booster sessions following treatment completion

Studies of PCIT fall in two categories: (1) those involving children with behavior problems regardless of whether they have any maltreatment history, and (2) those involving children with a history of abuse regardless of whether they have a diagnosable behavior problem. With respect to the first category, several quasi-experimental studies have been conducted. These have demonstrated improvement from pre- to post-treatment (Eyberg et al., 2001) and significantly better outcomes for children and parents who completed treatment versus families who were on the wait-list (Eyberg et al., 1995) or who did not complete treatment (Boggs et al., 2004). These positive outcomes have been maintained for as long as three to six years following treatment completion (Hood & Eyberg, 2003).

With respect to the second category, one RCT and two quasi-experimental studies have been conducted. The RCT randomly assigned

abusive parents and their children to PCIT, to enhanced PCIT (with additional individualized services), or to a standard community-based parenting group (Chaffin et al., 2004). PCIT and enhanced PCIT were similarly superior to the parenting group at decreasing subsequent reports of physical abuse.

The most recent quasi-experimental study examined PCIT for biological parent-child dyads with histories of maltreatment or at high risk for maltreatment (Timmer et al., 2005). From baseline to post-treatment, these families showed decreases in child behavior problems, parental stress, and risk for future abuse. Another earlier study examined a single case of a child and parent at risk for physical abuse (Borrego et al., 1999). The child's behavior problems decreased following treatment as did the mother's stress. The number of positive parent-child interactions also increased.

Given the fact that PCIT has garnered evidence for its effectiveness with both children with behavior problems and children with abuse histories, it is viewed as having great potential for children and families in foster care in which these problems often overlap.

In addition to these well-established interventions, four others have received support from controlled research and are cited or categorized as supported interventions in the reviews listed above. These treatments are also considered leading candidates, although the research lags slightly behind that of the three candidates presented above. These interventions, described briefly below, are included here to provide evidence for addressing types of trauma not targeted by the interventions above.

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) for Child Traumatic Grief

TF-CBT for Childhood Traumatic Grief is designed to help children suffering from traumatic grief after experiencing the loss of a loved one in traumatic circumstances. These children often have PTSD symptoms, depression, anxiety, and/or behavior problems that prevent them from successfully grieving their loss. The therapy model is calibrated for two age

groups: children up to 6 years, and children and adolescents over age 6 years. Treatment is provided to both child and caregiver (together and alone) and occurs over 12 to 16 sessions, focused at first on trauma and then on grief. The model pays special attention to cognitive, behavioral, and physiological reactions to the combination of trauma and bereavement, most notably sadness and fear (see Brown, Pearlman, and Goodman, 2004, and Cohen and Mannarino, 2004, for description). The components of the model are similar to those for TF-CBT but with added focus on fear and sadness resulting from bereavement.

The evidence base for TF-CBT for Childhood Traumatic Grief is only just emerging because the treatment is relatively new. Two open trials have focused on children age 6 to 17 years who lost parents in the September 11, 2001 terrorist attacks. These trials have linked specific components of treatment to targeted changes in symptoms over time (Cohen, Goodman, et al., 2004; Cohen, Deblinger, et al., 2004). These findings, along with the success of TF-CBT for child trauma, suggest that this intervention is a leading candidate for children who are doubly exposed to trauma and bereavement.

Cognitive Behavioral Intervention for Trauma in Schools (CBITS)

CBITS is a group intervention focused on building skills for children suffering symptoms of PTSD, depression, and anxiety related to trauma. Some of the skills taught include relaxation, social problem solving, challenging upsetting thoughts, and processing traumatic memories and grief. CBITS is commonly used for children age 10 to 15 years who have experienced or directly witnessed a traumatic event, including violence. One RCT compared early intervention CBITS to late intervention CBITS (Stein et al., 2003). Children who received CBITS earlier following trauma (the early intervention group) demonstrated more positive responses to outcome than those who received the intervention later. Both groups improved over time. A second quasi-experimental study involving 198 Latino immigrant children compared CBITS to a wait-list control group, revealing greater improvement in the CBITS group (Kataoka et al., 2003).

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

CPP-FV is an individual psychotherapy model for infants, toddlers, and preschoolers who have witnessed domestic violence or display symptoms of violence-related trauma such as PTSD, defiance, aggression, multiple fears, and difficulty sleeping. The treatment incorporates aspects of psychodynamic, attachment, trauma, cognitive-behavioral, and social-learning theories. Treatment is delivered in a dyad and targets the child-parent relationship and the individual child's functioning. Typically, treatment is delivered for one hour per week for approximately 12 months. Randomized trials have compared CPP-FV to non-intervention control groups as well as other interventions, e.g., psychoeducational home visitation, standard community treatment (Lieberman et al., 1991; Cicchetti et al., 2000; Toth et al., 2002). Findings have shown better outcomes for children who received CPP-FV compared to children receiving other control or comparison treatments. The outcomes that have been measured include behavior problems, symptoms of traumatic stress, and maternal avoidance (mother avoiding the child).

Project 12-Ways/Safe Care for Child Neglect

Project 12-Ways/Safe Care is focused on child neglect. Like abuse, neglect is a form of maltreatment that places children at risk for mental health problems. This is why Project 12-Ways is included here, despite the fact it is technically considered prevention. The intervention targets the ecology in which the child and family live and is based on behavioral principles (Lutzker, Van Hasselt, Bigelow, Greene, & Kessler, 1998). Parents are taught skills in safety, bonding, and health care. The intervention often incorporates video modeling and is used for both prevention and treatment. The evidence has been reviewed by Chaffin and Friedrich (2004) and Kolko and Swenson (2002) and consists of as many as 60 program evaluations and quasi-experimental studies, some of which are listed in Table 1. These evaluations have shown improvement in both interpersonal (social interactions, assertion skills) and functional (job training, home management skills) domains for parents.

These seven leading interventions are presented in Table 1 along with summary information regarding the target population, outcomes, and references for the controlled studies on each intervention. Many other treatments that are often provided to children in foster care are not included because the research on their effectiveness is either less promising or still emerging. Examples include Cognitive Behavior and Dynamic Play Therapy, Eye Movement Desensitization and Reprocessing, Physical Abuse-Informed Family Therapy, and others. Some treatments may be harmful, such as Corrective Attachment Therapy. This treatment features holding therapy, a type of physical restraint, which has led to physical injury in several reported cases. Readers are encouraged to visit the websites of the NCTSN (http://www.nctsnet.org) and the OVC (http://www.musc.edu/cvc/) for more information on these treatments.

Medication for Trauma

Pharmacological intervention is another option for children with histories of abuse. When medication is prescribed, this is usually done “off-label,” (i.e., the medication has not yet been explicitly endorsed for treatment of this population), and it is combined with behavioral treatment. One highly controlled, randomized study compared TF-CBT plus placebo to TF-CBT plus SSRI (sertraline/Zoloft) for children 10 to 17 years with PTSD related to sexual abuse (Cohen, 2005). The study found a significant effect for sertraline over and above the effects of TF-CBT alone in remitting PTSD symptoms. These very preliminary findings suggest that a combination of TF-CBT and SSRI treatment may be a promising topic for future research. Some caution is warranted here, however, as the sample size for this study was small (n=20 for each group).

Further research should be conducted on the potential utility of medication for maltreated children. Until more evidence is available on the efficacy of SSRIs for maltreated children, and until the current controversy surrounding the suicide risk of certain SSRIs in children moves towards resolution, caution should be taken in writing such prescriptions.

In summary, several treatments appear to be effective at improving outcomes for children who experience trauma-related symptoms related to a history of abuse. These treatments have been chosen and described by independent review teams. Research on these interventions has also shed light on some common characteristics of effective treatments for children who have experienced trauma. Specifically, treatment is more effective when it is brief and when parents are involved. These findings are promising and give hope that children who receive evidence-based treatment for child abuse and neglect can have significantly improved lives.

Disruptive Behavior Disorders

The evidence base on treatment for disruptive behavior disorders has been reviewed by Brestan and Eyberg (1998); Farmer, Compton, Burns, and Robertson (2002); and Weisz (2004). The discussion below follows from these reviews. Two models (Parent-Child Interaction Therapy [PCIT] and Multisystemic Therapy [MST]) that are evidence-based for disruptive behaviors are described in other sections because PCIT has also been evaluated for trauma and MST as an intensive home-based intervention will be described in a later section on community-based treatment. Table 2 presents the well established and probably efficacious treatments that were identified through review.

Parent Management Training

Parent management training programs were originally developed by Gerald Patterson at the Oregon Social Learning Center in the 1960s. These programs are based on the principles of operant conditioning, i.e., rewarding positive behaviors and ignoring or punishing deviant behaviors. Intervention is usually targeted for preschool-age children. Treatment is short term and teaches parents behavioral management skills. Compared to psychodynamic therapy and no-treatment controls, parent management training has produced superior outcomes for children with conduct disorder. Patterson's work has spawned

intervention development by a number of investigators (e.g., Chamberlain, Reid, Dishion, Forehand & McMahon, Webster-Stratton, Eyberg).

Table 2. Well-established and Probably Efficacious Interventions for Disruptive Behavior Disorders

Target age	Intervention
Preschool	Parent Management Training Incredible Years Parent-Child Interaction Therapy (age 2-8 years) Time Out plus Signal Seat
School age	Anger Coping Problem Solving Skills Training
Adolescent	Multisystemic Therapy Assertiveness Training Rational Emotive Therapy Anger Control Training with Stress Inoculation

Incredible Years

Incredible Years, an intervention developed by Webster-Stratton and with roots in parent management training, also teaches behavior management skills to parents of preschool-age children with behavior problems (see Farmer et al., 2002, for review). Videotapes depicting parent-child vignettes are shown to parents in a group setting, and subsequent discussion is guided by a therapist. Parents attend approximately 12 two-hour sessions. Incredible Years has been subjected to at least seven randomized trials where improved parenting skills have been achieved.

Time Out plus Signal Seat

Time-Out plus Signal Seat is a self-instructive parenting intervention, also based on operant conditioning and targeted for preschool-age children. A manual presents parents with specific instructions on using positive reinforcement and

time-out. The signal seat, on which the child sits during the time-out, is wired to produce a noise if the child leaves the seat. In a study comparing the intervention to wait-list control for children 2 to 7 years, those in the treatment group demonstrated fewer negative behaviors (Hamilton & MacQuiddy, 1984).

Anger Coping, Problem Solving, and Assertiveness Training

These interventions are most often provided in schools and are intended to help children and adolescents with behavioral problems to learn skills to cope in challenging situations. Controlled studies have been conducted in both school and clinical settings, comparing these types of programs to usual school services and parent management training (e.g., Huey & Rank, 1984; Lochman, Lampron, Gemmer, & Harris, 1989; Kazdin, Siegel, & Bass, 1992). These studies suggest that learning these skills can help children to control negative behaviors. Assertiveness training in particular has shown positive findings with African American adolescents (Feindler, Marriott, & Iwata, 1984). Positive results have been maintained up to one-year post-treatment.

Anger Control Training with Stress Inoculation

This intervention targets both anger management skills and coping skills. The therapist's goal is to help adolescents understand the causes and consequences of anger. The stress inoculation component exposes the adolescent to a trigger situation so that the child can practice his or her control and coping skills in a constructive environment. Treatment is provided by a therapist, in a clinical or school-based setting, over approximately 10 one-hour sessions. Controlled studies have supported its efficacy with 12- to 18-year-olds displaying delinquency or disruptive classroom behavior (Schlichter & Horan, 1981; Feindler et al., 1984).

Rational Emotive Therapy (RET)

RET incorporates cognitive components similar to that of CBT, including training in moral reasoning. This treatment is relevant for youth with conduct disorder because their moral reasoning and judgment skills are often underdeveloped. Treatment is short term and provided by a therapist in weekly sessions. Fonagy, Target, Cottrell, Phillips, and Kurtz (2002) have written the most recent review of RET for children with behavioral problems. They found that the only controlled studies in this area were conducted at least 20 years before (Block, 1978; Arbuthnot & Gordon, 1986). One study (Block) included both Hispanic and African American adolescents. Comparison groups received client-centered therapy or no treatment. In these studies, adolescents who received RET demonstrated higher school achievement and fewer disruptive behaviors. These positive results were maintained at six-month follow-up in the Block study and one-year follow up in the Arbuthnot and Gordon study.

Medication for Disruptive Behavior Disorders

The research evidence for psychopharmacological intervention for disruptive behavior disorders in children and adolescents was most recently reviewed by Fonagy et al. (2002) and Pappadopulos, Guelzow, Wong, Ortega, and Jensen (2004). What follows is a brief review of the evidence.

Stimulants are commonly used to treat behavior problems when they are comorbid with attention deficit hyperactivity disorder (ADHD). Meta-analysis has suggested that these drugs can have positive effects for children with both diagnoses (Steiner, Saxena, & Chang, 2003). However, one highly controlled RCT of methylphenidate (Ritalin) found that children with behavior problems but not ADHD experienced increases in disruptive behaviors when treated with methylphenidate (Klein et al., 1997). More research is needed for children with behavioral problems who do not have comorbid ADHD.

Antipsychotics such as risperidone have also been used to treat behavior problems in children and adolescents. Results from two recent RCTs suggest that risperidone may be effective, compared to placebo, for reducing disruptive behaviors (Turgay, Binder, Snyder, & Fisman, 2002; Aman, De Smedt, Derivan,

Lyons, & Findling, 2002). These improvements were maintained up to one year post-treatment. However, caution is warranted in interpreting these results. First, the children in the first study had IQs ranging from 36 to 84. Second, in both studies, negative side effects such as weight gain, headache, somnolence/drowsiness, and vomiting were reported by as many as 52% of those receiving risperidone.

Mood stabilizers such as lithium have also been studied in RCTs with children exhibiting behavior problems. Lithium, in particular, has shown positive results compared to placebo in reducing aggression (Geller et al., 1998; Malone, Delaney, Luebbert, Cater, & Campbell, 2000). In addition, two RCTs of divalproex (Depakote) have shown significant reductions in disruptive behaviors (Donovan et al., 2000; Steiner, Petersen, Saxena, Ford, & Matthews, 2003). As with antipsychotics, negative side effects have also been reported with mood stabilizers (e.g., vomiting, ataxia, enuresis, fatigue, weight gain).

Finally, research on SSRIs for children with behavior problems has begun to emerge. One quasi-experimental study involving 12 youths in outpatient treatment demonstrated positive effects for citalopram (Celexa) (Armenteros & Lewis, 2002). Because SSRIs can cause behavioral disinhibition, caution has been stressed in the use of SSRIs for this population. Although early findings are promising, it is clear that more research is needed to determine the safety and efficacy of SSRIs for children with disruptive behavior disorders.

Depression

Depression is another common mental health consequence for children who have been abused and neglected. Both psychosocial and psychopharmacological interventions have been studied. Weisz, Hawley, and Doss reviewed the evidence on psychosocial treatments for child mental health disorders in 2004. Research on medication was reviewed by Pappadopulos et al. in the same 2004 volume. Interventions that have received the strongest research support are summarized below. For more detail, see Weisz et al. and Pappadopulos et al..

Psychotherapy

The leading psychotherapy treatment models for depression are Coping with Depression and Interpersonal Therapy for Adolescents. Self-control training, relaxation therapy, and cognitive behavior therapy have also received support from controlled research.

Coping with Depression is a course, originally designed for adults, that has been calibrated for use with adolescents. The course consists of 16 two-hour sessions focusing on topics such as monitoring moods, relaxation training, developing social skills, decreasing anxiety, and conflict resolution. Coping with Depression is usually delivered in a group setting, and there is an optional parent component where parents are taught similar content in fewer sessions. Three large controlled trials with children have produced positive results for Coping with Depression compared to wait-list control (Lewinsohn, Clarke, Hops, & Andrews, 1990; Clarke, Rohde, Lewinsohn, Hops, & Seeley, 1999; Kaufman, Rohde, Seeley, Clarke, & Stice, 2005).

Interpersonal Therapy for Adolescents (IPT-A) has also received support from controlled research trials. IPT-A is a brief treatment that targets several interpersonal problems that often underlie depression. Two RCTs have been conducted, one of which was focused on Puerto Rican adolescents (Rosselló & Bernal, 1999; Mufson, Weissman, Moreau, & Garfinkel, 1999). In both studies, IPT-A was superior to wait-list control in reducing depressive symptoms and increasing social functioning. In addition, in the study involving Puerto Rican youth, IPT-A was equal to CBT in reducing symptoms and superior to CBT in improving general functioning (Rosselló & Bernal, 1999).

Kaslow and Thompson (1998) reviewed the evidence base for self-control therapy. This treatment incorporates cognitive and behavioral techniques to help the child monitor his or her mood and activity, manage aversive events, and develop his or her own self-reinforcement patterns. Treatment is time-limited and can be delivered in either an individual or group setting. Self-control therapy has been compared to behavioral problem-solving therapy and wait-list control (Stark,

Reynolds, & Kaslow, 1987). In this study, children in both intervention groups improved significantly more than children on the wait-list. Enhanced self-control therapy (with increased number of sessions and monthly family meetings) has also shown superior results to traditional counseling (Stark, Rouse, & Livingston, 1991).

Relaxation therapy was compared to CBT and self-modeling in one RCT (Kahn, Kehle, Jenson, & Clark, 1990) and to CBT in another (Reynolds & Coats, 1986). In these studies, relaxation therapy decreased depression and anxiety as well as increased self-esteem among junior high and high school students. Relaxation therapy is also commonly included as a component of group-based therapy such as Coping with Depression for adolescents.

The results for CBT are mixed (see Burns, Hoagwood, and Mrazek, 1999, and Fonagy et al., 2002, for review). CBT has demonstrated positive results in controlled studies (Reynolds & Coats, 1986; Brent et al., 1997), including one with Puerto Rican youth (Rosselló & Bernal, 1999). Two other studies have suggested no superior effects for CBT compared to control groups (Vostanis, Feehan, Grattan, & Bickerton, 1996; Clarke et al., 2002). Samples have included children with subclinical symptom levels, and sample sizes have been small. In addition, the little long-term follow-up research that has been conducted has not produced promising results (Wood, Harrington, & Moore, 1996). Some research suggests that monthly booster sessions following treatment completion can help reduce relapse (Kroll et al., 1996). Finally, two meta-analyses using different methods have found positive outcomes for CBT (Reinecke, Ryan, & DuBois, 1998; Harrington, Whittaker, Shoebridge, & Campbell, 1998). Future controlled research on CBT for children and adolescents with depression should help to clarify its potential role in treating this population.

Medication for Depression

The use of psychotropic medication to treat child and adolescent depression has increased over the last decade. RCTs comparing SSRIs to placebo for child and adolescent depression have produced significant, positive

findings in four studies (Emslie et al., 1997; Strober et al., 1999; Keller et al., 2001; Wagner et al., 2003) and positive but not statistically significant findings in one study (Simeon, Dinicola, Ferguson, & Copping, 1990). Tricyclic antidepressants have not shown similar positive results (see Hazell, O'Connell, Heathcote, and Henry, 2002, and Fonagy et al., 2002, for review). In these studies, medication is typically prescribed to children in the intervention group in low doses with close monitoring for approximately 12-16 weeks.

Combined Psychotherapy and Medication

A more recent multi-site trial (n=433) has examined the combined effects of psychosocial treatment and medication for child and adolescent depression. The Treatment for Adolescents with Depression Study (TADS) was an RCT with four conditions: (1) SSRI alone, (2) CBT alone, (3) combined SSRI and CBT, and (4) placebo (Treatment for Adolescents with Depression Study (TADS) Team, 2005a).[1] Adolescents who received combined SSRI and CBT showed the most improvement. Those who received SSRI alone experienced greater improvement than those who received CBT alone. The TADS was the first and only study to examine a combined medication and psychotherapy model in comparison to medication or psychotherapy alone. Although the initial results are promising, more research is needed to replicate these results and to clarify their meaning over time and for diverse child mental health needs.

As with the use of medication for child trauma, the main message on the use of pharmacological intervention for children with depression is one of cautious optimism. Because of the risk of an increase in suicidal symptoms, close medical monitoring in the early weeks of treatment with an SSRI is critical.

Substance Abuse

Children in the foster care system who suffer from PTSD, behavioral disorders, and/or depression often experience problems related to substance use during adolescence. These problems include early substance use (prior to age

14 years) and/or heavy use of substances in the mid- or late-adolescent period. Below, three treatment approaches with supporting evidence are reviewed broadly (brief interventions, cognitive behavior therapy, and family-based interventions). In addition, the evidence for residential treatment centers, inpatient treatment, the 12-step model, and medication is briefly reviewed to provide information on these commonly used interventions.

Brief Interventions

Brief interventions are used to reduce harmful consumption of alcohol, tobacco, and other drugs. These are shorter in tenure than more traditional interventions and are primarily intended to address an adolescent's motivation to attend treatment. A recent review of brief interventions (Tait & Hulse, 2003) identified 11 studies involving more than 3,000 adolescents. Most studies included motivational interviewing, the leading brief intervention model. Three studies included health education programs. Generally, these brief interventions have shown small to moderate effects. Specific improvements have included decreases in consumption as well as related problems and consequences, and increased treatment engagement (Tevyaw & Monti, 2004). Results have been stronger for those with heavier substance use or lower motivation at intake.

Cognitive Behavioral Therapy (CBT)

CBT has been adapted for substance abuse. In the adapted model, the therapist helps the client to identify high-risk situations that trigger substance use and to develop strategies to avoid or handle these situations in order to maintain sobriety. Other components of treatment include coping skills, self-efficacy, relapse prevention, and operant conditioning principles. Models of CBT for substance use are short- or moderate-term in length (5 to 12 sessions) and have been applied in both individual and group formats (see Waldron and Kaminer, 2004, for review).

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[1] For a detailed description of the study's methodology, see TADS (2005b).

Evidence for CBT as a treatment for substance abuse has emerged from several recent randomized trials. These trials demonstrate positive outcomes for both group-based and individual CBT and for both short- and moderate-term models (Waldron, Slesnick, Brody, Turner, & Peterson, 2001; Liddle, 2002; Dennis et al., 2004). The adolescents participating in these trials have mainly been from inner-city areas, and their problems have centered around alcohol and marijuana use. The comparison conditions have included other effective models such as family therapy and motivational interviewing. Little is known about the maintenance of positive effects over the long term. One study found continued improvement over a nine-month follow-up (Kaminer, Burleson, & Goldberger, 2002), while another found maintenance of effects but leveling off of improvement at a six-month follow-up (Liddle). A third study found high rates of relapse and reports of continued substance abuse and other problems at a 12-month follow-up (Dennis et al.).

Family-based Interventions

Family-based treatments recognize the role that the family environment often plays in the development, continuation, and successful recovery of substance use problems in adolescents. These treatments typically address family conflict, parenting practices, and neighborhood factors that contribute to and/or exacerbate the problem. Several family therapy models have been effective in treating adolescent substance abuse in controlled clinical trials. These models include Brief Strategic Family Therapy (BSFT), Functional Family Therapy (FFT), Multisystemic Therapy (MST), and Multidimensional Family Therapy (MDFT). Liddle (2004) and Diamond and Josephson (2005) have most recently reviewed the evidence for family-based treatments, separated by disorder.

The evidence for BSFT and FFT comes primarily from studies described later in this report, in which behavioral disorders were the main focus of treatment. Those studies suggest that these interventions are promising candidates for substance abusing adolescents, given the high rates at which

substance abuse occurs alongside behavioral disorders. One study of FFT did focus specifically on adolescent substance abuse. Friedman (1989) compared FFT to a parent group on frequency of substance use and severity of symptoms. The study found decreases in substance use and improved family functioning for both treatment groups.

MST (described later in a subsection on intensive community-based interventions) has been adapted for adolescents who have substance abuse problems in addition to delinquency. This adapted version includes frequent random urine screens to detect drug use, identification of triggers for drug use, developing a plan with the adolescent to address identified triggers when they occur, and training in drug avoidance skills (Randall, Henggeler, Cunningham, Rowland, & Swenson, 2001). This version of MST has shown efficacy in controlled trials with substance abusing adolescents. In a trial comparing MST to treatment as usual for substance-abusing juvenile offenders, those receiving MST demonstrated greater school attendance following treatment and at the 6-month follow-up (Brown, Henggeler, Schoenwald, Brondino, & Pickrel, 1999). A recent follow-up of this study examined the two groups four years after treatment (Henggeler, Clingempeel, Brondino, & Pickrel, 2002). Those who had participated in the earlier MST program showed fewer aggressive criminal activities and lower use of marijuana. An earlier study (Henggeler et al., 1991) compared MST to individual counseling and found that adolescents in MST had fewer substance-related arrests following treatment.

MDFT is the only family-based model that was developed to treat substance abuse as the primary disorder. The intervention is focused on three domains: the adolescent, the adolescent's interaction with his or her family, and the family's interaction with the social environment. One study compared MDFT to CBT for 224 substance abusing adolescents (Liddle, 2002). Both treatment groups experienced significant reductions in substance use and disruptive behaviors. However, at one year past treatment termination, the MDFT group was more successful at maintaining these positive outcomes. In another randomized trial, MDFT was compared to a peer group therapy intervention for

early-age substance users (11 to 15 years) with comorbid behavior problems. MDFT was superior to the comparison condition in decreasing substance use and also in reducing risk factors and increasing protective factors in family and community domains (Liddle, Rowe, Dakof, Ungaro, & Henderson, 2004).

Based on their research evidence and their superior outcomes to CBT in some studies, family-based interventions are the front-runners in treatment for adolescent substance abuse. Because children in foster care often come from families with high levels of dysfunction, this set of interventions may be the most appropriate for this population. Below, some of the more traditional models of substance abuse treatment are reviewed for the purpose of providing readers with the latest information on their research evidence. Their presence here is not meant to promote their use. These treatments are in dire need of more research on their effectiveness with adolescents.

Residential Treatment Centers

Residential treatment is based on the belief that a 24-hour commitment to treatment via removal from the community and placement in a clinical setting is necessary to produce the psychological changes that are required to function in society (Jainchill, Hawke, De Leon, & Yagelka, 2000). Planned or recommended length of stay ranges from 3 to 12 months.

Residential treatment models for adolescents typically target social skills such as anger management, assertiveness, and problem-solving skills that are thought to be especially powerful in a residential setting, because the entire context can teach and reinforce these skills. The 12-step model is also a common component of residential treatment models. Finally, the therapeutic influence of peers is considered a potentially powerful component of residential treatment, whereby adolescents can capitalize on opportunities to increase self-efficacy and cooperative responsibility. Many long-term residential substance abuse programs identify themselves as therapeutic communities (see De Leon, 2000, for description). The Drug Abuse Treatment Outcomes Study (DATOS), a national survey of substance abuse treatment for adults and adolescents, found

that about half of residential treatment centers place great emphasis on family therapy (Hser et al., 2001).

Research shows that long-term residential treatment is one of the most commonly utilized treatment models for adolescent substance abuse (Rounds-Bryant & Kristiansen, 1999; Williams & Chang, 2000; Hser et al., 2001). Despite the proliferation of residential treatment for children and adolescents with various mental health problems, the evidence base has been described as extremely weak (Burns et al., 1999).

Studies, such as DATOS, involving large, nationally representative samples have suggested two major findings for residential treatment over the last three decades: (a) treatment retention (i.e., length of stay) robustly predicts outcome, and (b) adolescents require a longer treatment tenure than adults (reviewed by Jainchill et al., 2000). One recent study examined outcomes for 1,057 adolescents across 10 treatment sites representing various levels of care (Dasinger, Shane, & Martinovich, 2004). At three months after treatment entry, the most pronounced decreases in substance use were reported for residential treatment. This was probably related to the highly controlled nature of the residential setting; i.e., these adolescents were subject to the most rigorous surveillance. Over the longer term, the highest rates of relapse were reported for long-term residential treatment. The study highlighted the important role of continuing care when residential models are used.

Another recent study compared substance using adolescents in a therapeutic community (see De Leon et al, 2000, for description) to those assigned to an alternative probation disposition (Morral, McCaffrey, & Ridgeway, 2004). At 12 months following treatment entry, adolescents in the therapeutic community group demonstrated lower substance use and better psychological functioning than those in the comparison group.

Findings on residential treatment for adolescent substance abuse suggest that it may be a better option than that typically offered by the juvenile justice system. Length of stay and follow-up care appear to be critical to obtaining and maintaining positive effects. However, given the high cost of residential care,

evidence-based individual and family-based outpatient models appear to be a better treatment option when available.

Inpatient Treatment

Short-term inpatient programs take place in medically controlled (i.e., hospital) environments. Services include several group and individual therapy sessions per week. Most of these programs also emphasize family therapy. Planned duration of stay ranges from 5 to 35 days. Upon completion of short-term inpatient treatment, patients are typically referred to outpatient follow-up treatment (Hser et al., 2001). Outcomes of inpatient treatment have not been assessed. These services should only be used in crisis situations with the intent to make a transition to longer-term treatment based in the community.

The 12-step Model

Almost three-fourths of inpatient and outpatient programs for adolescent substance abuse incorporate some version of the 12-step model (Lawson, 1992). The model views drug use as a disease and the primary source of problems in a person's life. The person must confront the disease before dealing with other related problems. Treatment occurs in group meetings in which participants work through the 12 individual steps (e.g., admitting the problem, asking for help, dealing with guilt and anger, turning the problem over to a higher power). Few studies on the program's efficacy with adolescents exist. One study found decreased substance use when adolescents were motivated and engaged in treatment (Kelly, Myers, & Brown, 2002). Wells and colleagues (1994) found that older adolescents (age 18 to 20 years) completing a 12-step program used alcohol less frequently than those who participated in a cognitive behavioral relapse prevention program. Both groups completed 12 weeks of treatment. At six-month follow-up, there were no differences in treatment groups, but both had decreased levels of substance use since before treatment. More studies are needed on this widely used intervention.

Medication for Substance Abuse

Pharmacological intervention is used in substance abuse cases for two purposes: as substitution therapy for addiction or dependence, and to treat comorbid mental health conditions such as depression, ADHD, anxiety, and disruptive behavior disorders. In the former case, drugs such as methadone for opiate addiction (e.g., heroine) and naltrexone for alcohol addition are used for patients who are severely dependent and have not responded to behavioral intervention (Whittington et al., 2004). This approach has been studied primarily in adult samples where methadone, in particular, has demonstrated moderate effectiveness at managing withdrawal in patients with long-standing addictions (Farrell & Taylor, 1994). There is little or no such evidence for adolescent populations. Because adolescents typically do not suffer from long-term addictions, pharmacological intervention for addiction has not generally been recommended.

Psychopharmacological interventions for substance abusing adolescents with comorbid psychiatric diagnoses have a similarly scant evidence base. One controlled trial found positive effects for lithium in treating adolescents with mood disorders and secondary substance abuse (Geller et al., 1998). No follow-up data has been published from this trial. One randomized study involving 10 adolescents with comorbid depression and alcohol abuse compared CBT plus sertraline to CBT plus placebo (Deas-Nesmith et al., 1998). After 12 weeks of treatment, the two groups demonstrated similar reductions in depression and alcohol use. Based on these findings, the use of medication for adolescents with substance use problems should involve serious caution and consideration, especially given the potential abuse liability in this population and high rates of psychiatric comorbidity.

Summary

This section examined the treatment for four high prevalence psychiatric conditions and also addressed the situation wherein children in foster care frequently experience several specific conditions that require targeted treatment.

The most prevalent conditions include PTSD and abuse-related trauma, disruptive behavior disorders (including ADHD), depression, and substance abuse. There is a strong evidence base for treating the first three conditions with interventions that are largely behavioral or cognitive-behavioral and that address symptoms, behavior, and functioning. Examples of such interventions include Trauma-Focused Cognitive Behavior Therapy, the Incredible Years, Parent-Child Interaction Therapy, and cognitive behavior therapy for depression. Such interventions tend to be relatively brief, and most are more effective when a caregiver is actively involved. A number are directed at the caregiver only, particularly when the focus is on managing the child's disruptive behavior. For adolescent substance abuse, family-based treatments such as MST and MDFT are the frontrunners. Dropping a child off at a clinic for individual therapy for most of these conditions is of very limited value. One caution about rapid endorsement of evidence-based treatment: At the present, these interventions are not uniformly available across the country. In addition, caution should be taken with regard to the use of psychotropic medications for these disorders until further research is conducted on the safety of their use with children and adolescents.

Intensive Home- and Community-Based Interventions

Community-based services are frequently provided for children in foster care in order to address their complex and multi-faceted needs and to prevent placement in more restrictive environments outside of the community. These interventions were both developed and tested in the community (versus a lab setting, with moderately to severely disturbed youth), possibly increasing the benefit for youth in foster care in contrast to clinic-based, diagnostic-specific therapies. These interventions are often delivered in the context of a system of care in which a team assesses, plans, and coordinates care for children and families. Most states pay for these services under Medicaid, and there are more powerful models that involve funding from other service sectors. There are a few impressive examples of efforts to achieve this in the literature. A model that was highlighted in the President's New Freedom Commission (2003), namely,

Wraparound Milwaukee, is jointly funded by juvenile justice and child welfare; the findings relative to preventing out-of-community placements and costs are dramatic.

Inclusion of foster parents in these interventions occurs in some parts of the country and the potential to increase their involvement needs attention. The evidence base for most of these interventions was last reviewed in 2004 by Farmer, Dorsey, and Mustillo. Several of these treatments are presented below along with a brief, updated description of the research evidence and are summarized in Table 3.

Table 3. Evidence for intensive home- and community-based interventions

Intervention	**Research**[a]	**Outcomes**
Treatment foster care	4 RCTs[b]	• More rapid improvement • Decreased aggression • Better post-discharge outcomes
Multisystemic Therapy	9 RCTs 1 quasi-experimental	• Fewer arrests • Fewer placements • Decreased aggressive behavior
Intensive case management (including wraparound)	4 RCTs 3 quasi-experimental	• Less restrictive placements • Some increased functioning
Mentoring	2 RCTs	• Less substance use and aggression • Better school, peer, and family functioning
Respite	2 wait-list controls	• Fewer placements • Reduced family stress
Crisis	1 quasi-experimental	• Most maintained home placement • Positive family outcomes • Increased social support
Day treatment/Partial hospitalization	1 wait-list control Many uncontrolled	• Reduced behavior problems • Decreased symptoms

		• Better family functioning
Transition to Independence	3 quasi-experimental	• Positive employment outcomes • Reduced school dropout, arrest, and homelessness • Reduced psychiatric hospitalization
Functional Family Therapy	2 RCTs	• Reduced recidivism • Reduced rate and severity of crime
Brief Strategic Family Therapy	6 RCTs 2 quasi-experimental	• Increased family functioning • Improved behavioral and emotional problems • Increased engagement in treatment
Family-based support services	5 RCTs Many quasi-experimental	• Increased knowledge and self-efficacy about mental health service use • Improved family interactions • Increased service retention
Therapeutic group homes	1 RCT 2 quasi-experimental	• Positive functional and psychological outcomes compared to no treatment • Outcomes inferior to TFC

[a] See report text for specific references for each study. [b] RCT = Randomized Clinical Trial

Treatment Foster Care (TFC)

TFC, while not an intervention for youth in stable foster care, is a frequently utilized placement for youth who cannot be effectively managed in foster care and, thus, it is reviewed here. TFC originated from the Oregon Social Learning Center and is based on social learning theory. Treatment foster parents are trained in the TFC model and receive ongoing supervision. Typically, only one foster child is placed in a home. Four RCTs have included TFC as a treatment group. Two studies found favorable results for TFC as compared to group home or hospital placement (Chamberlain & Reid, 1991, 1998), including improvements in behavior problems, less recidivism, and less movement to more restrictive treatment environments. These studies were reviewed by Farmer, Dorsey, and Mustillo (2004). Another study compared TFC (with an added case management component) to regular foster care (Clark et al., 1994). In general, the TFC children demonstrated greater behavioral improvements and were less likely to run away from home or be incarcerated. Evans, Armstrong, and Kuppinger (1996) compared TFC to wraparound. In this study, TFC did not demonstrate superior outcomes to wraparound although TFC did cost substantially more than wraparound. Further, a recent randomized trial to train regular foster parents caring for preschool-age children has demonstrated positive findings, i.e., a greater increase in positive attachment and a decrease in avoidant attachment (personal communication, P. Fisher, January 15, 2006). We would also note that this trial demonstrated improvement in permanent placement outcomes (Fisher, Berraston, & Pears, 2005), a system outcome important for children in foster care.

Multisystemic Therapy (MST)

MST is an ecologically oriented, family-based treatment model for children and adolescents with behavior and substance abuse problems. The model has more recently been applied to maltreated children with positive results (Swenson & Henggeler, 2003). MST is brief (3-6 months) and takes advantage of

community resources. An overarching aim of MST is family preservation. MST has been the subject of nine RCTs and at least one quasi-experimental study. Comparison treatments have included individual counseling (Borduin, Henggeler, Blaske, & Stein, 1990), usual juvenile justice services (Leshied & Cunningham, 2002), usual mental health services (Rowland et al., 2005), psychiatric hospitalization (Henggeler et al., 2003), and usual child welfare services (Ogden & Halliday-Boykins, 2004). MST has been linked to many positive outcomes such as decreased aggressive behavior, fewer arrests, fewer placements, and improvements in family functioning. Long-term follow-up findings have also been positive (Schaeffer & Borduin, 2005). Several reviews provide more detail on the findings for MST with one recent review critical of the evidence presented for its effectiveness in child welfare (Brestan & Eyberg, 1998; Kazdin, 2000; Burns, Schoenwald, Burchard, Faw, & Santos, 2000; Hoagwood, Burns, Kiser, Ringeisen, & Schoenwald, 2001; Aos, Phipps, Barnoski, & Leib, 2001; Chorpita et al., 2002; Curtis, Ronan, & Borduin, 2004; Littell, 2005).

Intensive Case Management

Case management models vary considerably and are generally not viewed as treatment but rather as an approach to plan, monitor, coordinate, and advocate for the set of services a child needs. Some provide individual case managers while others rely on case management teams. The amount of training required of case managers and the extent to which case managers also provide therapy vary as well. The research on case management includes several RCTs in which different models of case management are compared to each other as well as to other types of treatment. Other quasi-experimental studies have also examined change over time for children in case management. In general, these studies have suggested that case management is superior to usual services in gaining access to services (Paulson, Gratton, Stuntzer-Gibson, & Summers, 1995) and in improving functional outcomes for children with emotional and behavioral problems (Evans, Huz, McNulty, & Banks, 1996).

Intensive case management, in which the case manager receives special training and carries a low caseload, has produced results similar to or better than regular case management in two studies (Evans, Banks, Huz, & McNulty, 1994; Cauce et al., 1994), superior to TFC in another study (Evans et al., 1994; Evans, Armstrong, Kuppinger, Huz, & McNulty, 1998), and superior to case management provided by the child's regular therapist in a third study (Burns, Farmer, Angold, Costello, & Behar, 1996).

Mentoring

Mentors are usually volunteers (some trained and some untrained) who serve as role models and supportive adult figures to children in both community and school settings. They may focus on the development of social skills and provide opportunities for prosocial activities (e.g., recreation, work). In 2002, Dubois and colleagues published a meta-analysis of 55 mentoring programs, including Big Brother/Big Sister (DuBois, Holloway, Valentine, & Cooper, 2002). Their results suggest some positive outcomes. Mentoring was related to better school performance, peer relations, and family functioning. In addition, children with mentors exhibited less substance abuse and aggression. The meta-analysis also revealed some common features of effective mentoring programs such as providing ongoing training to mentors, having mentors with backgrounds in helping professions, including parent involvement or support, arranging organized activities, and setting expectations for frequency of mentor-mentee contact. Farmer, Dorsey, and Mustillo (2004) reviewed the research on mentoring, including the Dubois meta-analysis, and described the support as mixed, as some studies have reported no results or even negative results (Keating, Tomishima, Foster, & Alessandri, 2002) probably tied to failure to address the factors identified above.

Respite

Respite services are used to give caregivers of children with emotional and behavioral disorders time away from their parenting duties. Care is

temporarily provided by an alternate caregiver either in or out of the child's home. Controlled research on respite for this population is limited to two wait-list control experiments (Boothroyd, Kuppinger, Evans, Armstrong, & Radigan, 1998; Bruns & Burchard, 2000). These studies suggest that respite care can reduce the number of outside-of-home placements and can also decrease family stress. However, the Boothroyd et al. study also found that fewer families used respite services than expected. They speculated that this may have been due to lack of knowledge that these services were available.

Crisis

Crisis services are used in emergency situations to provide immediate care. The time and place at which crisis services are accessed is often the point of entry into longer-term mental health services. Crisis services include three main components: evaluation and assessment, crisis intervention and stabilization, and follow-up planning. Some examples of service settings are crisis hotlines, hospital emergency rooms, runaway shelters, walk-in crisis intervention services, and crisis group homes. Staff are available 24 hours a day every day and offer short-term services (e.g., four to six weeks).

The main goals are to link children and their families to services in the community, to involve families in treatment, and to avoid hospitalization. With the exception of one quasi-experimental study (Evans et al., 2003), the research base for crisis services consists of only uncontrolled studies. These uncontrolled studies have shown that crisis services are successful at diverting youth from institutional placement (see Kutash and Rivera, 1996, for review). The Evans et al. study randomly assigned children and families presenting with a mental health crisis to home-based crisis intervention or intensive case management that had been adapted for crisis situations. Families assigned to the home-based crisis intervention showed increased family cohesion immediately following treatment, but these positive outcomes were not maintained at six-month follow-up. Families assigned to both groups showed increased social support through the follow-up period. There was some evidence that these latter

increases occurred earlier during treatment for the families who received crisis intervention. Child welfare agencies should perhaps look more closely at these types of interventions given the promising results they have shown in successfully diverting children from placement (cf. Burt & Bleat, 1974).

Day Treatment

Day treatment, also known as partial hospitalization, is an intensive form of treatment that is less restrictive than inpatient care. Typically, these programs combine individual and family counseling, education, skills training, and recreation therapy. Day treatment can take place in a hospital, clinic, or school setting. The research base was most recently reviewed by Burns et al. (1999). All studies have been uncontrolled with the exception of one study that compared intensive day treatment to wait-list control for children (age 5 to 12 years) with disruptive behavior disorders (Greek, Parizeau, & Saying, 1993). At six months, children in day treatment had experienced more improvements in symptoms and family functioning.

Findings from uncontrolled studies have shown improvements in behavior and family functioning that have been sustained at long-term follow-up (see Greek, 1997, and Kutash and Rivera, 1996, for review). In terms of educational outcomes, about three-quarters of children in day treatment are reintegrated into mainstream schools with the help of special education and community resources. These studies also suggest that day treatment is effective at preventing more restrictive (e.g., residential) placement, and they point to family participation as an essential factor for achieving these positive outcomes.

Transition to Independence

Clark and Davis (2000) have described the Transition to Independence Process (TIP), an individualized program that helps prepare adolescents for the transition to adulthood. TIP encourages secondary education and teaches community living skills through exposure. The program emphasizes respect for individual values and goals through a strengths-based approach. Evidence on

the effectiveness of TIP is just now beginning to emerge. Results from uncontrolled evaluations suggest positive employment outcomes and reduced school dropout, arrest, homelessness, and psychiatric hospitalization (Bridge, Davis, & Florida, 2000; Clark et al., 2002).

Family Therapy

The main goal of family therapy models is family preservation, and this implies keeping children in the community as a priority. For this reason, these models fall under the category of community-based intervention. The two leading family therapy models are Functional Family Therapy (FFT) and Brief Strategic Therapy (BSFT).

FFT is a family-based therapy focused on decreasing maladaptive behaviors in children age 11 to 18 years at risk for or presenting with disruptive behavioral disorders and/or substance abuse. The specific components of the intervention are aimed at both enhancing protective factors and reducing risk. FFT can be delivered in the home, clinic, or juvenile facility. Treatment is brief, typically requiring no more than 26 hours of direct service time. Sexton and Alexander (2003) provided a more detailed description of FFT. In controlled trials, FFT has compared favorably to residential treatment in reducing re-offending (Sexton & Alexander, 2000) and in reducing onset of behavioral problems in siblings (Alexander, Pugh, Parsons, & Sexton, 2000).

BSFT is designed for children and adolescents age 6 to 17 years who exhibit emotional and behavioral problems, and also for families with problematic relations such as anger, blaming, and other negative interactions. BSFT can be provided in the home, clinic, and other community-based settings such as a social work agency. Szapocznik and Williams (2000) published a review of the research on BSFT over the prior 25 years. RCTs with Caucasian and Hispanic youth have demonstrated the positive effects of BSFT such as decreased behavior problems, decreased association with antisocial peers, increased family involvement in therapy, and increased family communication and warmth

(Szapocznik et al., 1988; Diamond & Liddle, 1996; e.g., Coatsworth, Santisteban, McBride, & Szapocznik, 2001; Santisteban et al., 2003).

Family-based Education and Support

Supportive family-based interventions provide parenting education, psychological support, and practical support to parents/caregivers of children with disruptive behavior disorders. Many programs also promote family engagement in the mental health service system. These programs are usually implemented in a group format. The goal is to give caregivers the skills and supports they need to cope with their child's mental health difficulties. As such, families have dual roles: (1) direct recipients of the intervention and (2) partners, or co-therapists, in providing treatment to their children. Five RCTs and several quasi-experimental studies have been conducted (for review, see Comer and Fraser, 1998; McKay and Bannon, 2004; Farmer et al., 2004; Hoagwood, 2005). Studies have demonstrated improved family interactions, increased service retention, and increased knowledge about the mental health service system.

Therapeutic Group Homes

Group homes are used for children and adolescents with behavioral disturbance to learn and practice their social and psychological skills. Homes can be based inside or outside the community and usually serve 5-10 clients at one time. The prominent group home model is the teaching family (TF) model, originally developed at the University of Kansas (Phillips, Phillips, Fixsen, & Wolf, 1974). In this model, two adults in the home act as parents. While research on group homes is sparse (as reviewed most recently by Farmer et al., 2004), the strongest available evidence is for the TF model.

In addition to many replication studies that have demonstrated successful implementation with strong fidelity to the TF model (reviewed by Fixsen, Blase, Timbers, and Wolf, 2001), three studies exist. An early study compared 13 teaching family group homes to 9 non-teaching family group homes (Kirigin, Braukmann, Atwater, & Wolf, 1982). During treatment, youths in the teaching

family homes had fewer criminal offenses and higher ratings of treatment satisfaction than youths in the comparison homes. However, these differences were not maintained at one-year post-treatment assessment.

Two further studies of treatment foster care (TFC) have included group homes as the comparison condition. The first study used a matched group design and found that group homes produced similar outcomes to TFC but were much more expensive to implement (Rubenstein, Armentrout, Levin, & Herald, 1978). A more recent study used a randomized design and found more positive outcomes in the TFC condition in a shorter period of time. TFC was also associated with longer maintenance in the community and decreased criminal involvement over one year following discharge (Chamberlain & Reid, 1998).

These findings suggest that although therapeutic group homes can have positive effects, TFC may be a better option for youth in foster care when a more highly structured placement is needed. Some very recent and current work is focused on the primary processes of group home treatment (Breland-Noble et al., 2004; Breland-Noble, Farmer, Dubs, Potter, & Burns, 2005). There is hope that this work will provide more information about which specific elements of these treatment models lead to lasting, positive outcomes.

How Are Evidence-based Interventions Spreading?

Consistent with national policy since the issue of the Surgeon General's Report on Mental Health (1999), a range of initiatives to spread evidence-based practice across the country has been undertaken. They vary in auspice (usually state) and the range of interventions. This part of the report provides two sets of examples that are relevant to mental health treatment of youth in foster care. First, we review initiatives that are being undertaken in children's mental health systems. These are likely to have an impact on treatment for children in foster care because most of the treatment is provided in mental health clinic settings. Second, we review initiatives that are being undertaken directly within child welfare/foster care service settings and which provide a direct application to a foster care population.

This report does not contain an exhaustive review but does identify exemplary initiatives to disseminate mental health treatment by states, the federal government, and foundations. With an emerging literature on such initiatives (see Burns, 2003; Chambers, Ringeisen, and Hickman, 2005), there are lessons about the challenges involved in moving evidence-based practice into the field. Future dissemination and implementation efforts will have the advantage of increased understanding of the stages of adoption, implementation, and sustainability including the specific processes at each stage. In the interim, several resources (Greenhalgh, Robert, MacFarlane, Bate, & Kyriakidou, 2004; e.g., Fixsen, Naoom, Blase, Friedman, & Wallace, 2005) can provide conceptual (and empirical) guidance about factors that require attention prior to and during such initiatives. Appendix C provides information about the availability of formal training and other educational resources for many of the evidence-based interventions described previously.

Briefly described are statewide efforts to move evidence-based practice into local mental health service systems for youth and families. Several states, particularly Ohio and California, have created training institutes that focus on designated interventions such as treatment foster care or functional family therapy. Agency participation is voluntary. In contrast, Michigan decided to train child mental health center staff statewide in two interventions that address the most common clinical conditions (i.e., cognitive behavior therapy for depression and parent management training for disruptive behavior disorders). Alternatively, Oregon selected an approach tied to reimbursement and established a list of evidence-based interventions that could be selected from with a four-year period to achieve 75% evidence-based practice.

An Annie E. Casey Foundation–supported initiative called BlueSkies has proposed a community-based continuum of care for seriously emotionally disturbed youth. Its three components include multisystemic therapy for intensive treatment; TFC for respite; and functional family therapy for maintenance. The communities being considered for a demonstration of this continuum of care have to demonstrate that resources will be available to continue services once

the demonstration is over; thus, the challenges of sustaining the provision of new services without ongoing support will be addressed.

The Substance Abuse and Mental Health Services Administration (SAMHSA)-supported Child Initiative is also engaged in tests of adding evidence-based interventions to System of Care sites. Randomized trials are currently being conducted in West Virginia, Oregon, Oklahoma, and Ohio of Parent-Child Interaction Therapy and of Brief Strategic Family Therapy.

The National Child Traumatic Stress Network, also supported by SAMHSA, is significantly engaged in efforts to disseminate Trauma-Focused Cognitive Behavior Therapy. This is occurring through trainings around the country, subsequent consultation/supervision, manual development, and an excellent website with online training. As the intervention developers train local clinicians who will in turn become trainers, a cascading effect should be seen in the greater availability of expert treatment. Use of the Internet for training in areas of the country where face-to-face training is not available (or in concert where trainers are available) is innovative and will further increase access to TF-CBT (go to www.musc.edu/tfcbt).

Finally, the Center for the Advancement of Mental Health at Columbia University is training and coaching mental health practitioners in California, Utah, Texas, and New York in evidence-based approaches.

The findings from these state-level, foundation-supported, and federal initiatives and others will inform directions for child welfare in collaboration with human service partners to specify and implement evidence-based clinical interventions for youth in foster care.

Foster Care Initiatives

A number of evidence-based initiatives are directly involving the child welfare/foster care system. The State of Oklahoma has partnered with Mark Chaffin and his colleagues at the University of Oklahoma School of Medicine to test and disseminate evidence-based interventions in child welfare populations and foster care settings. Their work to date has included initiatives with a strong

CDC- and NIMH-funded research component that seeks to implement PCIT and Project Safe Care across the state.

The State of California recently has funded the development of a Clearinghouse for Evidence-Based Practice in Child Welfare that is being implemented under contract from the Chadwick Center for Children and Families. This initiative will post reviews of the evidence for interventions in numerous areas, including mental health treatment for children and adolescents involved with child welfare. The Oregon Social Learning Center has recently partnered with the County of San Diego child welfare system and the Child and Adolescent Services Research Center at Children's Hospital in San Diego to test a parent management training intervention for foster parents that is modeled on the principles of Multidimensional Treatment Foster Care (MTFC). With funding from NIMH, the partnership has recently completed a two-phase study of the model's effectiveness with promising results in decreased behavior problems among children 6 to 11 years in foster care and better placement outcomes (decreased changes of placement and increased reunification).

Implications for Treating Common Conditions and Accessing Evidence-base Care

- Inform and educate child welfare workers (CWWs) about a select set of evidence-based interventions that work for the above conditions to facilitate appropriate referrals.
- Identify mental health providers in the community who have training in these interventions.
- At the agency level, clarify expectations about the importance of active foster parent participation in clinical interventions when this is appropriate or required.
- Train CWWs in approaches for engaging foster parents (and biological parents where appropriate) in treatment for the foster child.

Treatment for Complex and Co-occurring Conditions

Youth with complex combinations of mental health conditions and functional impairment associated with long-term risks such as multiple episodes and types of maltreatment, other trauma (e.g., domestic violence and loss), and instability of placements would benefit from intensive home- and community-based services. Children in foster care often move on to “deep end” services in institutional settings because of failure to manage their behavior in the community. The benefit of care in institutional settings is not well substantiated and may even be deleterious due to close association with deviant peers, the risk of contagion, loss of contact with family and peers, and other factors.

Fortunately, there are alternatives to the care and treatment of these youth today. Increasing the availability of intensive home- and community-based services while in foster care could benefit children and prevent further movement away from family and community. These are intensive interventions that tend to be long –term, which could more effectively address the needs of such youth. Major examples include intensive case management, multisystemic therapy, treatment foster care, crisis services, respite care, mentoring, and several types of family therapy, in addition to special education services in school or recreational and work opportunities in the community. The critical challenge to creating such a continuum of care is to engage the relevant other providers (e.g., schools, juvenile justice, Medicaid) in a joint endeavor.

Implications for Developing Intensive Home- and Community-based Services

- A true partnership among the relevant human services agencies at the state or county level is necessary to create the policy and structure for delivering these services in an integrated manner.
- Although theoretically supported by Medicaid through Early Periodic Screening Detection and Treatment (EPSDT) legislation (services are reimbursed in many states), engaging the state Medicaid office for such

initiatives is essential to help ensure that adequate funds will be available in a timely way.

- Developing service capacity requires resources for training, ongoing supervision/consultation, and monitoring outcomes.
- A review of model programs and class action suits may offer guidance for planning and implementation.

Test Evidence-based Mental Health Practices within the Child Welfare System

Evidence-based interventions have been identified with the potential to address the mental health needs of youth in foster care delivered largely by the mental health system. What may be more innovative is the provision of specific mental health interventions within the child welfare system. Several important studies are underway to test their applicability within child welfare. Very promising is the state-wide implementation of Parent-Child Interaction Therapy in an experimental design across the state of Oklahoma.

A second important study will test the potential to adapt treatment foster care principles of parent management training for a training approach to regular foster care parents. A third significant initiative sponsored by the National Child Traumatic Stress Training Center will train clinicians in 12 sites across the country to provide Trauma-Focused Cognitive Behavior Therapy (for child sexual and/or physical abuse). Further, other studies are examining strategies for the dissemination of diagnostic-specific interventions, and the lessons learned from them will also be applicable to increasing the availability of evidence-based practices for maltreated youth in child welfare.

Implications for the Spread of Evidence-based Interventions in Child Welfare

- Track the progress of dissemination studies of mental health interventions in foster care and clinical interventions relevant to the needs of these children to determine readiness for large-scale adoption.

- Learn from the challenges of intervention adoption and dissemination efforts (e.g., stakeholder buy-in, the importance of policy and organizational factors, and factors contributing to sustainability) prior to making policy decisions.
- Consider additional candidate interventions for implementation within child welfare, in contrast to those more likely to be provided in the mental health system.
- For evidence-based interventions that require the expertise and resources of the mental health system, develop a partnership with clearly explicated roles for each system, preferably with joint child welfare and mental health and/or Medicaid funding.

IV. LEGAL INTERVENTION

The final section of the report addresses this question posed by the Casey Family Programs: “How many lawsuits have been filed because of the failure to meet the mental health needs of foster youth?”

This section benefits by having access to a recently completed study *Child Welfare Consent Decrees: Analysis of Thirty-Five Court Actions from 1995 to 2005* (Kosanovich & Joseph, 2005) that was jointly sponsored by the Child Welfare League of America and the ABA Center on Children and the Law. This short section summarizes the findings from the study related to the mental health care issue.

Class-action litigation has become a highly frequent action in the United States to force reform of child welfare policy and practice. Within the past decade, the study found that “there has been child welfare class action litigation in 32 states, with consent decrees or settlement agreements in 30 of these.” The study investigators found that “twenty-one states currently operate under court consent decrees, settlement agreement or are under pending litigation brought against public child welfare agencies (pg. 6).”

The decrees have addressed a wide range of child welfare issues. All of the 35 state cases were coded for whether they addressed any one or more of these following issues:

1. Properly license and train foster parents
2. Place children in adequate and safe foster and group homes
3. Properly report, investigate, and address abuse and neglect incidents
4. Provide needed medical, dental, and mental health services to foster children
5. Ensure adequate parent-child or sibling visitation
6. Ensure social workers have manageable caseloads, training, and supervision
7. Provide children and families with adequate case planning and review.

The fourth issue most directly addresses the question raised by Casey Family Programs. In their analysis, the study investigators found that 20 of the 35 decrees have addressed service provision, including 12 decrees explicitly dealing with mental health care. We would note that 6 decrees addressed substance abuse problems and 7 decrees among the 35 addressed the more generic treatment needs of children in foster care.

Limiting the number of decrees to those dealing with the narrow definition of failure to provide treatment for the mental health needs of children in foster care may underestimate the scope of this issue within the decrees. Many other issues may be indirectly linked to provision of mental health care, such as training of caseworkers and foster parents, education and independent living services for children in foster care, parent-child visitation, minimizing disrupted placements and reduction in number of placements, residential facility placement, and support and supervision of foster parents. These latter issues may be especially linked to mental health care because of the high prevalence of externalizing problems seen in children who are involved in foster care and the findings that externalizing problems are best addressed through parent-mediated interventions.

In summary, mental health care is a significant part of the 35 court actions that have occurred over the past decade. We would also note that we know of no research that has *systematically* examined the impact of legal action on quality of child welfare practice relative to mental health care or on improvement in outcomes for the children receiving such care.

V. RECOMMENDATIONS

This report has reviewed a wide scope of literature related to the mental health care of children in foster care. In this final section, we highlight selected findings on which we base a small number of recommendations.

The majority of children residing in foster care demonstrate need for mental health care and related services to address developmental problems.

Increase Access To Care

- Inform child welfare workers (CWWs) about the importance of early identification and treatment.
- Institute a standard protocol for screening and assessment to identify need for mental health care upon entry into the child welfare system.
- Educate CWWs about local resources and create a liaison with mental health providers to facilitate rapid referrals into mental health services.
- Monitor referrals and follow-up with foster parents to ensure that youth receive services.

There is a high rate of use of mental health services for children in foster care with most care being delivered in standard outpatient services as well as a high rate of use of institutional care. While there is little evidence that these well-tested interventions are being routinely used in usual care settings, several candidate solutions are especially relevant for children in foster care, including

cognitive behavior treatments for PTSD and abuse-related trauma, intensive interventions such as treatment foster care as well as parent management training models.

Moving Beyond Usual Outpatient and Institutional Care

- Examine the evidence base for interventions to treat common clinical conditions and more complex conditions experienced by youth in foster care.
- Assess the availability of evidence-based interventions at the local and national levels to assure relevance and explore adaptations needed for youth in foster care.
- Identify candidate evidence-based interventions to meet mental health needs at the local level.

There are a number of very effective interventions and promising practices that have been developed for the four conditions likely to be found in children residing in foster care, as discussed above. There are many challenges to integrating these effective interventions into the services that are provided for children in foster care. Strong efforts are underway to address these challenges in selected areas.

Increase the Use of Evidence-Based Interventions in Child Welfare

- Track the progress of dissemination studies of mental health interventions in foster care and those on clinical interventions relevant to the needs of these children to determine readiness for large-scale adoption.
- Learn from the challenges of intervention adoption and dissemination efforts (e.g., stakeholder buy-in, the importance of policy and organizational factors, and factors contributing to sustainability) prior to making policy decisions.

- Consider additional candidate interventions for implementation within child welfare, in contrast to those more likely to be provided in the mental health system.
- For evidence-based interventions that require the expertise and resources of the mental health system, develop a partnership between mental health and child welfare with clearly explicated roles of each system and preferably with joint child welfare and mental health and/or Medicaid funding.

There is substantial use of legal remedies, such as consent decrees and settlements across the United States, to leverage improvements in services to children in the foster care system. There is a need for systematic research on the impact of these legal remedies on mental health service delivery.

Finally, we would suggest that foundations such as the Casey Family Programs have a vital role to play in efforts to improve mental health care for children in child welfare and we offer a small number of modest recommendations.

Using Evidence to Improve Practice and Policies in Child Welfare

- Consider the unique leverage points that Casey Family Programs can use to assist initiatives to improve mental health care for children in foster care through increased use of very promising interventions.
- Use the unique experience of Casey Family Programs to initiate and support partnership dialogue between child welfare and mental health service systems around efforts to integrate evidence-based interventions into services for children in foster care.
- Provide leadership to the child welfare community as it works to improve service delivery through the use of evidence about interventions that show great promise for improving well-being for children in foster care.

Appendix A

Resources and Registries for Identifying Evidence-Based Interventions for Children and Adolescents

Federal/National

SAMHSA's National Registry of Evidence-based Programs and Practices (NREEP):

http://www.modelprograms.samhsa.gov/

The Office of Juvenile Justice and Delinquency Prevention's Model Programs Guide (MPG):

http://www.dsgonline.com/mpg2.5/mpg_index.htm

National Institute of Drug Abuse

Preventing Drug Use Among Children and Adolescents: A Research Based Guide for Parents, Educators, and Community Leaders:

http://www.drugabuse.gov/pdf/prevention/RedBook.pdf

National Center for Injury Prevention and Control, Centers for Disease Control and Prevention

Using Evidence-Based Parenting Programs to Advance CDC Efforts in Child Maltreatment Prevention:

http://www.cdc.gov/ncipc/pub-res/parenting/ChildMalT-Briefing.pdf

Center for Substance Abuse Treatment (CSAT)

Center for the Application of Substance Abuse Technologies (CASAT)

Centers for the Application of Prevention Technologies (CAPT):

Western CAPT: http://captus.samhsa.gov/western/about/index.cfm

Mountain West Addiction Technology Transfer Center (MWATTC):

http://casat.unr.edu/mwattc/newsite/

Frontier Recovery Network (FRN): http://casat.unr.edu/frn/

Northeast CAPT: http://captus.samhsa.gov/northeast/about/about.cfm

Child Welfare League of America, Research to Practice Initiative:

http://www.cwla.org/programs/r2p/default.htm

National Association of State Mental Health Program Directors Research Institute, Inc. (NRI): http://www.nri-inc.org/

Office of Juvenile Justice and Delinquency Prevention (OJJDP)

Blueprints for Violence Prevention Initiative

http://www.ncjrs.org/html/ojjdp/jjbul2001_7_3/contents.html

Selected State Initiatives

The Nevada Practice Improvement Collaborative (PIC):
http://casat.unr.edu/nevadapic/

New York State Office of Mental Health Evidence-Based Practices :
http://www.omh.state.ny.us/omhweb/EBP/WebResources.htm

Hawaii Child and Adolescent Mental Health Division (CAMHD):
http://www.hawaii.gov/health/mental-health/camhd/index.html

Oregon Commission on Children and Families (OCCF):
http://www.oregon.gov/OCCF/Mission/BestPrac/besthm/mibesthm.shtml

Research and Training Center on Family Support and Children's Mental Health
Portland State University, Portland, Oregon
Promising Practices Initiative:
http://www.rtc.pdx.edu/pgProjPromising.php

The California Child Welfare Clearinghouse for Evidence-Based Practice:
http://www.cachildwelfareclearinghouse.org/

California Healthy Kids Resource Center (CHKRC):
http://www.californiahealthykids.org/

Washington State Institute for Public Policy: http://www.wsipp.wa.gov/

Organizations and University-Based Groups Engaged in Analysis of Treatment Research Literature:

The Cochrane Collaboration: http://www.cochrane.org/

The Campbell Collaboration: http://www.campbellcollaboration.org/

National Implementation Research Network (NIRN): http://nirn.fmhi.usf.edu/

RAND Corporation Promising Practices Network (PPN):
http://www.promisingpractices.net/

Major Published Reviews:

Mental Health: A Report of the Surgeon General (1999)
http://www.surgeongeneral.gov/library/mentalhealth/home.html

Youth Violence: A Report of the Surgeon General (2001)
http://www.surgeongeneral.gov/library/youthviolence/youvioreport.htm

The President's New Freedom Commission on Mental Health (2003)
http://www.mentalhealthcommission.gov/reports/reports.htm

Closing the Quality Chasm in Child Abuse Treatment: Identifying and Disseminating Best Practices, The Findings of the Kauffman Best Practices Project to Help Children Heal from Child Abuse (2004):
http://musc.edu/cvc/kauffmanfinal.pdf

Child Physical and Sexual Abuse: Guidelines for Treatment (2002)
Office for Victims of Crime, Office of Justice Programs, U.S. Department of Justice
http://musc.edu/cvc/guide1.htm

Synthesis of Reviews of Children's Evidence-based Practices
Jacqueline Yannacci, M.P.P., and Jeanne C. Rivard, Ph.D.
Center for Mental Health Quality and Accountability,
NASMHPD Research Institute, Inc.
http://ebp.networkofcare.org/uploads/Synthesis_of_Reviews_of_the_Research_on_Evidence_Based_and_Promising_Practices_9592994.pdf

Office of Juvenile Justice and Delinquency Prevention (OJJDP)
Strengthening America's Families: Exemplary Parenting and Family Strategies for Delinquency Prevention: http://www.strengtheningfamilies.org/

Mihalic, S.F., and Aultman-Bettridge, T. (2004). A guide to effective school-based programs. In: *Policing and School Crime* (W.L. Turk, Ed.). Englewood Cliffs, NJ: Prentice Hall.

Appendix B

Office for Victims of Crime (OVC) Criteria for Evidence-Based Treatments[2]

1. Well-supported, Efficacious Treatment

1. The treatment has a sound theoretical basis in generally accepted psychological principles.

2. A substantial clinical-anecdotal literature exists indicating the treatment's value with abused children, their parents, and/or their families.

3. The treatment is generally accepted in clinical practice as appropriate for use with abused children, their parents, and/or their families.

4. There is no clinical or empirical evidence or theoretical basis indicating that the treatment constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.

5. The treatment has a book, manual, or other available writings that specifies the components of the treatment protocol and describes how to administer it.

6. At least two randomized, controlled treatment outcome studies (RCT) have found the treatment protocol to be superior to an appropriate comparison treatment, or no different or better than an already established treatment when used with abused children, their parents, and/or their families.

[2] Saunders, B. E., L. Berliner, & Hanson, R.F. (December 10, 2002). *Child physical and sexual abuse: Guidelines for treatment.* Charleston, SC: Office for Victims of Crime.

7. If multiple treatment outcome studies have been conducted, the overall weight of evidence supports the efficacy of the treatment.

2. Supported and Probably Efficacious Treatment

1. The treatment has a sound theoretical basis in generally accepted psychological principles.

2. A substantial clinical-anecdotal literature exists indicating the treatment's value with abused children, their parents, and/or their families.

3. The treatment is generally accepted in clinical practice as appropriate for use with abused children, their parents, and/or their families.

4. There is no clinical or empirical evidence or theoretical basis indicating that the treatment constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.

5. The treatment has a book, manual, or other available writings that specifies the components of the treatment protocol and describes how to administer it.

6. At least two studies utilizing some form of control without randomization (e.g., matched wait list, untreated group, placebo group) have established the treatment's efficacy over the passage of time, efficacy over placebo, or found it to be comparable to or better than an already established treatment.

7. If multiple treatment outcome studies have been conducted, the overall weight of evidence supports the efficacy of the treatment.

Appendix C

National Training Resources for Evidence-Based Interventions

The interest in and push toward an increase in evidence-based practice has spawned training organizations with expertise in an intervention. The training model typically involves didactic teaching in combination with ongoing consultation or supervision. Information about how to access such resources is available below.

The Incredible Years

The Incredible Years programs were developed by Carolyn Webster-Stratton, M.S.N., M.P.H., Ph.D., Professor and Director of the Parenting Clinic at the University of Washington, Seattle.

http://www.incredibleyears.com/

Parent-Child Interaction Therapy (PCIT)

In the early 1980s, Sheila Eyberg at the Oregon Health Sciences University developed an intensive treatment method for preschoolers with disruptive behavior disorders and their parents. Because poor parent-child interaction is an important source of disruptive behavior problems, Eyberg's Parent-Child Interaction Therapy (PCIT) focuses on teaching parents a set of specific behavior management techniques within play therapy techniques with their child.

http://www.ucdmc.ucdavis.edu/caare/mental/pcit.html

http://www.ucdmc.ucdavis.edu/caare/mental/pcit_traincenter.html

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

Trainers include Judy Cohen, M.D., Tony Mannarino, M.D., and Esther Deblinger, Ph.D. National trainers can be identified through the National Child Traumatic Stress Network.

http://www.nctsn.org/

Brief Strategic Family Therapy (BSFT)

Olga Hervis, MSW, LCSW, is the co-author and developer of the nationally-validated, award-winning family therapy model known as Brief Strategic Family Therapy. The Family Therapy Institute of Miami (FTTIM) provides training leading to certification in BSFT and also provides training in Family Effectiveness Training, also an award-winning model program, which is a psycho-educationally-based adaptation of BSFT to be utilized with younger, prevention/early intervention target populations.
http://www.brief-strategic-family-therapy.com/bsft-training

Functional Family Therapy (FFT)

FFT is an empirically grounded, well –documented, and highly successful family intervention for at-risk and juvenile justice-involved youth.
http://www.fftinc.com/index.php

FFT Clinical Services System

An integrated system for monitoring the practice of Functional Family Therapy in community practice settings.

http://www.fftcss.com/

Treatment Foster Care (TFC)

Treatment foster care is a clinically effective and cost-effective alternative to residential treatment facilities that combines the treatment technologies typically associated with more restrictive settings with the nurturing and individualized family environment. The website for the Multidimensional Treatment Foster Care model at the Oregon Social Learning Center and two more generic websites are included below.

http://www.mtfc.com

http://www.ffta.org/links/other_resources.html

http://www.fosterparentcollege.com/

Multisystemic Therapy (MST)

The major goal of MST is to empower parents with the skills and resources needed to independently address the difficulties that arise in raising teenagers and to empower youth to cope with family, peer, school, and neighborhood problems. Within a context of support and skill-building, the therapist places developmentally appropriate demands on the adolescent and family for responsible behavior. Intervention strategies are integrated into a social ecological context and include strategic family therapy, structural family therapy, behavioral parent training, and cognitive behavior therapies.
http://www.mstservices.com/

Teaching-Family Model

The Teaching-Family Model provides behavioral treatment to client populations in need of such residential care. There is research and information about disseminating the Teaching-Family Model beginning with its origin, through its replication, and into its adaptations.

http://www.teaching-family.org/

http://www.teaching-family.org/bibliography.html

http://www.familyinnovations.org/tfs.html

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