Mental Health Practices in Child Welfare Guidelines Toolkit

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Acknowledgments

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The guidelines presented within this Toolkit have been endorsed by the following organizations:

- **American College of Clinical Pharmacy (ACCP)**
- **American Psychiatric Association (APA)**
- **Annie E. Casey Foundation**
- **Bazelon Center for Mental Health Law**
- **Carter Center Mental Health Program**
- **Casey Family Programs**
- **California Institute of Mental Health (CIMH)**
- **College of Psychiatric and Neurologic Pharmacists (CPNP)**
- **Child Welfare League of America (CWLA)**
- **Foster Family-based Treatment Association (FFTA)**
- **National Foster Care Coalition (NFCC)**

The guidelines were originally published in February 2009 Special Issue of *Child Welfare – Mental Health Practices in Child Welfare: Context for Reform,* Volume 88(1). This Toolkit was created to accompany this journal and provide practical implementation tips, tools, and resources for integrating and sustaining the guidelines within child welfare agencies and other settings that serve children in child welfare.

Table of Contents

Introduction

As a result of the Best Practices for Mental Health in Child Welfare Consensus Conference, 32 mental health practice guidelines for child welfare were developed. These guidelines cover mental health screening, assessment and treatment, parent support, and youth empowerment. The guidelines and their rationale as well as critical papers on the guideline topic areas are presented in a special issue of *Child Welfare* (volume 88 #1) entitled *Mental Health Practice Guidelines for Child Welfare: Context for Reform*.[1]

Guidelines alone rarely result in behavior change on an individual or organizational basis. In order for guidelines to lead to change, they must be clearly operationalized and accompanied by practical tools that facilitate implementation. This toolkit will help child welfare agency administrators and staff members to put the Mental Health Practice Guidelines into action by providing suggestions and resources for applying the guidelines in their agencies.

Five sections corresponding to the guideline topic areas—mental health screening and assessment, psychosocial interventions, psychotropic medication, parent support, and youth empowerment—make up the toolkit. Each section presents the guidelines, why they are important, and practical suggestions for how an agency might implement them. In addition, each section includes a comprehensive list of tools and resources related to the guideline topic area.

When applicable, the tools/resources described are rated on the scale presented below to provide a quick indication of the level of evidence in support of their use.

Evidence-Based Practice Rating Scale

1 = Well-Supported by Research Evidence
2 = Supported by Research Evidence
3 = Promising Research Evidence
4 = Emerging Practice

This scale represents the top four rating categories of the California Clearinghouse Scientific Rating Scale.[2] The specific criteria used to determine each rating are summarized below.

Evidence-Based Practice Rating Scale:

1 = Well-Supported by Research Evidence 2 = Supported by Research Evidence
3 = Promising Research Evidence 4 = Emerging Practice

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

*Adapted from the scientific rating scale developed by the California Evidence-Based Clearinghouse (CBEC) for Child Welfare. Evidence Fails to Demonstrate Effect, Concerning and NR (Not able to be rated) practices are not included in this rating scale. A rating of 4 refers to emerging practices that are not part of the current CBEC scale.

Mental Health Screening and Assessment Guidelines

Despite the recognized importance of mental health concerns existing among youth in the child welfare population, data suggest that there is a significant gap between children who need services and children who receive services. One major problem is that many children in need of mental health services are not being identified and offered help. Therefore, child-welfare-relevant mental health screening procedures, tools, and resources are critical.

This section of the toolkit contains the following:

Mental Health Screening and Assessment Guidelines (page 16)

The four guidelines presented in this section identify recommendations for how child welfare agencies can address the problem of unmet mental health needs in children who are in the child welfare system. Each guideline is supported with information underscoring its importance, in addition to tips on how to implement it at your agency.

Mental Health Screening and Assessment Flowchart (page 21)

The flowchart outlines the mental health screening and assessment process in accordance with the guidelines and suggests tools that can be used at each stage.

Mental Health Screening and Assessment Tools Table (page 22)

This table summarizes key characteristics of the evidence-based screening and assessment tools mentioned in the flowchart.

Mental Health Screening and Assessment Tools & Resources (page 24)

The Tools & Resources section provides descriptions and information for each screening and assessment tool, including purchasing, Web site address, and training information.

Guideline 1.
Stage 1 Screening for Emergent Risk

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

Rationale: Why is this Guideline important?

- Children entering the foster care system are likely to have high levels of distress due to maltreatment, a history of trauma that might be triggered, the events surrounding the actual removal (such as violence in the home) especially if the police were involved and/or the level of distress that is created in the family/child, the child welfare investigation itself, and/or separation from the things they are familiar with, in particular their family, friends, school, and community.
- Screening within 72 hours of entry into care provides valuable information about a child's level of acute distress, and the risk for harming himself or herself or others. Note: If an acute risk is identified (i.e., the child is exhibiting psychotic behaviors or severe emotional or behavioral symptoms, and there is a risk of self-harm or runaway), have the child immediately seen by a mental health provider for further assessment. It is important to remember to pay attention not only to the more obvious outward signs; children who are quiet and seem to be adjusting may well be suicidal.
- Early screening also allows the agency to determine if immediate intervention is required.[3]

Implementation: How can I incorporate this Guideline at my agency?

- Identify staff members or nurses who will conduct Stage 1 screening. This screening does not have to be conducted by a mental health professional, although staff members should be trained appropriately.
- Consider administering the screening during the mandatory body check all children coming into care go through within the first 24 hours. Have a staff member or nurse who is based in the medical unit conduct it.
- Choose a screening tool(s) that includes questions about self-harm, psychotic behavior, runaway risk, and severe emotional or behavioral symptoms. Whenever possible, choose a culturally appropriate tool. Refer to the Mental Health Screening and Assessment Flowchart and Tools and Resources section (pages 22-24) for suggested tools.
- Provide training to identified staff members in use of the screening tool. Prepare them to make observations and, if possible, to ask questions of the child, family, and any other key case participants who can provide the information needed to ascertain if further assessment is needed.
- When the screening takes place, make sure a mental health provider is available by phone to address any urgent issues that may arise.
- Maintain all screening results in the child's case record to allow for comparison between each screening and future results.

  Note: It is important that the child has a physical exam in order to make sure that his or her behavioral or emotional symptoms are not a response to a medical condition.

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

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

Rationale: Why is this Guideline important?

- A second screening is important for evaluating overall functioning and identifying children who may need mental health services.
- It is also important to gather information on the child's past and present trauma history, as well as his or her emotional, behavioral, and developmental status from current caregivers and, where feasible, from caregivers of origin for a more comprehensive evaluation.

  Note: The goal of this screening is to determine if a comprehensive assessment is needed (see Guideline 3). The screening is not meant to determine if a child meets diagnostic criteria or requires treatment.)

Implementation: How can I incorporate this Guideline at my agency?

- Identify staff members who will conduct Stage 2 screening. This screening does not have to be conducted by a mental health professional, although staff members should be trained appropriately.
- Provide training to identified staff members in use of the screening tool. Prepare them to make observations and to ask questions of the child, family, and any other key case participants who can provide the information needed to ascertain if further assessment is needed.
- Have a mental health provider interpret the results of the screen.
- Collect screening information from caregivers during regular or prescheduled visits at the agency. If the caregiver rarely visits the agency or has a history of failing to show up for scheduled appointments, make the screening part of the caseworker's mandated routine visit.

- Maintain all screening results, and related referrals for additional evaluation and/or treatment in the child's case record
- Refer to the Screening and Assessment Tools & Resources section (pages 22-39) for suggested screening tools.

Note: It is important that the child have a physical exam in order to make sure that his or her behavioral or emotional symptoms are not a response to a medical condition.

Guideline 3.
Comprehensive Assessment for Children with Positive Screening Results

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

Rationale: Why is this Guideline important?

- A comprehensive mental health assessment provides a more in-depth evaluation of mental health and substance abuse concerns, and assesses specific problems and symptoms. This ensures that children suspected of needing mental health services receive the appropriate help.
- Many children who come into care are treated without identifying their traumas or abuse. As a result, they are often being treated for multiple diagnoses with a significant amount of drugs. Therefore, it is crucial that these children have a comprehensive assessment in order to determine the accurate diagnosis and the correct medication needed.

Implementation: How can I incorporate this Guideline at my agency?

- Identify qualified mental health providers who will conduct the comprehensive mental health assessment. It is important to keep in mind the cultural background of the child and, when possible, to choose a mental health provider of a similar background or one who is multi-culturally competent.
- Qualified mental health providers should receive regular enrichment training about the identification of mental health problems among youth in the child welfare population. This training should emphasize the importance of including the following topics in a comprehensive mental assessment:
  - Detailed psychosocial history including emotional and behavioral problems, psychiatric treatment, current and past trauma exposure, life stressors, educational functioning, involvement with other agencies (e.g., juvenile justice), family relationships and social supports, peer development, social skills and deficits, etc.
  - Safety concerns: risk of harm to self or others, risk of running away from placements, child drug or alcohol use.
  - Family or parent risk factors (e.g., parent drug or alcohol abuse, parent severe mental illness, parent intellectual/cognitive/physical impairment, impaired parenting skills, monetary problems, domestic violence, etc.) and strengths.
  - Community risk factors (e.g., neighborhood safety, exposure to community violence, etc.).
  - Strengths and adaptive functioning at home, school, and other environments.
  - Specific description of treatment needs.
- Refer to the Mental Health Screening and Assessment Tools & Resources section (pages 22-39) for suggested assessment instruments.
- Develop strategies for completing the assessment in a timely fashion (e.g., pool of mental health providers to conduct assessment, flexibility in where the assessment is conducted—agency, clinic, home, or school). This may be challenging for many agencies that depend on community mental health clinics, but forming partnerships with community agencies may facilitate the assessment process.

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

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

Rationale: Why is this Guideline important?

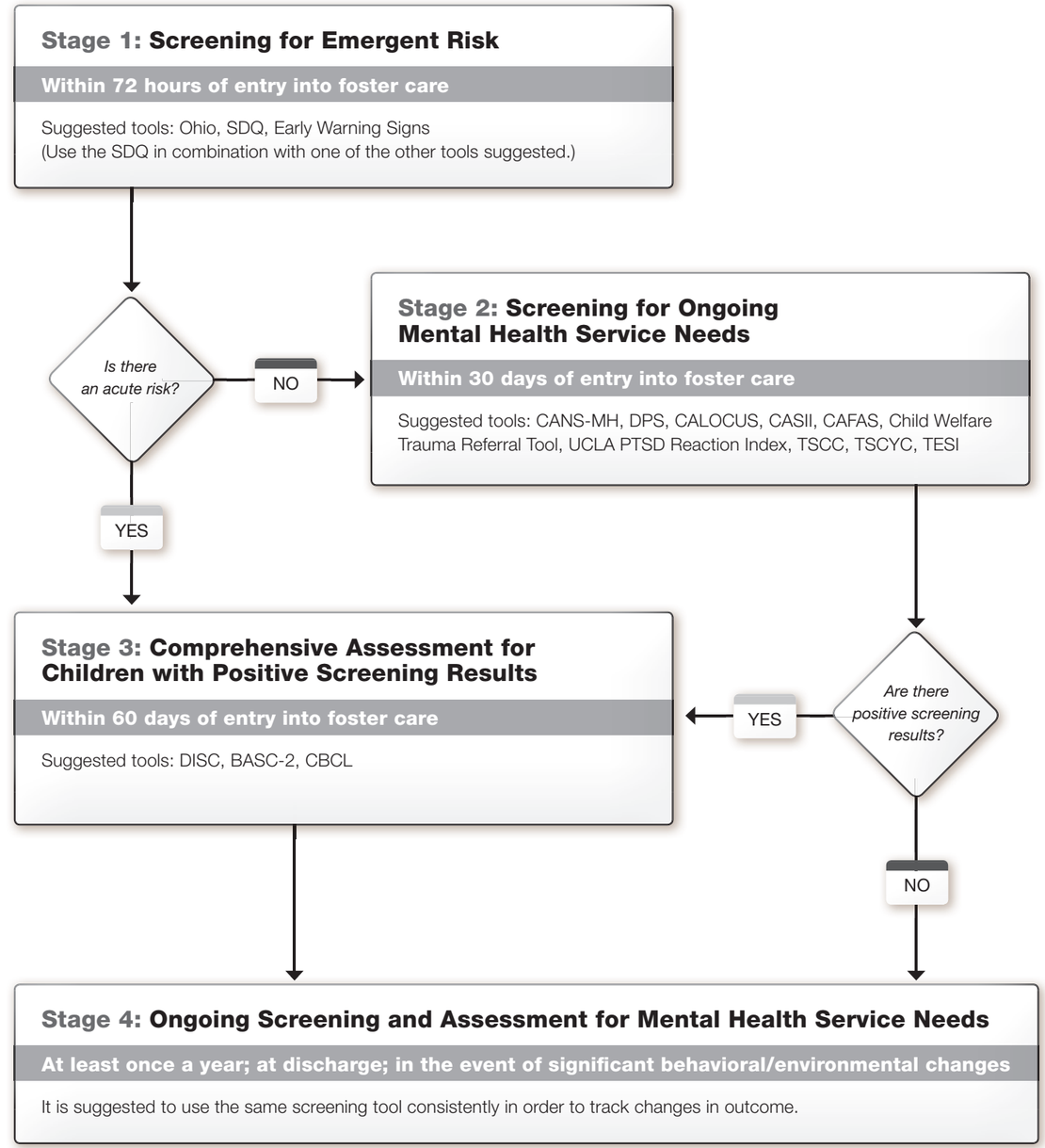
- Children who do not have mental health problems upon entry into the child welfare system may develop problems at a later time. Most of the children in the child welfare system enter the system with a trauma history and they are particularly vulnerable to the development of emotional or behavioral problems and to being re-victimized/traumatized. Often past traumas or traumatic responses are triggered, thereby making it difficult for them in their placement, school, relationships, etc. This guideline helps to ensure their continued safety and well-being by recommending ongoing screening and assessment.
- For many children, the circumstances that brought them into care may not resolve quickly or ever and they remain in care. There is much uncertainty in these children's lives and it causes significant distress for them. The longer the situation goes on, the more upset and depressed the child may get.
- Children being reunified with their family or adopted may need ongoing mental health treatment and support.

- Children leaving the system and moving into self-sufficiency may still require assistance in dealing with issues related to their family and their individual mental health needs. Therefore, it is important to assist those who need, or desire, further mental health services to obtain adequate referral and follow-up plans and to assure continuity of care.

Implementation: How can I incorporate this Guideline at my agency?

- Have the child's current caseworker administer the screening during the yearly re-evaluation.
- Provide training to caseworkers in use of the screening tool. Prepare them to make observations and ask questions of the child, family, and any other key case participants who can provide the information needed to ascertain if further assessment is needed.
- If the child is already in therapy, have his or her current therapist conduct this screening.
- Choose the screening tool that was used in stage 1 or stage 2. When the screening takes place, make sure a mental health provider is available by phone to address any urgent issues that may arise.
- Maintain all screening results in the child's case records.

Mental Health Screening and Assessment Flowchart



Mental Health Screening and Assessment Tools

Measure	Description	Target Age	Time (minutes)	Digital format available?
Behavior Assessment System for Children (BASC-2)	Measures emotions and behaviors	2-25	10-30	Y
CASII	Measures a child's strengths and needs	6-18	5-10 (short version) 10-20 (long version)	N
Child Behavior Checklist (CBCL)	Measures social competence and behavioral functioning in four general domains (externalizing symptoms, general symptomatology, internalizing symptoms, and mood and anxiety symptoms)	1.5-18	10-20	Y
Child and Adolescent Functional Assessment Scale (CAFAS)	Measures functional impairment	6-17	10	N
Child and Adolescent Level of Care Utilization System (CALOCUS)	Determines the level of care of a child based on the child's clinical needs	6-18	Varies	Y
Child and Adolescent Needs and Strengths, Mental Health (CANS-MH)	Assesses strengths and mental health risk factors	0-5 5-18	10	N
Child Welfare Trauma Referral Tool	Helps child welfare workers make trauma-informed decisions about the need for referral to trauma-specific and general mental health services	1-20	15-30	N
Diagnostic Interview Schedule for Children (DISC)	Assesses for most DSM-IV disorders	6-18 (Parent version)	Varies	Y

Mental Health Screening and Assessment Tools (continued)

Measure	Description	Target Age	Time (minutes)	Digital format available?
Diagnostic Interview Schedule for Children Predictive Scales (DPS)	Assesses for most DSM-IV diagnosis	9-17	10-15	Y
Early Warning Signs	Assesses at-risk behaviors that may indicate potential mental health problems	6-18	2	N
Ohio Youth Problem, Functioning and Satisfaction Scales (OHIO Scales)	Assesses problem severity, functioning, satisfaction, and hopefulness	5-18	5	N
Strengths and Difficulties Questionnaire (SDQ)	Assesses positive and negative attributes on five scales (emotional, conduct, hyperactivity, peer problems, pro-social behavior)	4-10 11-17	5	N
Trauma Events Screening Inventory (TESI)	Assesses for history of exposure to traumatic events	6-16	20-30	N
		(Parent version available for children under 7)		
Trauma Symptom Checklist for Children (TSCC)	Evaluates acute and chronic post-traumatic symptomatology and other symptom clusters found in some children who have experienced traumatic events	3-17 (Parent report)	15	N
Trauma Symptom Checklist for Young Children (TSCYC)	Caretaker-report instrument developed for the assessment of trauma-related symptoms in youth children	3-12 (Parent report)	15	N
UCLA PTSD Reaction Index	Self-report and interviewer-administered scale for children that assesses DSM-IV PTSD symptoms as well as trauma-related guilt and fears of recurrence	6-18	15-30	N

Mental Health Screening and Assessment

This section provides more information on screening and assessment tools that can be used in accordance with the Mental Health Screening and Assessment Guidelines. Please refer to the flowchart when choosing a tool; the flowchart suggests tools that can be used at each stage. It is important to keep in mind that different types of tools are used in the screening stage versus the comprehensive assessment stage.

Behavior Assessment System for Children (BASC-2)

The BASC is a comprehensive and developmentally sensitive measure of the emotions and behaviors of youth age 2-25. It is composed of eight scales:

- Anger control
- Bullying
- Developmental social disorders
- Emotional self-control
- Executive functioning
- Negative emotionality
- Resiliency

Versions of the BASC exist for youth (self-report), parents (parent rating scales, structured developmental history, and parenting relationship questionnaire), and teachers (teacher rating scale, student observation system, and portable observation program). Each version takes approximately 10-30 minutes to complete.[4]

Contact Information

James A. Simone
Pearson Measurement Consultant
Clinical Assessment
Phone: (347) 726-7022
Fax: (917) 591-3212
E-mail: jim.simone@pearson.com
Web site: www.pearsonassessments.com/basc.aspx

Training Information:

There are multiple levels of training. The first level of training is a general overview of how to administer and score the BASC-2, and how to interpret the scores. This takes approximately 2.5-3 hours. A second level of training includes the interpretation of 2-3 case studies. It takes 5-6 hours to complete both levels of training. Training is done on site and includes materials and handouts.

Additional Information:

The BASC can be administered and scored in a number of ways, including paper and pencil with manual scoring; paper and pencil with scanned scoring; general “Assist” narrative and scoring software; advanced “Assist Plus” narrative and scoring software; or with client server. “Assist Plus” gives outcomes for 10 clinical scales related directly to the DSM-IV.

The Child and Adolescent Service Intensity Instrument (CASII)

The CASII is an adaptation of the CALOCUS used to measure the strengths and needs of children, age 6-18, who are seriously emotionally disturbed or have a mental health, developmental, or substance use disorder. The instrument helps service providers determine the appropriate level of service intensity for a child and may be completed by multiple informants. It measures six dimensions:

- Risk of harm
- Functional status
- Co-occurrence of conditions
- Recovery environment
- Resiliency and/or response to service
- Involvement in services

The short version takes 5-10 minutes to complete; the long version takes 10-20 minutes.[5]

Contact Information

Kristin Kroeger Ptokowski
3615 Wisconsin Avenue, NW
Washington, DC 20016
Phone: (202) 966-7300 ext. 108
Fax: (202) 966-1944
E-mail: kkroeger@aacap.org

Available Training:

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

Additional Information:

The one-day training costs $2000 per day, plus travel expenses and training manuals. The two-day training costs $3,750, plus travel expenses and training manuals. The cost of the manuals is $25-35 depending on the quantity purchased. (Prices as of 2009).

Child Behavior Checklist (CBCL)

The Child Behavior Checklist (CBCL) is a standardized, norm-reference measure of social competence and behavioral functioning in four general domains (externalizing symptoms, general symptomatology, internalizing symptoms, and mood and anxiety symptoms) for children age 1.5-18. Parent/teacher-completed and child-completed (ages 11-17 only) versions of the measure exist. Each version has 113 items and takes approximately 15-20 minutes to complete.[6]

Contact Information

ASEBA/Research Center for Children, Youth and Families
1 South Prospect Street
St. Joseph's Wing (3rd Floor, Room 3207)
Burlington, VT 05401
Phone: (802) 656-5130
Fax: (802) 656-5131
E-mail: cbcl@uvm.edu
Web site: www.aseba.org/products/manuals.html

Training Information:

No formal training is available.

Additional Information:

CBCL software, forms, and manuals are available at the Web site listed above. The cost of each varies depending on the version of the CBCL used.

Dr. Thomas Achenbach, the developer of the CBCL, can be reached at thomas.achenbach@uvm.edu

Child and Adolescent Functional Assessment Scale (CAFAS)

The CAFAS measures functional impairment for children age 6-17 who are at risk for developing emotional, behavioral, substance use, psychiatric, or psychological problems. The measure contains 315 multiple choice items and takes about 10 minutes to administer. The PECFAS is a version of the same scale for children age 3-7.[7]

Contact Information

Functional Assessment Systems
3600 Green Court, Suite 110
Ann Arbor, MI 48105
Phone: (734) 769-9725
Fax: (734) 769-1434
E-mail: hodges@provide.net
Web site: www.cafas.com

Training Information:

Self-training and group-training materials are available. Self-training entails purchasing a $25 manual and completing the vignettes provided. A letter is then sent stating that the individual has passed the training and can score the CAFAS but not train others.

Group trainings are offered 1-2 times per year in Michigan. Group training consists of an intensive 2-day workshop that teaches participants how to score the CAFAS and train others. Participants attending group training receive a manual, *The Manual of Training Coordinators, Clinical Administrators and Data Managers*. This manual can also be purchased separately.

Child and Adolescent Level of Care Utilization System (CALOCUS)

The CALOCUS is designed to determine the level of care that a child needs based on the child's clinical needs. It is not a diagnostic measure, but rather it assesses the presenting problems and related co-morbid conditions of the child. The CALOCUS may be used at multiple time points (i.e., admission, continued stay, and discharge), eliminating the need to use different tools at different times. Information for the CALOCUS is obtained by a professional conducting a clinical assessment.[8]

Contact Information

Robert D. Benacci, Project Development Specialist

Deerfield Behavioral Health, Inc.

2808 State Street

Erie, PA 16508

Phone: (814) 456-2457

Fax: (814) 456-7679

E-mail: robb@dbhn.com

Web site: www.locusonline.com

Training Information:

Training is offered on site and includes information on developing, understanding, and using the instrument. The cost is $1000 for four hours of training, including 20 training manuals, plus travel expenses.

Additional Information:

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

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

The CANS-MH assesses strengths as well as mental health risk factors for children age 0-5 and 5-18 in three domains:

- Risk behaviors
- Behaviors/emotions
- Functioning

The scale has 42 items that are used to assess the child, or the child's family, currently or retrospectively. It can be completed in about 10 minutes.[9]

Contact Information

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praedfoundation@yahoo.com

Web site: www.buddinpraed.org

Training Information:

Training is available through Web sites such as:
http://www.dcfscansnu.com/ (online training only)
http://www.communimetrics.com/CansCentralIndiana/ (online or on site training available)

Training at http://www.dcfscansnu.com/ takes 4.5-4 hours, and includes a copy of the CANS manual, two videos, practice vignettes, and a certification test. For more training options or to find a trainer, please contact Melanie Buddin Lyons or John Lyons.

The CANS manuals and forms are available at no cost from the Buddin Praed Web site, www.buddinpraed.org, after registration. The Buddin Praed maintains the copyright to ensure intellectual integrity. The manuals explain how to administer and score the CANS.

Additional Information:

The contact information above is for obtaining copies of the CANS-MH. John S. Lyons, PhD, the developer of the CANS-MH, may be reached at the following address: Mental Health Services and Policy Program, Abbott Hall, Suite 1205, 710 North Lake Shore Drive, Chicago, IL 60611. Dr. Lyons can also be reached at jsl329@northwestern.edu or (312) 908-8972.

Child Welfare Trauma Referral Tool

The Child Welfare Trauma Referral Tool is designed to help child welfare workers make more trauma-informed decisions about the need for referral to trauma-specific and general mental health services. It is to be completed by the child welfare worker through record review and key informants (i.e., birth parent, foster parent, child therapist, school-aged children or adolescents if appropriate, and other significant individuals in the child's life).

This tool allows the child welfare worker to document the following:

- Trauma exposure history and duration
- Severity of child's traumatic stress reactions
- Attachment problems
- Behaviors requiring immediate stabilization
- Severity of the child's other reactions/behaviors/functioning

The final section of the Child Welfare Trauma Referral Tool provides strategies for making recommendations to general or trauma-specific mental health services by linking the child's experiences to his or her reactions.[10]

Contact Information

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Treatment Outcome Coordinator, Trauma Counseling
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Fax: (858) 966-7524
E-mail: rigelman@rchsd.org
Web site: www.chadwickcenter.org or
http://www.chadwickcenter.org/Documents/Trauma_History_Profile_Tool_draft_8%2023%2006n.pdf

Training Information:

No formal training is available.

Additional Information:

The forms are available at no cost at the Web site listed. A briefer version of the tool is currently in development.

Diagnostic Interview Schedule for Children (DISC)

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

The instrument is organized as a series of modules. The first module assesses demographic information (e.g., age, grade, and names of siblings, etc.). The next six modules target disorder areas (i.e., anxiety, mood, disruptive, substance use, schizophrenia, and miscellaneous disorders).[11]

Contact Information

Prudence Fisher, PhD (general or training information)
NIMH-DISC Training Center at Columbia University/NYSPI
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1051 Riverside Drive
New York, NY 10032
Phone: (212) 543-5357
(212) 543-5189
E-mail: nimhdisc@child.cpmc.columbia.edu
fisherp@childpsych.columbia.edu

Training Information:

Training is available at Columbia University, New York, or at individual sites. The training is 1-2 days and consists of the use and scoring of the computerized and paper versions of the DISC, data analysis, and role-plays. Individuals at sites can be trained to train others on the use of the DISC. Training is $400 per day at Columbia University, New York or $1,200 per day at home sites (for the first 10 people), plus travel expenses. For an additional fee of $600, an additional 8 individuals can be trained on site.

Additional Information:

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

Diagnostic Interview Schedule for Children Predictive Scales (DPS)

The DPS is a brief, diagnostic screening measure based on the DSM. Parent and youth versions of the DPS exist for children age 9-17. The DPS has approximately 90 items and takes about 10 minutes to complete. It accurately predicts whether a child is likely to meet criteria for a DISC diagnosis. It includes a series of diagnostic-specific symptom scales that uses the minimum number of questions to efficiently predict a probable diagnostic status.[12]

Contact Information

Christopher P. Lucas, MD
Associate Professor,
Institute for Prevention Science
Director, Early Childhood Service
NYU Child Study Center
215 Lexington Avenue, #1414
New York, NY 10016
Phone: (212) 263-2499
E-mail: chris.lucas@med.nyu.edu

Training Information:

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

Additional Information:

Paper versions of the DPS are available at a cost of $1 per form. The computerized version of the measure costs $250 for installation plus a $1000 site licensing fee.

Early Warning Signs Checklist

The Early Warning Signs Checklist is a list of “at risk” behaviors that may indicate potential mental health problems and a need for intervention. The checklist is made up of 11 warning signs for potential internalizing and externalizing disorders. It is self-administered by both youth and their birth and foster parents, and takes less than 2 minutes to complete. If any items have been checked, the child should be referred for further evaluation.

Contact Information

Lisa Hunter Romanelli, PhD
Director of Programs
The REACH Institute
708 Third Avenue, 5th Floor
New York, NY 10017
Phone: (212) 209-3871
Fax: (212) 209-7123
E-mail: lisa@thereachinstitute.org
Web site: www.thereachinstitute.net

Training Information:

Formal training is available at the REACH Institute.

Additional Information:

The Early Warning Signs is available in Spanish.

Ohio Youth Problems, Functioning and Satisfaction Scales (OHIO Scales)

The OHIO Scales assess problem severity, functioning, hopefulness, and satisfaction with behavioral health services in child age 5-18. The scales have three parallel forms that can be completed by the child's parent or primary caregiver, the child (12 and over), and the youth's caseworker. The screen consists of 44 items and takes approximately 5 minutes to complete.[13]

Contact Information

Office of Program Evaluation and Research
Ohio Department of Mental Health
30 E. Broad St., Suite 1170
Columbus, OH 43215
Phone: (614) 466-8651
E-mail: outcome@mh.state.oh.us
Web site: www.mh.state.oh.us/oper/outcomes/instruments.index.html

Training Information:

No formal training is available.

Additional Information:

The OHIO Scales forms as well as the user and technical manuals are available at no cost at the Web site listed. The manuals provide information about administering and scoring the measure.

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

Strengths and Difficulties Questionnaire (SDQ)

The Strengths and Difficulties Questionnaire (SDQ) is a brief questionnaire consisting of 25 items assessing positive and negative attributes on five scales:

- Emotional
- Conduct
- Hyperactivity
- Peer problems
- Pro-social behavior

An Impact Supplement is also available to assess chronicity, distress, and social impairment. A self-report version of the measure exists for adolescents, age 11-17, as well as teacher and parent versions for children age 4-10 and 11-17. It takes approximately 5 minutes to complete. Follow-up questionnaires for both age ranges should be given approximately one month following the last visit.[14]

Contact Information

Robert Goodman, PhD
Department of Child and Adolescent Psychiatry
Institute of Psychiatry
DeCrespingy Park
London SE5 8AF, United Kingdom
Web site: www.sdqinfo.com

Training Information:

No formal training is available.

Additional Information:

SDQ forms and scoring information are available at no cost at the Web site. The SDQ is available in 46 languages.

Trauma Events Screening Inventory (TESI)

The Trauma Events Screening Inventory (TESI) inquires about a variety of traumatic events (e.g., current and previous injuries, domestic violence, sexual abuse, etc.) and assesses trauma-related symptoms. It is a 24-item scale designed for children age 6-18. There is a self-report for youth age 8 and older, and a parent-report for youth age 7 and younger. Each form takes 20-30 minutes to complete.[15]

Contact Information

The National Center for PTSD

VA Medical & Regional Office Center

White River Junction, VT 05009

E-mail: ncptsd@ncptsd.org

Web site: http://stage.web.fordham.edu/images/academics/graduate_schools/gsss/catm%20-%20history%20of%20trauma%203.pdf

Training Information:

No formal training is available.

Additional Information:

The TESI forms are available at no cost at the Web site listed.

Trauma Symptom Checklist for Children (TSCC)

The Trauma Symptom Checklist for Children (TSCC) is a self-report questionnaire that assesses distress and other related symptoms after an acute or chronic trauma for youth age 8-16. The screen is 54 items and takes approximately 15-20 minutes to complete.

Contact Information

John Briere

Psychological Trauma Program

USC Psychiatry

2020 Zonal Avenue

Los Angeles, CA 90033

E-mail: Jbriere@usc.edu

Web site: www.Johnbriere.com

Training Information:

No formal training is available.

Additional Information:

The TSCC forms are available at a cost of $59 for a packet of 25 forms at the Web site listed.
The TSCC is also available in Spanish, Chinese, Dutch, French, Japanese, Latvian, Slovenian, and Swedish.

Trauma Symptom Checklist for Young Children (TSCYC)

The Trauma Symptom Checklist for Young Children (TSCYC) is a 90-item caretaker-report instrument designed to assess trauma-related symptoms in children age 3 to 12. It takes approximately 15 minutes to complete.[16]

Contact Information

John Briere
Psychological Trauma Program
USC Psychiatry
2020 Zonal Avenue
Los Angeles, CA 90033
E-mail: Jbriere@usc.edu
Web site: www.Johnbriere.com

Purchasing Information

Psychological Assessment Resources, Inc.
16204 N. Florida Avenue
Lutz, FL 33549
Phone: (800) 331-8378
E-mail: custsup@parinc.com
Web site: www3.parinc.com/products/product.aspx?Productid=TSCYC

Training Information:

No formal training is available.

Additional Information:

The TSCYC forms are available at a cost of $44 for a packet of 25 forms at the Web site listed.
The TSCYC is also available in Spanish and Swedish.

UCLA PTSD Reaction Index

The UCLA PSTD Reaction Index is a screening questionnaire based on the DSM-IV diagnostic criteria for PTSD that assesses post-traumatic stress reactions among children and adolescents age 7 and older. Both self- and parent-report forms are available. The screening questionnaire contains 20 to 22 items for the child and adolescent versions, respectively.[17]

Contact Information

Robert Pynoos
UCLA Trauma Psychiatry Service
300 UCLA Medical Plaza, Suite 2232
Los Angeles, CA 90025
Phone: (310) 206-8973
E-mail: rpynoos@mednet.ucla.edu

Training Information:

No formal training is available.

Additional Information:

More information on the UCLA PTSD Reaction index as well as scoring forms can be obtained by contacting Dr. Pynoos at the phone number or e-mail listed.

Psychosocial Interventions

Youth in foster care experience mental health disorders at rates higher than those in the general population.[18] Accordingly, attention to the use of psychosocial interventions in child welfare settings has increased, with a strong focus on the use of evidence-based interventions. While there are many treatments available, it may be difficult for child welfare workers to identify appropriate and effective mental health interventions for youth and link them with these services.

This section of the toolkit contains the following:

Psychosocial Intervention Guidelines (page 42)

The four guidelines presented in this section emphasize the importance of individualized, evidence-based, and strengths-focused interventions for youth in the child welfare system. Each guideline is supported with information underscoring its importance and tips on how to implement the guideline at your agency.

Psychosocial Interventions (page 46)

These table summarizes the key characteristics of the evidence-based psychosocial interventions.

Psychosocial Intervention Tools & Resources (page 52)

The Tools & Resources section provides descriptions and additional information about how to access evidence-based psychosocial interventions, including details on available trainings and manuals.

Guideline 1.
Access to Evidence-Based Interventions

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

Rationale: Why is this Guideline important?

- Evidence-based practices are built on the foundation of scientific research and are proven to effect positive change for youth and families; they acknowledge the clinical experience of practitioners and seek to underscore the importance of family values in treatment decisions. These practices are informed by research evidence and clinical experience, and coincide with patient values.[19]
- Evidence-based practices are superior in improving mental health care among children, youth, and families connected to the child welfare system compared to less promising interventions.

Implementation: How can I incorporate this Guideline at my agency?

- Identify evidence-based psychosocial interventions that fit the needs of your agency and its clients.
- Refer to the Psychosocial Intervention Tools & Resources section (page 52) and the California Evidence-Based Clearinghouse (CEBC) for child welfare (www.cachildwelfareclearinghouse.org).
- Identify licensed providers with training in evidence-based interventions (EBIs).
- Contact the developers or local representatives of specific interventions (see contact information in the Psychosocial Intervention Tools & Resources section).
- Contact provider organizations with a focus on evidence-based interventions (e.g., Association for Behavioral and Cognitive Therapies [ABCT]).
- Ask providers if they have training in EBIs.

Guideline 2.
Individualized and Strengths-Based Interventions

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

Rationale: Why is this Guideline important?

- Individualized treatment is critical for addressing the unique needs of youth and their families.
- Individualized treatment planning takes into account (1) the strengths of the client and (2) directly involves the caregivers and client, when feasible, in the development and choice of treatment planning, all while considering the unique characteristics of the child welfare system (permanency planning) and foster care (e.g., temporary and permanent caregivers, goal of reunification).[20]
- The involvement of parents and caregivers in their child's psychosocial interventions can enhance treatment outcomes, resulting in more significant, generalized, and longer-lasting improvements[21]; refer to Guideline #8, Parent Engagement (page 111).

Implementation: How can I incorporate this Guideline at my agency?

- Make sure mental health services providers serving your agency have experience working with youth in the child welfare system and the skills necessary to individualize EBIs for this population.
- Inform mental health providers of a child's permanency plan, while affording them the opportunity to have input in an evolving permanency plan. Conversely, ensure that the child's permanency plan and related child welfare activities (e.g., visitation) are communicated to the mental health clinician and accounted for as part of the child's mental health treatment.
- Whenever possible, provide interventions to youth that encourage caregiver involvement.
- Most of the interventions described in the Psychosocial Interventions Tools & Resources section encourage caregiver involvement for successful treatment. For instance, if reunification is a goal, both the birth parent and the foster parent should receive psychoeducation and be encouraged to participate in the child's treatment or portions of the treatment. It may also be possible to begin treatment with foster parent participation and transition to birth parent participation, and/or engage the foster parent and birth parent concurrently. Decisions about birth and foster parent involvement in treatment should be made by the mental health provider in consultation with the child's caseworker.

Guideline 3.
Collaboration with Mental Health Partners

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

Rationale: Why is this Guideline important?

- The child welfare system has three critical functions: 1) protecting children (safety), 2) preserving families (permanence), and 3) safeguarding child well-being.[22] This last function, addressing the well-being of children, requires services that are frequently delivered by agencies and service delivery systems outside of child welfare, such as physical, mental health, developmental, and education services.
- Research has found that increased coordination between the mental health and child welfare systems is associated with greater service use by children at the highest level of need. Also, coordination improves mental health care access among children, youth, and families who have been routinely subjected to disparities in the provision of effective health services.[23]

Implementation: How can I incorporate this Guideline at my agency?

- Identify local mental health partners and related service delivery systems.
- Form a collaborative partnership with these organizations to enhance communication between stakeholders for improved case management and goal attainment.
- When feasible, restrict mental health services exclusively to those mental health providers who affiliate with the child welfare agency and who thereby agree to comply with child welfare regulations and practices concerning consent, confidentiality, and the collection and sharing of protected health information.

Guideline 4.
Outcome Tracking

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

Rationale: Why is this Guideline important?

- Tracking psychosocial outcomes is a critical component of treatment and is necessary to ensure that children and their families are receiving services that are helping them to meet treatment goals (e.g., reduced out-of-home placements, reduced psychopathological symptoms, etc.). Without the tracking of treatment outcomes, it is difficult, if not impossible, to measure if an intervention has been effective for the client in producing sought outcomes.
- The large gap between what is known from research on the effectiveness of psychosocial interventions and what is found in usual mental health practice within child welfare further necessitates the need for (1) monitoring for beneficial changes in important outcomes (even when evidence-based practices have been put in place) and (2) assessing a diverse set of outcomes.

Implementation: How can I incorporate this Guideline at my agency?

- Identify the outcomes meaningful for your agency and work with mental health provider(s) to collect associated data. Some outcome data to consider include:
  - Standard mental health outcomes:
    - Psychosocial functioning
    - Client satisfaction
  - Outcomes that enforce the child welfare mission:
    - Placement stability
    - Permanency
    - Minimal length of stay in foster care
- Determine if there are outcome measures related to the psychosocial interventions being employed at your agency that can be used to track client outcomes. Refer to the Mental Health Screening and Assessment Tools & Resources for possible measures (page 22).
- If there is an existing outcome measure, review it to see if all of the outcomes of interest are incorporated. If not, you may need to develop a secondary measure to track additional outcomes of interest.
- If an appropriate outcome measure is not available, consider developing one that incorporates the mental health and child welfare outcomes listed above.

Evidence-Based Practice Rating Scale:

1 = Well-Supported by Research Evidence 2 = Supported by Research Evidence
3 = Promising Research Evidence 4 = Emerging Practice

Evidence-Based Psychosocial Interventions—PTSD and Abuse-Related Trauma

Intervention	Developer(s)	Description	Target Age	EBP Rating
Trauma-Focused CBT (TF-CBT)	J. Cohen, A. Mannarino, & E. Deblinger	Treatment of behavioral and emotional symptoms related to past trauma; incorporates both parent and child during 12-16 sessions	4-18	1
TF-CBT for Childhood Traumatic Grief	J. Cohen, A. Mannarino, & K. Knudsen	Treatment of children suffering from traumatic grief; incorporates both parent and child during 12-16 sessions	4-18	3
Abuse-Focused CBT (AF-CBT)	D. Kolko	Utilized in an outpatient settings for abusive parents and their children; 12-18 sessions	4-18	3
Parent Child Interaction Therapy (PCIT)	S. Eyberg, S. Boggs, & J. Algina	Structured therapy for abusive parents and their children; 12-20 sessions	4-12	1
Child-Parent Psychotherapy for Family Violence (CPP-FV)	A. Lieberman & P. Van Horn	For children who have witnessed violence or display violence-related symptoms; weekly sessions over 12 months	Up to 5	3
Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)	R. DeRosa, M. Habib, D. Pelcovitz, J. Rathus, et al.	Group intervention for chronically traumatized youth; weekly sessions over a 16 week period	12-18	4
Cognitive Behavioral Intervention for Trauma in Schools (CBITS)	L. Jaycox, B. Stein, M. Wong, & S. Kataoka	Skills-based, cognitive-behavioral program for children to reduce symptoms of PTSD, depression, and anxiety related to trauma exposure. CBITS is a 10-week program that includes youth group and individual sessions, two parent sessions, and a teacher session.	10-15	2

Evidence-Based Practice Rating Scale:

1 = Well-Supported by Research Evidence 2 = Supported by Research Evidence
3 = Promising Research Evidence 4 = Emerging Practice

Evidense-Based Psychosocial Interventions—Disruptive Behavior Disorder

Intervention	Developer(s)	Description	Target Age	EBP Rating
Parent Management Training	G. Patterson, R. Littman, & W. Hinsey	Short-term treatment teaches parents behavioral management skills; session length varies	Under 5	1
Incredible Years	C. Webster-Stratton	Support group based on parent management training and teaches behavior management skills to parents; 12 sessions	2-10	1
Time Out plus Signal Seat support	S. Hamilton & S. MacQuiddy	Self-instructive intervention using positive reinforcements and time-out utilizing a signal seat wired to produce noise if child leaves seat	2-7	3
Project Keep	P. Chamberlain, S. Moreland, & K. Reid	Support group for foster and kinship parents to increase parenting skills in working with children with significant behavioral problems (i.e., externalizing); 16 sessions	5-12	3
Anger Coping Therapy	J. Lochman	School or clinic intervention intended to provide children with coping skills for challenging situations; 12-18 sessions	8-12	1
Problem Solving Skills Training (PSST)	A. Kazdin	Individual child and parent therapy implementing cognitive problem-solving skills to improve behavioral problems; 12-20 sessions	6-14	3

Assertiveness Training	W. Huey & R. Rank	Training teaches effective relationship skills; 8-10 sessions	12-18	3
Anger Control Training with Stress Inoculation	K. Schlichter & J. Horan	Anger management skills and coping skills with stress inoculation component; 10 sessions	12-18	3
Rational Emotive Behavior Therapy (REBT)	A. Ellis	Incorporates cognitive and moral reasoning components to improve moral reasoning and judgment skills	12-18	3

Evidence-Based Practice Rating Scale:

1 = Well-Supported by Research Evidence
2 = Supported by Research Evidence
3 = Promising Research Evidence
4 = Emerging Practice

Evidense-Based Psychosocial Interventions—Depression

Intervention	Developer(s)	Description	Target Age	EBP Rating
Coping with Depression (CWD-A)	P. Lewinsohn, G. Clarke, H. Hops, & J. Andrews	Intervention explores techniques for use in combating depression; 16 sessions	Adolescents	3
Interpersonal Therapy for Adolescents	L. Mufson, D. Moreau, M. Weissman, & G. Klerman	Brief individual or group treatments used to target and resolve the interpersonal issues contributing to depression; 12 sessions	Adolescents	1
Self-Control Therapy	K. Stark, W. Reynolds, & N. Kaslow	Brief treatment teaches cognitive and behavioral techniques to help reduce symptomatology; 12 sessions	School-age and Adolescents	4
Enhanced Self-Control Therapy	K. Stark, L. Rouse, & R. Livingston	Uses an increased number of sessions and family meetings; up to 24 sessions	School-age and Adolescents	4
Relaxation Therapy	W. Reynolds & K. Coats	Utilizes relaxation techniques to reduce stress, muscle tension, and depression; 10 sessions	Adolescents	4
Cognitive Behavioral Therapy (CBT)	A. Beck	Cognitive and behavioral techniques to help reduce symptomology; 12-16 sessions	Adolescents	3

Evidence-Based Practice Rating Scale:

1 = Well-Supported by Research Evidence 2 = Supported by Research Evidence
3 = Promising Research Evidence 4 = Emerging Practice

Evidense-Based Psychosocial Interventions—Substance Abuse				
Intervention	**Developer(s)**	**Description**	**Target Age**	**EBP Rating**
Brief Interventions	Varies based on intervention	Varies based on intervention, i.e., health education programs	Varies	4
Cognitive Behavioral Therapy (CBT) for Substance Abuse	H. Waldron, N. Slesnick, J. Brody, C. Turner, et al	Cognitive and behavioral techniques to help reduce substance use; ranges from 5 to 12 sessions	13-25	3
Brief Strategic Family Therapy (BSFT)	J. Szapocznik, W. Kurtines, F. Foote, A. Perez-Vidal et al	Family therapy focused on children with emotional and behavioral problems and families with problematic relations	6-17	1
Functional Family Therapy (FFT)	T. Sexton & J. Alexander	Family therapy for use with children presenting with disruptive behavioral disorders and/or substance abuse	11-18	1

Evidence-Based Practice Rating Scale:

1 = Well-Supported by Research Evidence 2 = Supported by Research Evidence
3 = Promising Research Evidence 4 = Emerging Practice

Systemic/Multi-dimensional Comprehensive Interventions			
Intervention	**Developer(s)**	**Description**	**EBP Rating**
Multidimensional Treatment Foster Care (MTFC)	P. Chamberlain	Provides intensive therapeutic, supervisory, and case management services for children exhibiting chronic disruptive or anti-social behavior	1
Multisystemic Therapy (MST)	S. Henggeler	A brief family- and community-based treatment for children with behavior and substance abuse problems	Well-Supported by Research Evidence for juvenile justice population. Insufficient evidence to judge effectiveness with child welfare populations
Intensive Case Management (ICM)	N/A	Used to plan, monitor, coordinate, and advocate for the needs of children in various settings, including child welfare	NR
Wraparound	L. Behar	A process for identifying, planning, and coordinating the service needs of children and families with complex emotional and behavioral issues	NR
Triple P—Positive Parenting Program	M. Sanders	A multi-level system of parenting and family support applicable to children's social, emotional, behavioral, and health problems, and to prevention of child maltreatment	1

Psychosocial Interventions

This section of the toolkit provides informed descriptions for several evidence-based psychosocial interventions for psychiatric disorders most commonly found in children involved with the child welfare system. These disorders include post-traumatic stress disorder and abuse-related trauma, disruptive behavior disorders, depression, and substance abuse.

Most of the interventions described are short-term and based on cognitive-behavioral or behavioral principles. While only a few of the interventions have been specifically used in child welfare settings, most have been used with success in mental health clinics or schools—two settings with whom child welfare workers often collaborate. In addition, they all can involve birth parents and foster parents when indicated.

The information presented draws heavily from a comprehensive review of mental health care for children and adolescents in foster care prepared for Casey Family Programs and the Best Practices for Mental Health and Child Welfare Consensus Conference by John Landsverk, Barbara Burns, Leyla Faw Stambaugh, and Jennifer Rolls Reutz. Furthermore, a variety of sources, including medical and psychological databases (i.e., Medline and PsychInfo) and relevant intervention-specific, child welfare, and university Web sites, were referenced for this section of the toolkit.

The interventions listed below include a detailed description, information on how to purchase the intervention manual, training requirements, and contact information. The tables (pages 46-51) summarize all the psychosocial interventions described below.

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)[24]

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

TF-CBT for Childhood Traumatic Grief[25]

TF-CBT for Childhood Traumatic Grief is a relatively new treatment for children suffering from traumatic grief as a result of the traumatic loss of a loved one. Each session lasts one hour over a span of 12-16 sessions. The treatment is similar to TF-CBT but focuses more on fear and sadness associated with bereavement.

Contact Information

The Center for Traumatic Stress in Children and Adolescents
Allegheny General Hospital
Department of Psychiatry
4 Allegheny Center, 8th Floor
Pittsburgh, PA 15212
Phone: (412) 330-4328
Fax: (412) 330-4377
Web site: www.pittsburghchildtrauma.org

Training Information:

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

Additional Information:

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

Abuse-Focused Cognitive Behavioral Therapy (AF-CBT)[26]

AF-CBT is a 12-18 (one-hour sessions) intervention for physically abusive parents and their children, age 4 to 18, designed for delivery in clinic or home settings. This intervention teaches a variety of skills to parents and children including interpersonal skills, thinking and feeling skills, coping, relaxation, and anger management. In addition, the promotion of prosocial behavior and discouragement of coercive or aggressive behavior are key components of the intervention.[27, 28]

Contact Information

David J. Kolko, PhD

Western Psychiatric Institute and Clinic
University of Pittsburgh School of Medicine
541 Bellefield Towers
Pittsburgh, PA 15213

Phone: (412) 246-5888
Fax: (412) 246-5341
E-mail: kolkodj@upmc.edu
Web site: www.pitt.edu/~kolko

Training Information:
No formal training is available.

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

Cognitive Behavioral Intervention for Trauma in Schools (CBITS)

CBITS is a skills-based, cognitive-behavioral program for children to reduce symptoms of PTSD, depression, and anxiety related to trauma exposure such as exposure to violence. CBITS is a 10-week program that includes youth group and individual sessions, two parent sessions, and a teacher session. CBITS emphasizes the practice of skills to reduce the distress related to traumatic experiences and encourages collaboration between student and therapist facilitator to develop plans to practice these skills. CBITS also offers flexibility in the issues that are discussed in sessions.

Contact Information

Lisa Jaycox, PhD

RAND Corporation

1200 South Hayes Street
Arlington, VA 22202

Phone: (703) 413-1100
Fax: (703) 413-8111
E-mail: jaycox@rand.org
Web site: http://www.rand.org/health/projects/cbits/

Training Information:
Contact Audra Langley at UCLA for details: alangley@mednet.ucla.edu.

Additional Information:
Stein, B. D., Jaycox, L.H., Kataoka, S.H., Wong, M., Tu, W., Elliot, M.N., et al. (2007). A mental health intervention for schoolchildren exposed to violence. *Journal of the American Medical Association, 290*(5), 603-611.

Kataoka, S., Stein, B. D., Jaycox, L. H., Wong, M., Escudero, P., Tu, W., Zaragoza, C. & Fink, A. (2003). Effectiveness of a school-based mental health program for traumatized Latino immigrant children. *Journal of the American Academy of Child and Adolescent Psychiatry, 42*(3):311-318.

www.tsaforschools.org

The CBITS manual and a guide for adapting CBITS for youth in foster care are available through RAND.

Parent Child Interaction Therapy (PCIT)[29]

PCIT is a structured, brief intervention ranging from 12 to 20 one-hour sessions depending on problem severity. This intervention was originally developed for children with behavioral problems and has been specifically adapted for use with physically abusive parents and their children age 4-12. PCIT sessions involve live coaching during which parents learn how to apply specific parenting skills (i.e., relationship-enhancing, positive discipline and compliance) while playing with their children in the presence of a clinician.

Contact Information

Child Study Center

University of Oklahoma Health Sciences Center

1100 NE 13th Street

Oklahoma City, OK 73117-1039

Phone: (405) 271-5700 x 45128
Fax: (405) 271-8835
E-mail: darden-white@ouhsc.edu
Web site: www.pcit.org

Training Information:

A 5-day workshop is available through the University of Oklahoma Health Sciences Center, Cincinnati Children's Hospital Trauma Treatment Training Center, the University of Florida, the University of California, and the Davis CAARE Center. The workshop is followed by a booster session after three months and one year of weekly group consultation calls. Trainings are limited to 12 trainees. Costs vary.

Additional Information:

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

Child-Parent Psychotherapy for Family Violence (CPP-FV)[30]

CPP-FV targets young children (infancy to 5 years) and their parents, who have witnessed domestic violence or display violence-related trauma symptoms. The intervention is delivered in one-hour weekly sessions over the course of approximately 12 months. Sessions include both the parent and child and address the parent-child relationship and the child's functioning.[31]

Contact Information

Early Trauma Treatment Network University of California-San Francisco
Box 0852, SFGH Bldg 20 2100
San Francisco, CA 94143-0852
Phone: (415) 206-5377
Fax: (415) 206-5328
E-mail: patricia.vanhorn@ucsf.edu

Training Information:

The training consists of an initial 3-day intensive training followed by bi-weekly case consultation calls. Trainings are followed by 8-hour booster sessions every three months for the year following the initial training. Trainings take place at the University of California-San Francisco and on site at community agencies and are provided regionally through a series of learning collaboratives sponsored by the National Child Traumatic Stress Network. The cost of the training is approximately $1500 a day.

Additional Information:

A. F. Lieberman & P. Van Horn. (2004). *"Don't hit my mommy!" A Manual for Child-Parent Psychotherapy for Young Witnesses of Family Violence*. Zero to Three Press.

Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)[32]

SPARCS is a 16-session (one-hour per session) group intervention for adolescents age 12-21 who have experienced chronic trauma and developed problems in several areas of functioning. SPARCS uses cognitive-behavioral and dialectical-behavioral techniques in order to both enhance current strengths and foster resilience.[33] The goals of the intervention include improving adolescents' abilities to cope more effectively in the moment, cultivate awareness, enhance self-efficacy, connect with others, and create a sense of meaning in their lives. SPARCS can include a brief parental component with parent-clinician meetings held independently of the adolescent group.[34]

Contact Information

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Training Information:

The training consists of an initial 2-day training (composed of didactic presentations, demonstrations, role-plays, and mindfulness practice), a 1.5-day follow-up training 4-6 weeks after the start of group, and consultation calls throughout the duration of the implementation phase. Contact treatment developers for information on training locations and cost.

Psychosocial Interventions—Disruptive Behavior Disorders

- Parent-Focused Interventions
- Child-Focused Interventions
- Systems-Focused Interventions

Parent-Focused Interventions

Parent Management Training (PMT)[35]

PMT typically targets the parents of young children (under 5 years) with behavioral problems. The intervention uses principles of operant conditioning to teach parents behavioral management skills such as rewarding positive behavior, ignoring, and appropriate use of punishment. The intervention can be conducted in groups or with individual families.

Contact Information

The Parenting Center and Child Conduct Clinic
Department of Psychology
Yale University
314 Prospect Street
New Haven, CT 06520
Phone: (203) 432-9993
Fax: (203) 432-5225
E-mail: childconductclinic@yale.edu
Web site: www.yale.edu/childconductclinic

Training Information:

The 2-day training for therapists costs $500 per attendee.

Additional Information:

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

Incredible Years[36]

Incredible Years shares a common theoretical foundation with PMT and also targets the parents of young children with behavior problems. This intervention uses parent-child videotape vignettes to illustrate and teach key behavioral management techniques to parents. The intervention is delivered in a group format by a trained clinician over the course of 12 two-hour sessions.

Contact Information

Lisa St. George
1411 8th Avenue West
Seattle, WA 98119
Phone: (206) 285-7565
Fax: (888) 506-3562
E-mail: lisastgeorge@comcast.net
Web site: www.incredibleyears.com

Training Information:

The training is 2 to 3 days in length and certification varies based on level sought: basic to advanced. Trainings are provided at the Seattle, Washington site or privately upon arrangement. The 2-day training is $300 and a 3-day version is $400 per person.

Time Out Plus Signal Seat[37]

Time Out plus Signal Seat is a self-instructive intervention for parents of young children (age 2-7) with behavior problems. The intervention is based on the principles of operant conditioning and teaches parents how to use positive reinforcement and time-out to manage behavior. The Signal Seat is a seat wired to produce a noise if a child leaves it before a time-out period has expired.

Contact Information

Scott B. Hamilton, PhD
Colorado State University
Fort Collins, CO 80523
E-mail: sham@lamar.colostate.edu

Hamilton, S. B. & MacQuiddy, S. L. (1984). *Self-administered behavioral parent training: Enhancement of treatment efficacy using a time-out signal seat. Journal of Clinical Child Psychology, 13*, 61-69.

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

Project Keep is a 16-week group intervention that provides 7 to 10 foster and kinship parents with coping tools and support for their work with children, age 5-12, who exhibit externalizing symptoms and other behavioral and emotional problems. A comprehensive set of skills are covered in Project Keep, including, but not limited to, effective limit setting, encouraging participation, strengthening interpersonal relationships, and parental stress management.[38]

Contact Information

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10 Shelton McMurphey Blvd.
Eugene, OR 97401
Phone: (541) 485-2711
Fax: (541) 485-7087
E-mail: pattic@oslc.org
Web site: www.oslc.org

Training Information:

There is on site training for 5 days, followed by weekly phone supervision for 1 year and 1.5 years of consultation. There is a manual that also explains how to implement this program.

Child-Focused Interventions

Anger Coping[39]

Anger Coping is a 12-18 session group intervention designed for children age 8-12 with disruptive behavior problems. The intervention can be implemented in school or clinic settings and uses a social-cognitive perspective to teach problem recognition, physiological awareness, and problem-solving skills. Within school settings, teachers are responsible for making child referrals and may have the opportunity to co-lead sessions with a school psychologist. Parents (birth and/or foster) are highly encouraged to come into the school to learn about the intervention and provide consent. Furthermore, parallel parental involvement within a parent management training program is highly recommended and can further reduce aggressive behaviors.[40]

Contact Information

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Phone: (205) 348-3535
Fax: (205) 348-8648
E-mail: jlochman@gp.as.ua.edu

Additional Information:

J. Larson & J. E. Lochman. (2002). *Helping School Children Cope with Anger*. The Guilford Press.

Problem Solving Skills Training (PSST)[41]

PSST is a 12-20 session (30-50 minutes each) individual intervention for children, age 6-14. Treatment focuses on teaching cognitive problem-solving skills that address interpersonal problems and impulsivity through various procedures including modeling, role play, and reinforcement as well as critical reliance on the therapeutic provision of social reinforcement. Concurrent work with custodial parents is essential for helping parents learn about the problem-solving steps and promoting their child's use of these steps.[42]

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Fax: (203) 432-5225
E-mail: childconductclinic@yale.edu
Web site: www.yale.edu/childconductclinic

Anger Control Training with Stress Inoculation[43]

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

Contact Information

Donald Meichenbaum
University of Waterloo
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Training Information:

Workshops ranging from 1, 2, and 5 days are available.

Rational Emotive Behavioral Therapy (REBT)[44]

REBT is an individual, short-term treatment (10-20 sessions) with therapeutic aspects similar to cognitive behavioral therapy (CBT).[45] REBT is designed to improve the moral reasoning and judgment skills of youth with conduct disorder. REBT seeks to challenge thinking and irrational beliefs while promoting rational self-talk and various strategies to achieve these goals. Some strategies include disputing irrational beliefs, reframing, problem solving, behavior reversals, role-playing, and modeling.[46]

Contact Information

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E-mail: info@albertellis.org
Web site: www.albertellis.org

Training Information:

Tiered trainings are available including a 1-day workshop, a 3-day Primary Practicum (with four lectures and four rounds of supervision) and a 4-day Advanced Practicum. Training costs vary.

Additional Information

A. Ellis & C. MacLaren. (2007). *Rational Emotive Behavior Therapy: A Therapist's Guide*. Impact.

Multiple Family Group (MFG)[47]

Groups are co-facilitated by two therapists on a weekly basis over 16 weeks (1.5 hours per session) and consist of 6-8 families, including caregivers and children. Content surrounding four aspects of family functioning and linked to improvements in youth with externalizing behavioral problems is as follows: (1) rules, (2) responsibility, (3) relationships, and (4) respectful communication. The intervention is manualized with Cognitive Behavioral Therapy (CBT) components.

Contact Information

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Web site: http://marymckay.wordpress.com

Coping with Depression (CWD-A)[48]

CWD-A is a 16-session (2 hours per session) group intervention designed to teach depressed adolescents specific skills for combating depression. Skills covered in the group include mood monitoring, relaxation training, and conflict resolution skills. The intervention includes an optional parent component designed to help parents learn these skills and assist their children in using them.

Contact Information

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Web site: www.kpchr.org

Additional Information:

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

Interpersonal Psychotherapy for Adolescents (IPT-A)[49, 50]

IPT-A, an adaptation of Interpersonal Psychotherapy (IPT), is a brief treatment originally developed for the treatment of depressed, non-bipolar adults.[51] IPT aims to decrease depressive symptomatology and increase interpersonal functioning by placing the depressive episode in the context of interpersonal relationships and focusing on current interpersonal conflicts.

IPT-A has been adapted to treat outpatient adolescents who are suffering from a non-bipolar, non-psychotic, depressive episode. It is a 12-session (60-90 minutes per session) manualized individual or group treatment that addresses developmental issues most common to adolescents, including separation from parents; development of dyadic, romantic interpersonal relationships; initial experiences with the death of a relative or friend; and peer pressures. Parents (birth and foster parents) as well as other family members may be involved in various phases of IPT-A as needed and to address special issues that arise in the treatment of the adolescent.[52]

Contact Information

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New York State Psychiatric Institute
1051 Riverside Drive
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Phone: (212) 543-5561
Fax: (212) 543-6660
E-mail: lhm3@columbia.edu

Additional Information:

L. Mufson & D. Moreau. (2004). *Interpersonal Psychotherapy for Depressed Adolescents*. The Guilford Press.

Cognitive Behavioral Therapy for Adolescent Depression[53]

CBT for depressed children and adolescents is a brief, structured intervention that focuses on the relationship between thoughts, feelings, and behavior. Numerous CBT for depression manuals designed for use with children and adolescents exist, i.e., *Adolescent Coping With Depressing Course* (CWD-A), *Collaborative Care, Cognitive-Behavioral Program for Depressed Youth in a Primary Care Setting*,[54] *Cognitive Therapy Treatment Manual for Depressed and Suicidal Youth*[55]. The treatments described in each manual share a common focus on psychoeducation, mood monitoring, behavioral activation, and cognitive restructuring.

Contact Information

Western Psychiatric Institute and Clinic
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Phone: (412) 246-5619
Fax: (412) 246-5610
E-mail: brentda@upmc.edu
Web site: www.starcenter.pitt.edu/

Additional Information:

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

Psychosocial Interventions—Substance Abuse

- Cognitive Behavioral Therapy
- Family-Based Interventions

Cognitive Behavioral Therapy

Cognitive Behavioral Therapy for Substance Abuse[56]

CBT for Substance Abuse is a 5-12 session individual or group intervention that assists adolescents in identifying and avoiding high-risk situations that may trigger substance use by teaching coping, self-efficacy, and relapse prevention skills.

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Fax: (860) 679-1312
E-mail: kadden@psychiatry.uchc.edu

Additional Information:

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

Family-Based Interventions

Brief Strategic Family Therapy (BSFT)[57]

BSFT is a 12-15 session treatment (60-90 minutes per session) that targets children, age 6-17, who are exhibiting emotional and behavioral problems, and families with problematic relations (i.e., anger, blaming, etc.). Therapists seek to change maladaptive family interaction patterns as they occur in session by coaching the family in how to interact more functionally. Additional techniques include joining or engaging with the family, identifying maladaptive interactions and family strengths, and restructuring maladaptive interactions.[58] BSFT can be delivered in home-, clinic-, and community-based settings.

Contact Information

Family Therapy Training Institute of Miami
1221 Brickell Ave, 9th Floor
Miami, FL 33131
Phone: (888) 527-3828
Fax: (305) 661-5172
E-mail: info@bsft-av.com
Web site: www.brief-strategic-family-therapy.com/bsft

Training Information:

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

Additional Information:

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

Functional Family Therapy (FFT)[59]

FFT is a brief intervention for children, age 11-18, at risk for or presenting with disruptive behavior disorders and/or substance abuse. FFT typically involves 8-15 one-hour sessions and may be delivered in a variety of settings, including the home, clinic, or juvenile facility. The model consists of a systematic and multiphase intervention map that provides a framework for clinical decisions, within which the therapist can adjust and adapt the goals of the phase to the individual needs of the family. The three intervention phases, (1) engagement and motivation, (2) behavioral change, and (3) generalizations, are sequentially linked to specific goals for each family interaction. The intervention aims to enhance protective factors and reduce risk factors within the family through processes of engagement, motivation, assessment, behavior change, and generalization.

Contact Information

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Web site: www.fftinc.com

Training Information:

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

Additional Information:

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

Comprehensive Interventions

Multidimensional Treatment Foster Care (MTFC)[60]

MTFC provides intensive therapeutic, supervisory, and case management services for children exhibiting chronic disruptive[61] or anti-social behavior, who might otherwise be incarcerated, in residential or group treatment, or in the hospital[62]. In addition to MTFC for adolescents, an MTFC program has also been designed for pre-school aged children.[63] Treatment typically lasts 6-9 months.[64]

MTFC programs requires close collaboration between all those involved in a child's life, including the program supervisor; case worker; parole or probation officer, if any; the child's teachers and/or work supervisors; foster parents; and birth parents. MTFC foster parents receive a great deal of support and training from program staff and are expected to provide a structured, supportive home for the child. Foster parents are contacted seven times per week regarding their foster child, including a two-hour group, five 10-minute phone calls, and additional calls as needed. Foster parents use behavior management techniques with their foster child, provide close supervision, and keep the child away from delinquent peers.

The goal of MTFC is to return the child to his or her birth parents. While their child is in MTFC, birth parents receive support from the therapist, who teaches them how to use the behavior management skills being used in the foster home. Additionally, birth parents attend a one-hour group each week to build skills. Throughout a child's placement, birth parents are encouraged to attend supervised home visits with their child and maintain communication with their child's therapist.

Contact Information

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

Training Information:

Quarterly 4-5-day trainings are held in Eugene, Oregon, with weekly phone consultation thereafter. During the first year of implementation, 3 implementation progress reviews and a program evaluation are completed.

Additional Information:

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

Multisystemic Therapy (MST)[65]

MST is a brief (3-6 month) family- and community-based treatment for children with behavior and substance abuse problems. The treatment has been recently applied to children in the child welfare system. MST aims to preserve families by empowering parents/caregivers to deal with the difficulties of raising teenagers, and empowering youth to manage family, school, peer, and neighborhood problems. Although brief, MST is an intensive treatment that requires the active participation of parents and youth and provides 24/7 access to therapists.[66, 67]

Contact Information

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E-mail: marshall.swenson@mstservices.com

Web site(s): www.mstservices.com
www.mstinstitute.org

Training Information:

Training is offered only to teams in agencies with a licensed MST treatment program. There are 5-day orientations for clinical staff and 2-day supervisor orientations. An advanced supervisor workshop is also offered. Training includes initial on site training, quarterly on site consultation, and weekly consultation calls.

Additional Information:

For information about the costs of training in MST, please contact Marshall E. Swenson.

Wraparound[68]

Wraparound is a process for identifying, planning, and coordinating comprehensive community-based services for children and families with complex emotional and behavioral needs. Although numerous definitions of Wraparound exist, the following common elements emerge:

- Voice and choice
- Youth and family team
- Community-based services
- Cultural competence
- Individualized and strength-based services
- Natural supports
- Continuation of care
- Collaboration
- Flexible resources
- Outcome-based services

Within the field of child welfare, Wraparound emphasizes the importance of including birth parents in the service planning process for their children.[69] Wraparound consists of a team including the child, his or her birth parents and foster parents, and child welfare support networks, with both formal and natural supports.[70]

Contact Information

National wraparound initiative

Web site: Rtc.pdx.edu/nwi

Training Information:

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

Family Team Decision Making (FTDM)[71]

FTDM involves the supportive collaboration of key stakeholders (families, community members, and service providers) and helps in the development and implementation of relevant plans of action. These plans provide a road map for family members to identify and build upon their strengths through acquiring the services and resources necessary to enhance their capacity to provide safe and healthy home environments for their children.

Contact Information

American Humane Association

63 Inverness Drive East

Englewood, CO 80112

Phone: (800) 227-4645 or (303) 792-9900

Fax: (303) 792-5333

E-mail: info@americanhumane.org

Web site: http://www.americanhumane.org/protecting-children/programs/family-group-decision-making/

Triple P—Positive Parenting Program (Triple P)

Triple P is a multilevel system or suite of parenting and family support interventions that is organized for population dissemination but also implementable within a single organization. Triple P is intended for the prevention of (and early intervention for) social, emotional, and behavioral problems in childhood, the prevention of child maltreatment,[72] and the strengthening of parenting and parental confidence. Supported by a strong and growing evidence base,[73] Triple P can be tailored to family needs through flexible formats and delivery. This intervention system can serve several applications including differential response services, family-based child mental health treatment, assistance to foster parents, intervention with parents at risk for child maltreatment, and population-based prevention of child maltreatment.

Contact Information

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E-mail: contact.us@triplep.net

Web site: www.triplep.net (choose “United States” portal)

Training Information:

Training is delivered through organizations and communities to 20 service professionals per training course, typically at the host organization site. The first part of training is 3-5 days (depending on Triple P level and program variant) followed 6-8 weeks later by a second part (typically 1 day) to promote mastery and accreditation. Contact TPA for procedures and cost of training.

Additional Information:

TPA provides technical assistance and support, including managerial briefings, peer support network workshops, consultation to supervisors and coordinators, and assistance with Universal Triple P (the media and informational component that is added after other levels of Triple P are fully operational).

Psychopharmacological Interventions

This set of guidelines focusing on the proper use of psychotropic medication addresses the challenge of managing health care in the child welfare system. The diversity of mental health disorders and symptoms combined with the unique circumstances of children in child welfare calls for the close monitoring and evaluation of prescribed medications.

Research suggests that youth in foster care are often prescribed psychotropic medication at rates significantly higher than their non-foster care peers.[74] While youth in foster care do have higher rates of psychiatric disorders , little data exist to support the prescription of multiple psychotropic medications to treat these disorders.[75] Given the concerns about the possible overuse of psychotropic medication in youth in care, these guidelines are particularly important and encourage child welfare agencies to carefully monitor the use of psychotropic medication for such youth, with technical assistance as needed.

When children enter the child welfare system, the first step is to conduct an assessment to determine if mental health services are needed. If services are needed, in the absence of psychiatric emergencies, psychosocial interventions[76] alone should be considered first, followed by psychotropic medications in conjunction with psychosocial interventions (refer to Psychosocial Intervention Guidelines (page 42)). Psychotropic medication should only be prescribed when a clear DSM-IV diagnosis has been made and the disorder causes significant impairment or distress to the youth.

This section of the toolkit contains the following:

Psychopharmacological Guidelines (page 79)

The nine guidelines presented in this section have been developed to guide the use of psychotropic medications among children in foster care. Each guideline is supported with information underscoring its importance in addition to tips on how to implement it at your agency.

Medication Information (page 90)

This table summarizes the types of prescribed medications for mental health disorders:

- Stimulants
- Atomexatine
- Alpha agonists
- Antidepressants
- Antipsychotics
- Mood stabilizers

Psychopharmacological Tools & Resources (page 96)

The Tools & Resources section provides detailed information about measures that may be used to assess how prescribed psychotropic medications affect symptoms of:

- ADHD (page 96)
- Depression (page 98)
- Anxiety (page 100)

In addition, this section provides a list of Web sites with more information on the proper use of psychotropic medication.

Guidelines

Guideline 1.
Informed Consent

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

Rationale: Why is this Guideline important?

- Except in emergency situations, informed consent is legally required for all medical treatment.
- An informed caregiver is more likely to make positive decisions regarding the care of their child than one who has misleading information or no information.[77]
- The role of the prescriber is to provide the information necessary for the decision maker, i.e., the child's birth parent or legal parental surrogate, to come to a decision about the care of the child.
- Efforts must be made to include the youth as soon as possible through the assent process. This is particularly important for children aging out of state custody who are required to act as the arbiter for their own care between the ages of 18 and 21, in those states where foster care services are extended until age 21.

Implementation: How can I incorporate this Guideline at my agency?

- Use language the consenter understands to explain all the information he or she needs in order to make an informed decision. This may mean using simpler terms or making sure materials and information are provided in the client's and/or the consenter's language.
- This information includes:
  - All treatment options, including various environmental, psychosocial, and medication interventions available.
  - The risks and side effects of the medication.
  - The benefits of the medication.
  - What symptoms are being targeted.
  - Treatment plan and schedule.
  - Encourage the caregiver to ask any questions, to freely express any concerns he or she might have, and integrate those concerns into the child's treatment plan.

Guideline 2.
Access to and Documentation of Psychotropic Medication

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

Rationale: Why is this Guideline important?

- Because of the lack of permanency in their lives, children in the child welfare system often receive care that lacks coordination and integration. Therefore, when it comes to the child's health, it is especially important that the child's healthcare professional is fully informed of the child's medical history and current health status.
- A single storage for medical information that can travel with the child between placements or is held in a single location (medical home model or medical passport program) has been shown to improve outcomes for children in the child welfare system.[78]

Implementation: How can I incorporate this Guideline at my agency?

- Make sure all relevant information regarding prescribed psychotropic medication is documented in the child's case record and available to current and future healthcare providers.
- Consider adopting the medical home model or medical passport program in your agency.
- The foster care medical home is staffed by child healthcare professionals who understand the unique culture of foster care and provides:[79]
  - Health information gathering at time of removal
  - Initial medical screening
  - Ongoing health information gathering
  - Comprehensive health assessment
  - Follow-up assessment
  - Periodic preventative healthcare
  - Health information at time of discharge to appropriate caregivers and new primary care child health professional (if applicable)

Guideline 3.
Ongoing Communication with Child and Caregivers

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

Rationale: Why is this Guideline important?

- Psychotropic medications can be associated with significant side effects that cannot be predicted. In order to ensure that a child is not negatively affected from a medication trial, frequent follow-up visits are necessary.
- Side effects are most common in the initiation of a medication trial and close observation of the child is particularly important during the first few months of treatment with a new medication.

Implementation: How can I incorporate this Guideline at my agency?

- Caseworkers should check in regularly with the child with phone calls.
- Have caseworkers communicate frequently with the prescriber concerning the child's response to medication, as well as to make sure the child is seen regularly during the medication trial.
- During follow-up visits with the patient and caregivers, clinicians should evaluate environmental factors and/or changes that may improve or worsen the child's symptoms and determine adherence to prescribed treatment. Clinicians should also assess whether addressing such environmental factors and/or changes would address the child's symptoms as an alternative to psychopharmacology. Collect family insight to aid in this level of surveillance.[80]
- Clinicians should maximize communication by first inquiring about caregivers' and the child's pre-existing concerns, beliefs, and understandings about the causes, consequences, and interventions for specific symptoms/diagnoses[80] and integrate that into a shared understanding of the diagnosis and treatment plan.
- Encourage the child's caregiver and birth parent to communicate with the prescriber, ask questions, and express concerns. Questions may include:[81, 82]

  Before medication is prescribed:

  - What is the diagnosis?
  - What is the medicine, and how does it work?
  - Have studies been done on the medication?
  - Which tests need to be done before my child starts the medication?
  - Will any tests need to be done while my child is taking the medication?

- How soon will I see improvement?
- How often will my child have to take the medicine?
- What is the recommended dosage?
- Will a child and adolescent psychiatrist be monitoring my child's response to the medication and make dosage changes if necessary? How often will progress be checked and by whom?
- How will the decision be made to stop it?
- What are the negative side effects of the medicine?
- What will happen if my child doesn't take it?
- Are there any medications or foods that my child should avoid while taking the medication?
- Are there any activities that my child should avoid while taking this medication?

Once child is on medication:

- How do you feel the medication is working to address my child's symptoms?
- Should my child have any tests to monitor his or her response to the medication?
- I've noticed a side effect of the medication. What should I do?
- My child seems much better. Should we consider stopping the medication?

Note: The caseworker should be requesting this information from the prescriber as well.

- Once the child is on medication, encourage the caregiver to contact the child's prescriber if any troubling side effects develop.
- Keep all lines of communication open and encourage the caregiver and child to contact you if they have any questions or concerns.
- Side effects rating forms should be utilized as appropriate (e.g., Abnormal Involuntary Movement Scale (AIMS); please see the Pharmacological Tools & Resources section (page 96-101) for more information.

Guideline 4.
Reliable and Valid Rating Scales

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

Rationale: Why is this Guideline important?

- The use of reliable and valid rating scales help prescribers of psychotropic medication determine whether a child's symptoms are responding to the medication. Information from these scales in conjunction with observation, parent report, and child report can guide treatment decisions. Informed choices can lead to better outcomes.

Implementation: How can I incorporate this Guideline at my agency?

- Assess target symptoms using available scales and rating tools. Consider using the rating scales listed below for the following diagnoses:
  - ADHD
    - SNAP-IV Teacher and Parent Rating Scale
    - Vanderbilt Assessment Scale Parent and Teacher Form
    - Conners Parent and Teacher Rating Scales
  - Depression
    - CDI (Children Depression Interview)
    - BDI (Beck Depression Inventory)
    - PHQ-9 (Patient Health Questionnaire)
  - Anxiety
    - SCARED (Self-Report for Childhood Anxiety Related Emotional Disorders)
- Use one scale consistently in order to track changes in outcome.
- For more information on these scales refer to the Psychopharmacological Interventions Tools & Resources section (pages 96-101).

Guideline 5.
Child Mental Health Training for Caseworkers

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

Rationale: Why is this Guideline important?

- Caseworkers represent the front line of intervention, and they must serve as advocates to ensure that children receive the mental health treatment they require.
- In order to identify when a child's behavior or development is atypical and in need of further assessment and/or treatment and to ensure that a child is receiving appropriate treatments, caseworkers must have a basic knowledge of normal development, the impact of parental substance use on development, and common mental health disorders.

Implementation: How can I incorporate this Guideline at my agency?

- Partner with a local mental health agency to provide relevant mental health training to case workers.
- Consider having caseworkers go through the Parent Engagement and Self Advocacy (PESA) training described in the Parent Engagement and Support Tools & Resources section (pages 113-118).
- Funding for mental health training to caseworkers may be available through Title IV-E, a major source of federal funds for educating and training the child welfare workforce. Refer to the following Web site for more information: http://www.acf.hhs.gov/programs/cb/

Guideline 6.
Information for Children and Families

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

Rationale: Why is this Guideline important?

- Ultimately, children and their caregivers will be responsible for implementing treatment and effecting change in their lives; therefore, it is important to keep them fully informed of possible diagnoses and treatment options.

Implementation: How can I incorporate this Guideline at my agency?

- Have pamphlets, resource lists, and literature (translated as needed) available to caretakers and youth dealing with mental health challenges.
- Consider connecting children and families to the following Web sites that give comprehensive mental health information on topics like depression, suicide, anxiety, ADHD etc.:
  - Mental Help Net: www.mentalhelp.net
  - National Institute of Mental Health: www.nimh.nih.gov
- Make information clear and easy to understand. Use language caregiver and child understand.
- Encourage caregiver or child to ask questions and to freely express any concerns they might have.
- Co-develop a crisis plan with the family that outlines how emergency situations should be handled. Identify potential in-patient and out-patient clinical services.[80]
- Provide referrals for the family (if necessary) to primary care physicians, insurance companies, local hospitals, and universities, etc.[80]
- Additionally, refer families to relevant resources in the community, including parent advocates and relevant family support groups to assist them in their coping with disruptions to the family dynamic, and to learn about how to access educational and health care services that can procure stability.[80]

Guideline 7.
Transition Planning

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

Rationale: Why is this Guideline important?

- For youth transitioning out of care or aging out of the child welfare system, sufficient information and resources should be provided so they can serve as their own case managers, take care of themselves effectively, and continue to access treatments.
- If the youth has been given adequate information about their mental health condition and provided a role in the decision making regarding their treatment, they are more likely to continue treatment once they leave care.

Implementation: How can I incorporate this Guideline at my agency?

- Check with your state's health department or local Social Security administration offices to determine the eligibility requirements for Medicaid for youth.
- Provide assistance to youth to secure Medicaid benefits
- Help youth find a jobs that offers medical insurance. Consider connecting youth to Employment Preparation Services mentioned in the Youth Empowerment Guidelines (page 122).
- Refer the child to a mental health provider that he or she can continue to see once he or she leaves care.

Guideline 8.
Support for Birth Families

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

Rationale: Why is this Guideline important?

- The following statistics illustrate the importance of this guideline and emphasize the need for parents to receive treatment for their mental health and substance abuse disorders in order to successfully reunify with their child(ren) and effectively take care of their child(ren) when they do:
  - 53% of children exiting foster care in 2006 were reunified with their biological parents or primary caretaker.[83]
  - In a national sample of children involved with child welfare, 40% of caregivers received a diagnosis of depression, a rate that exceeds the rate of depression in the general population (16.6%).[84] Depressed parents have been found to be 3.45 times more likely to initiate physical abuse than their non-depressed counterparts. Substance abuse is also associated with both physical abuse and neglect.[85]

Implementation: How can I incorporate this Guideline at my agency?

- Refer birth families to appropriate mental health services when indicated.
- Refer to Guideline #4, Comprehensive Family Assessments, of the Parent Engagement and Support Guidelines (page 107).
- Refer to Guideline #6, Referral to Substance Abuse and Mental Health Treatment When Needed, of the Parent Engagement and Support Guidelines (page 109).

Guideline 9.
Periodic Reviews of Psychotropic Medication Use Patterns

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

Rationale: Why is this Guideline important?

- There is a significantly higher rate of psychotropic medication use for children in state custody compared to non-custodial children receiving Medicaid services or the general population of youth. In order to ensure that the use of psychotropic medication is both safe and appropriate, agencies should be responsible for monitoring internal rates of psychotropic medication use to prevent inappropriate prescription practices and possible harm to youth in state care.
- However, it is important to note that higher prescription rates among foster children do not, per se, indicate inappropriate or unsafe practices. Foster children's higher rates of abuse, neglect, and disrupted attachment can increase the intensity of symptoms. This developmental adversity leads to situations in which medications are used appropriately to decrease the behavioral and emotional dysregulation (e.g. aggression, tantrumming, or self-injury), which can result as part of a post-traumatic, attachment, or adjustment disorder.
- Specific psychotropic risks to foster children include:
    - Medication too high in dosage
    - Too many medications
    - Too prolonged in the event of medication(s) used to stabilize transient aggression that may subside as the child's living environment is stabilized.

Implementation: How can I incorporate this Guideline at my agency?

- Look at the agency's prescribing trends in terms of percentage of children taking a psychotropic medication on a quarterly basis:
    - % by age
    - % by race
    - % by region
    - % by prescriber
    - % by level of care
- In addition, assess the more specific pitfalls of psychotropic prescribing among children in foster care at your agency. Consider:
    - Polypharmacy: Can you monitor the numbers of medications, and numbers of medications in the same class that each child takes?
    - Multiple simultaneous medication trials, particularly on inpatient units: Are start dates of medications staggered so as to indicate initiating one trial at a time?
    - Medication in the absence of behavioral interventions: How many children are getting medication only?
    - Prolonged trials of mood-stabilizing medications for primarily behavioral targets/ adjustment disorders: Have there been efforts to taper mood stabilizers and atypical antipsychotics among non-bipolar, non-psychotic children? Have behavioral therapies been tried?
- On a case-specific basis, monitor dosing and ensure that the medication is appropriate for the diagnosis, target symptoms identified, appropriate symptom rating scales used, adverse medication effects and lab parameters monitored, and that there is appropriate follow-up and documentation that the benefits outweigh the risks associated with the medication.

Medication Information[86]

This table summarizes the side effects, dosages, and dosing medications typically prescribed for children with mental health disorders. Please consult with a psychiatrist for more information.

Drug	Initial and Starting Dose	Initial Target Dose	Maximum Dosage	Schedule	Side Effects and Patient Monitoring Parameters
Stimulants					
Amphetamine mixed salts (Generic available) Adderall® Adderall®XR	5 mg/day	N/A	60 mg/day	IR: Once or twice daily SR: Once daily	Decreased appetite Nervousness Insomnia Hypersensitivity reactions Increased heart rate Weight loss Growth delays with long-term use
Dextroamphetamine (Generic available) Dexedrine® Dextrostat®	5 mg/day	N/A	60 mg/day	IR: Once or twice daily SR: Once daily	
Lisdexamfetamine Vyvanse®	30 mg/day	N/A	70 mg/day	Once daily in the morning	
Methylphenidate (Generic available) Ritalin® Ritalin®SR Ritalin®LA Metadate™ER Methylin®ER Concerta™ Daytrana® TD	10 mg/day	N/A	60 mg/day (30 mg/day-TD) (72 mg/day-CRTA)	IR: Once or twice daily SR: Once daily TD[a]: Once daily CRTA[b]: Once daily	
Dexmethylphenidate Focalin Focalin XR	N/A	N/A	N/A	N/A	
Atomoxetine					
Atomoxetine Atomoxetine Strattera®	Children: 0.3 mg/kg/day Adolescents: 40 mg/day	N/A	Children: 1.2-1.8 mg/kg/day Adults: 80-100 mg/day[c]	Once or twice daily	Nervousness Insomnia Hyper-sensitivity reactions Increased heart rate Weight loss Liver toxicity

Drug	Initial and Starting Dose	Initial Target Dose	Maximum Dosage	Schedule	Side Effects and Patient Monitoring Parameters
Alpha Agonists					
Clonidine (Generic available) Catapres®	0.05 mg/day	N/A	0.4 mg/day	Once to four times daily	Sedation Dry mouth Dizziness Constipation Decreased blood pressure when rising
Guanfacine (Generic available) Tenex®	0.5 mg/day	N/A	4 mg/day	Once to four times daily	
Antidepressants, Other					
Bupropion[d] (Generic available) Wellbutrin® Wellbutrin®SR Wellbutrin®XL	N/A	N/A	The lesser of: 3-6 mg/kg/day or 400 mg/day (SR) 450 mg/day (XL)	IR: Once to three times daily SR: Once to twice daily XL: Once daily[e]	Headache Nausea Insomnia Dry mouth Constipation Seizures
Imipramine (Generic available) Tofranil®	N/A/	N/A	5 mg/kg/day or 300 mg/day (Adolescent)	Twice daily	Blurred vision Urinary retention Constipation Dry mouth Decreased blood pressure when rising Increased heart rate Sedation Weight gain
Nortriptyline (Generic available) Aventyl® Pamelor® Nortrilen®	N/A	N/A	3 mg/kg/day or 150 mg/day (Adolescent)	Twice daily	

Drug	Initial and Starting Dose	Initial Target Dose	Maximum Dosage	Schedule	Side Effects and Patient Monitoring Parameters
Antidepressants, Other, continued					
Citalopram (Generic available) Celexa®	Children: 10-20 mg/day Adolescents: 10-20 mg/day	Children: 20 mg/day Adolescents: 20 mg/day	Children: 40 mg/day Adolescents: 40 mg/day	Once daily	Agitation Constipation Diarrhea Dizziness Dry mouth Fatigue Headache Insomnia Loss of appetite Nausea Nervousness Potential emergence of suicidality Sexual dysfunction Sedation Sweating
Escitalopram Lexapro®	Children: 5-10 mg/day Adolescents: 5-10 mg/day	Children: 10 mg/day Adolescents: 10 mg/day	Children: 20 mg/day Adolescents: 20 mg/day	Once daily	
Fluoxetine (Generic available) Prozac®	Children: 5-10 mg/day Adolescents: 10-20 mg/day	Children: 10-20 mg/day Adolescents: 10-20 mg/day	Children: 60 mg/day Adolescents: 60 mg/day	Once daily	
Paroxetine (Generic available) Seroxat® Paxil® Paxil®CR	Children: NR Adolescents: 10-20 mg/day	Children: NR Adolescents: 10-20 mg/day	Children: NR Adolescents: 40 mg/day	Once daily	
Sertraline (Generic available) Zoloft®	Children: 25mg/day Adolescents: 25-50 mg/day	Children: 25-75 mg/day Adolescents: 50-100 mg/day	Children: 200 mg/day Adolescents: 200 mg/day	Once daily	
Antidepressants, SNRIs					
Venlafaxine Extended Release Effexor XR®	Children: IE Adolescents: IE	N/A	Children: IE Adolescents: IE	Once daily	Anxiety Decreased appetite Dizziness Dry mouth Fatigue Insomnia Nausea Somnolence Sweating
Duloxetine Cymbalta®	Children: IE Adolescents: IE	N/A	Children: IE Adolescents: IE	Once or twice daily	

Drug	Initial and Starting Dose	Initial Target Dose	Maximum Dosage	Schedule	Side Effects and Patient Monitoring Parameters
Antipsychotics, Atypical					
Aripiprazole Abilify®	Children: 2.5 mg/day Adolescents: 5 mg/day	N/A	Children: 15mg/day Adolescents: 30mg/day	Once daily	EPS Agitation Nausea Insomnia Constipation
Clozapine (Generic available) Clozaril® Fazaclo®	Children: 6.25-25 mg/day Adolescents: 6.25-25 mg/day	N/A	Children: 150-300 mg/day Adolescents: 200-600 mg/day	Once daily	Weight gain Orthostatis Tachycardia Excess salivation Fever Agranulocytosis Myocarditis Seizures
Olanzapine Zyprexa®	Children: 2.5 mg/day Adolescents: 2.5-5 mg/day	N/A	Children: 12.5 mg/day Adolescents: 30 mg/day	Once to twice daily	Weight gain Dizziness Constipation Dry mouth
Quetiapine Seroquel®	Children: 12.5 mg/day Adolescents: 25 mg/day	N/A	Children: 300 mg/day Adolescents: 600 mg/day	Once to twice daily	Decreased blood pressure upon standing Weight gain Cataracts Headache Dry mouth
Risperidone Ripserdal®	Children: 0.25 mg/day Adolescents: 0.5 mg/day	N/A	Children: 1.5-2 mg/day Adolescents: 2-4 mg/day	Once to twice daily	Weight gain Decreased blood pressure upon standing EPS TD Prolactin elevation
Ziprasidone Geodon®	Children: 10 mg/day Adolescents: 20 mg/day	N/A	Children: IE Adolescents: 180 mg/day	Twice daily	EPS Dizziness Rash Vomiting ECG changes

Drug	Initial and Starting Dose	Initial Target Dose	Maximum Dosage	Schedule	Side Effects and Patient Monitoring Parameters
Antipsychotics, Typical					
Haloperidol (Generic available) Haldol®	<35 kg: 0.25-0.5 mg/day ≥35 kg: 1 mg/day	N/A	<35 kg: 3-4 mg/day ≥35 kg: 10 mg/day	Once to three times daily	Sedation Decreased blood pressure upon standing EPS Photosensitivity of the skin Tardive dyskinesia Constipation Dry mouth Increased heart rate Prolactin elevation
Pimozide Orap®	1-2 mg/day	N/A	2-6 mg/day	Once to twice daily	EPS Dyskinesias Tardive dyskinesia ECG changes Dry mouth Constipation Prolactin elevation
Mood Stabilizers					
Divalproex Sodium Depakote®	N/A	N/A	N/A	Twice daily or at bedtime	Dizziness Tremor Unsteady gait Rash Sedation GI upset Weight gain Hair loss Cognitive impairment Decreased platelets in the blood
Lithium (Generic available) Eskalith® Eskalith®CR Lithobid®	N/A	N/A	N/A	Once or twice daily	Tremor Nausea Dizziness Sedation Thirst Increased urination Weight gain ECG changes

[a] TD = Transdermal.

[b] CRTA = once-daily, long-acting formulation Concerta™.

[c] Maximum dosage should not exceed 1.4mg/kg/day or 100mg/kg/day, whichever is less.

[d] Sustained - or extended-release formulation is recommended.

[e] Extended-release bupropion tablets cannot be split prior to administration.

Assessment Scales for ADHD

SNAP-IV Teacher and Parent Rating Scale

The SNAP-IV is an 18-item checklist that is designed to determine if symptoms of ADHD are present. The form is used by a healthcare provider when performing an assessment and can be completed by either a parent or other caregiver or an educator.

Contact Information

Web site:

http://www.adhd.net/snap-iv-form.pdf
http://www.adhd.net/snap-iv-instructions.pdf

Training Information:

No formal training is available.

Additional Information:

SNAP-IV forms and scoring information are available at no cost at the Web site listed.

Vanderbilt Assessment forms—Parent Form

The Vanderbilt Assessment Scale for parents is a 55-item rating scale that assesses symptoms and impairment of performance at home and school, and in social settings. It takes approximately 10 minutes to complete. This scale also screens for symptoms of oppositional defiant disorder, conduct disorder, and anxiety and depression in addition to ADHD.

Contact Information

Web site: http://www.psychiatrictimes.com/clinical-scales/adhd/vadrs

Training Information:

No formal training is available.

Additional Information:

SNAP-IV forms and scoring information are available at no cost at the Web site listed.

Vanderbilt Assessment forms—Teacher Form

The Vanderbilt Assessment Scale for teachers is a 43-item rating scale that assesses symptoms and impairment of performance at school. It takes approximately 10 minutes to complete. This scale also screens for symptoms of oppositional defiant disorder, conduct disorder, and anxiety and depression in addition to ADHD.

Contact Information

Web site: http://www.psychiatrictimes.com/clinical-scales/adhd/vadrs

Training Information:

No formal training is available.

Additional Information:

The Vanderbilt SNAP-IV forms and scoring information are available at no cost at the Web site listed.

Conners Teacher Rating Scale

The Conners Teacher Rating Scale assesses ADHD and problem behaviors in youth age 12-17. There are two versions available:

- Long version: 59 items; takes 15-25 minutes to complete
- Short version: 28 items; takes 5-10 minutes to complete

Contact Information

Web site: http://www.pearsonassessments.com/crsr.aspx

Training Information:

No formal training is available.

Additional Information:

The complete manual is available for $55, the technical manual for $85, and the forms (packet of 25) for $47 (long version) and $45 (short version) at the Web site listed.

Conners Parent Rating Scale

The Conners Parent Rating Scale assesses ADHD and problem behaviors in youth age 12-17. There are two versions available:

- Long version: 80 items; takes 20-25 minutes to complete
- Short version: 28 items; takes 5-10 minutes to complete

Contact Information

Web site: http://www.pearsonassessments.com/crsr.aspx

Training Information:

No formal training is available.

Additional Information:

The complete manual is available for $55, the technical manual for $85, and the forms (packet of 25) for $47 (long version) and $45 (short version) at the Web site listed.

Assessment Scales for Depression

Children Depression Inventory (CDI)

The Children Depression Inventory (CDI) is a 27-item self-report that assesses cognitive, affective, and behavioral symptoms of depression in children and adolescents age 6-17. It can be completed in 5-10 minutes.

It assesses the child on 5 scales:

- Negative mood
- Interpersonal difficulties
- Negative self-esteem
- Ineffectiveness
- Anhedonia (inability to experience pleasure)

Contact Information

Web site: http://www.pearsonassessments.com/depressioninvent.aspx

Training Information:

No formal training is available.

Additional Information:

The complete CDI manual is available for $68 and the CDI forms for $43 at the Web site listed

Beck Depression Inventory (BDI)

The Beck Depression Inventory (CDI) is a 21-item form that assesses specific symptoms related to depression in children and adolescents age 13 and up. It can be completed in 5 minutes.

Contact Information

Web site: http://pearsonassess.com/HAIWEB/Cultures/en-us/Productdetail.htm?Pid=015-8018-370&Mode=summary

Training Information:

No formal training is available.

Additional Information:

The complete BDI kit that includes the manual and 25 recording forms is available for $109 at the Web site listed. The BDI forms are available for $49 per packet (25 forms per packet).

The BDI is also available in Spanish.

Patient Health Questionnaire-9 (PHQ-9)

The Patient Health Questionnaire-9 (PHQ-9) is a 9-item questionnaire that assesses symptoms and functional impairment, as well as the severity of symptoms associated with depression. It can be completed in less than 5 minutes.

Contact Information

Web site: http://www.phqscreeners.com/

Training Information:

No formal training is available.

Additional Information:

PHQ-9 forms are available at no cost at the Web site listed.

PHQ-9 forms are available in many languages; please refer to the Web site listed for more information.

Assessment Scales for Anxiety

Self-Report for Childhood Anxiety-Related Emotional Disorders (SCARED)

The Self-Report for Childhood Anxiety-Related Emotional Disorders (SCARED) is a 41-item questionnaire that assesses the child or adolescent on 5 subscales:

- Panic
- General anxiety
- Separation anxiety
- School phobia
- Social phobia

It takes approximately 10-15 minutes to complete.

Contact Information

Self-report for children ages 8-18:

Web site: http://www.wpic.pitt.edu/research/CARENET/CARE-NETPROVIDERS/PDFForms/ScaredChild-final.pdf

Parent-report for children ages 6-18:

Web site: http://www.wpic.pitt.edu/research/CARENET/CARE-NETPROVIDERS/PDFForms/ScaredParent-final.pdf

Training Information:

No formal training is available.

Additional Information:

SCARED forms are available at no cost at the Web sites listed.

Side Effects Rating Forms

Abnormal Involuntary Movement Scale (AIMS)

The Abnormal Involuntary Movement Scale is used in periodic screenings for tardive dyskinesia that sometimes develops as a side effect of long-term treatment with antipsychotic medications. The form takes 5-10 minutes to complete and records scores for 7 body areas: face, lips, jaw, tongue, upper extremities, lower extremities, and trunk.

Contact Information

Web site: http://www.psychiatrictimes.com/clinical-scales/movement_disorders

Training Information:

No formal training is available.

Additional Information:

The AIMS forms are available at no cost at the Web site listed.

Additional Information

Psychotropic Medication Utilization Parameters for Foster Children

Texas Department of State Health Services:
www.dshs.state.tx.us/mhprograms/PsychotropicMedicationUtilizationParametersFosterChildren.pdf

Treatment Recommendations for the Use of Antipsychotic Medications for Aggressive Youth (TRAAY)

Journal of the American Academy of Child and Adolescent Psychiatry 2003; 42:145-161.

Texas Children's Medication Algorithm Project (CMAP)

Major Depressive Disorder Algorithm
www.dshs.state.tx.us/mhprograms/mddpages.shtm

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

Florida's Best Practice Psychotherapeutic Medication Guidelines for Children and Adolescents—University of South Florida

http://flmedicaidbh.fmhi.usf.edu/recommend_child_guidelines.htm

Includes guidelines for ADHD, bipolar, chronic impulsive aggression, depression.

American Academy of Child and Adolescent Psychiatric (AACAP) Practice Parameters

http://www.aacap.org/cs/root/member_information/practice_information/practice_parameters/practice_parameters

Includes practice parameters for several mental health disorders including, ADHD, PTSD, bipolar, conduct disorder, and depression.

Parent Engagement And Support

Family involvement plays a pivotal role in service outcomes for children. However, for children involved in the child welfare system, engaging both them and their families can be challenging. Children and families within the child welfare system can benefit from active, informed, and involved parents. Parent engagement and support strategies and programs can help caregivers cope more effectively with the challenges associated with involvement in the child welfare system[87].

This section of the toolkit contains the following:

Parent Engagement and Support Guidelines (page 104)

The eight guidelines presented in this section identify recommendations for how child welfare agencies can strengthen, provide structure, and professionalize parent support services for parents with children in the child welfare system who are challenged by mental health problems. The guidelines are based on the belief that parent support services are likely to be more effective when they are[88]:

- Non-stigmatizing
- Culturally responsive
- Informed by research that demonstrates positive impact[89]
- Delivered in locations and at times that are accessible and convenient
- Cost-efficient
- Offered early—before major problems arise

Parent Engagement and Support Programs (page 112)

The key characteristics of promising parent engagement programs are summarized in this table.

Parent Engagement and Support Tools & Resources (page 113)

The Tools & Resources section provides descriptions and information on how to access parent engagement and support programs, including details on available trainings and manuals.

Guidelines

Guideline 1.
Use of Peer (Adult) Family Mentors

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

Rationale: Why is this Guideline important?

- Peer family mentors are able to provide direct family-to-family services, which are likely to help:
  - Improve access to services
  - Increase family engagement
  - Mitigate the distrust that often accompanies parent involvement in child welfare services
- Peer mentor outreach has been found to help families (1) navigate the child welfare and mental health systems and (2) reduce obstacles to service use[90] resulting in the following outcomes:
  - Improved health behaviors and family functioning
  - Reduced high-risk behaviors[91]
  - Increased service use[92]
- The use of peer family mentors working as staff in child welfare agencies is likely to alleviate workforce shortage issues and to bring the insights of experienced parents into the decision-making process.

Implementation: How can I incorporate this Guideline at my agency?

- Hire advocates (e.g., birth, foster, kinship, etc.) as full and/or part-time agency staff (e.g., foster parent mentors, etc.).
- Train the advocates to become peer family mentors. Several training programs are available and detailed in the Tools & Resources section.
- Some alternate options may include employing pre-trained peer family mentors or consultants for ongoing agency collaboration.
- Peer family mentors may be recruited from your local family advocacy organization chapter (e.g., FFCMH, NAMI, CHADD, etc.)
- A few training programs that have been developed to help child welfare systems form community collaborations include Better Together by Casey Family Programs and Parent Empowerment and Self-Advocacy (PESA) developed by the REACH Institute. More information on these training programs can be found in the Parent Engagement and Support Tools & Resources section (page 113-118).

Guideline 2.
Use of Peer (Adult) Family Mentors

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

Rationale: Why is this Guideline important?

- Peer family mentors require ongoing training, consultation, and supervisory support in order to stay informed about new evidence-based practices, to remain current with their skills, and to develop new skills.[93]
- Providing ongoing training and supervision for peer family mentors ensures that they can continue to learn the skills they need to perform their job most effectively contingent with the changing needs of the youth and families they serve. Such training and consultation may also aid mentors in identifying novel, promising practices that may further improve family outcomes.

Implementation: How can I incorporate this Guideline at my agency?

- Programs and workshops to enhance the skills of peer family mentors are disseminated through numerous organizations including:
  - Family advocacy organizations
  - Foundations
  - Not-for-profit entities
- Identify local organizations that provide training for peer family mentors. Consider local Federation of Family and Child Mental Health (FFCMH) and National Alliance on Mental Illness (NAMI) state chapters.
- Please refer to the Parent Engagement and Support Tools & Resources section for available parent advisor training programs (page 113-118).
- In order to maximize the contribution of peer family mentors and to clarify their roles and responsibilities, it is recommended that special attention be paid to clearly defining their job functions and that cross-training and co-supervision be available to enhance the seamless integration of peer family mentors into other case management and clinical functions within agencies.

Guideline 3.
Agency Practices to Support Parents

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

Rationale: Why is this Guideline important?

- Involvement with child welfare services brings families into contact with a complicated array of service systems, including the legal, mental health, and education systems. Faced with complex demands, parents and families in crisis are at a heightened risk of failing to meet court and service system requirements, which can result in a lengthy reunification process or, in extreme cases, the termination of parental rights. Thus, an immediate orientation on family rights and responsibilities is paramount to aiding families through this complex system.
- Peer family mentors can help guide this orientation process by: (1) providing vital information and support to families, (2) navigating related court proceedings, and (3) working with child welfare and other services to address the issues that precipitated placement.

Implementation: How can I incorporate this Guideline at my agency?

- Provide parents with a copy of their rights and responsibilities at intake.
- Ensure that the parent's rights and responsibilities are discussed by the caseworker and (if available) a peer family mentor at intake.
- Include parental rights and responsibilities as part of peer family mentor training.
- Have the mentor or caseworker check in with the family on an ongoing basis to ensure understanding of the rights and responsibilities.
- Hire or have available mentors to assist families in navigating the child welfare system and the interface with the child mental health system. This could take the form of an ongoing support group, informational sessions for parents that are widely advertised, or a formal mentoring relationship.

Guideline 4.
Comprehensive Family Assessments

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

Rationale: Why is this Guideline important?

- Assessments that are not comprehensive and/or are completed by only one member of the stakeholder team (e.g., child, birth parent, foster parent, caseworker, etc.) are often one-dimensional, failing to identify overall child and family service needs.
- The goal of comprehensive family assessments is to "permit the identification and provision of services that are specifically targeted to address the family's needs and problems and insure the child's safety, well-being, and permanency."[94]

Implementation: How can I incorporate this Guideline at my agency?

- Identify comprehensive assessments that can be used with multiple informants/key stakeholders. Several assessments are provided in the Mental Health Screening and Assessment Tools & Resources section.
- Train staff to implement ongoing assessments into the service planning process.
- Revisit and refine assessments over the course of a family's involvement with child welfare services to ensure that service planning and delivery is maximally responsive to family strengths and needs.
- Identify interventions and practices that support and maintain ongoing collaborations between the key stakeholders (e.g., family members, child welfare workers, and service providers). Several collaborative interventions are listed in the Psychosocial Interventions Tools & Resources section, including including Wraparound (page 73) and Family Team Decision Making (FTDM) (page 74).
- Enhance parental engagement in ongoing planning processes through the use of peer mentor support because active family involvement and input are essential to developing valid assessments.
- Regularly include information on the provision of assessments and services to families as a part of case records.

Guideline 5.
Family Engagement Training for Child Welfare Staff

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

Rationale: Why is this Guideline important?

- Linking evidence-informed engagement practices to the delivery of evidence-based treatments is likely to improve the overall quality of services received by children with mental health problems and their families connected to the child welfare system.
- Targeted programs aimed at improving the intake process can (1) increase family retention in services, (2) reduce no-show rates, and (3) improve family attitudes about services.[95]
- Engaging birth and foster parents in the child welfare system can be difficult and, in turn, keep families from receiving essential services. Research on engaging families in therapy offers approaches that may prove beneficial in child welfare.

Implementation: How can I incorporate this Guideline at my agency?

- Identify engagement strategies that fit both agency and client needs. Successful family engagement strategies include the following factors:
  - Clarifying, with the family, the roles of those working with the family.
  - Discussing service options.
  - Incorporating cultural responsive strategies.
  - Building necessary rapport for working collaboratively with the family.
  - Looking at practical, concrete issues that can be addressed quickly.
  - Developing plans to overcome barriers, increase family inclusion, and reduce dropping out of the therapy process.[95]
- Refer to the Psychosocial Interventions Tools & Resources section for several specific models that target first visit and ongoing retention in services. Details on the following interventions can be found in the aforementioned section:
  - Motivational interviewing[96]
  - Strategic Family Therapy[97]
  - Functional Family Therapy[98]
  - Brief strategic family engagement[99]
  - Engagement interventions[100]
- Consider utilizing participatory decision-making meetings (e.g., family group conferences, family team meetings, etc.), which offer well-established strategies for engaging families and are particularly valuable in the initial phase of child welfare involvement.[101]

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

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

Rationale: Why is this Guideline important?

- If issues related to parental substance abuse and/or other mental health needs are not addressed, parents are much less likely to be able to address the issues associated with their child's removal from their care. Furthermore, there is a higher likelihood of failed reunification and/or termination of parental rights.
- The provision of services during child removal and reunification is paramount as research findings indicate that the stress of being separated from their children and then re-establishing parenting can lead to relapse for parents with substance abuse issues.[102]
- A comprehensive service plan is necessary to, first, assess for needs that may otherwise be overlooked, then, provide referral to evidence-based substance abuse and/or mental health services.
- Parent interventions are most effective when they are contingent on necessary parenting and family interventions as such a process will support and drive reunification efforts.

Implementation: How can I incorporate this Guideline at my agency?

- Identify local substance abuse or adult mental health treatment services to secure appropriate rehabilitation programs and mental health services for parents and caretakers. Given the high incidence of intergenerational trauma among families involved in the child welfare system, ensure that parent treatment services are trauma-informed.
- Develop partnerships with substance abuse and mental health treatment providers to facilitate referrals of services to parents. Ensure that parent substance abuse and mental health service providers understand the foster care system and the parent's legal rights and responsibilities. Collaborate with the child's caseworker so that parent deficits can be addressed as part of parental treatment and that the treatment and permanency timing and goals are aligned.

Guideline 7.
Early Assistance Services for Families

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

Rationale: Why is this Guideline important?

- Providing prevention-focused services to vulnerable families, providers, and communities can assist with building up the resiliency of children and their families to reduce pervasive stressors and enhance coping skills.

Implementation: How can I incorporate this Guideline at my agency?

- Identify preventative and differential response services that fit the needs of your agency and its clients.
- Identify agency staff or peer volunteers to attend training and implement preventative services.
- Differential response services should be incorporated contingent with the family's level of service need:[103]
    - Low level of service needs – Utilize a community response by identifying a community agency to respond to the family as needed.
    - Low to moderate level of service needs – Utilize a joint response, a collaborative effort between child protective services and a community agency, to assess the family and provide services to meet the family's needs.
    - Moderate to high risk of harm to child (in addition to at least one safety issue) – Implement a child protective services-only response in which a social worker visits the family, assesses the situation, and takes appropriate action, whether it be offering voluntary services or, for the most serious cases, removing the child.

Guideline 8.
Parent Involvement in Services

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

Rationale: Why is this Guideline important?

- Supporting parental involvement in services can (1) positively influence access to services, (2) shape attitudes toward service use that are critical to outcomes, and (3) provide important knowledge about their children, family circumstances, and cultural context, which can inform valid assessments and appropriate intervention planning.[104]
- The ongoing involvement of parents and kin in children's mental health interventions is of critical importance because:
    - Parents need to better understand their child's experiences and needs, including the impact that trauma, abuse, and/or neglect has had on their child's functioning, in order to improve their parenting.
    - Children's emotional and behavioral problems tend to escalate after they return home from foster care.[105]
    - Parents with substance abuse issues may relapse due to the stress of re-establishing parenting with these children.[106]
- Anticipating and preventing these challenges involves actively engaging parents while their children are still in care, to ensure that parents understand their children's evolving developmental needs and can learn and implement therapeutic strategies in the home setting upon reunification.[107]
- Even if reunification is unlikely, research has shown that family involvement is critical to the long-term well-being of many children in care.[108]

Implementation: How can I incorporate this Guideline at my agency?

- Determine if parental involvement and support can be incorporated into mental health interventions currently in use at your agency. To ensure fidelity to the intervention model, contact the developer or a local representative of the intervention to determine if parental involvement is feasible and for tips on how it should be incorporated.
- Identify programs and intervention that incorporate parental support and best fit the needs of your agency and its clients. Refer to the interventions outlined in the Parent Engagement and Support Tools & Resources, section (page 113).

Evidence-Based Practice Rating Scale:

1 = Well-Supported by Research Evidence 2 = Supported by Research Evidence
3 = Promising Research Evidence 4 = Emerging Practice

Parent Engagement and Support Programs		
Program	**Description**	**EBP Rating**
Co-Parenting	A 12-week shared training program for birth and foster parents that focuses on creating a collaborative birth-foster parent partnership with regards to how to parent the youth in care.	3
Parents Anonymous	A parent-to-parent support group for parents involved in the child welfare system.	4
Parent Engagement and Self- Advocacy (PESA) Program	Aims to improve the mental health of children in child welfare by teaching birth parents, foster parents, and agency workers how to work together to advocate for the mental health and educational needs of children in care.	4
Parent Mentoring Program	Specially trained foster parents mentor birth parents on issues related to why their child came into care.	4
Shared Family Care	Shared Family Care places a parent and one or two children in a community home where they are offered support and mentorship by a trained host family.	4

Tools & Resources:

Parent Engagement and Support

This section of the toolkit outlines parent engagement and support programs for birth and foster parents. Parent engagement and support programs can help birth and foster parents cope more effectively with the challenges associated with involvement in the child welfare system. Most of the existing parent engagement and support programs primarily rely on peer support and mentoring. These programs typically bring together parents who have successfully navigated the child welfare system with those currently involved with the system and encourage mutual sharing and support. Some programs focus on the development of advocacy skills (e.g., PESA, Powerful Families), while others emphasize the development of more collaborative relationships between birth and foster families (e.g., Shared Family Care, Co-Parenting).

Information presented in this section draws primarily from *Engaging Parents in Child Welfare Services: Challenges, Promising Practices, and Policy Opportunities*, a critical paper by Susan Kemp, Maureen Marcenko, William Vesneski, and Kimberly Hoagwood, commissioned for the *Best Practices for Mental Health and Child Welfare Consensus Conference.*[88]

The programs listed below include a detailed description, information on how to purchase the intervention manual, training requirements, and contact information. The Parent Engagement and Support Programs table (page 112) summarizes the programs described below.

Co-Parenting

Co-Parenting is a 12-week shared training program for birth and foster parents that focuses on creating a collaborative birth-foster parent partnership with regards to how to parent the youth in care.[109]

Contact Information

Oriana Linares, PhD
Associate Professor of Psychiatry
NYU Child Study Center
215 Lexington Avenue, 13th Floor
New York, NY 10016
Phone: (212) 263-8847
Fax: (212) 263-3690
E-mail: oriana.linares@med.nyu.edu

Training Information:

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

Parents Anonymous (PA)[110]

PA is a parent-to-parent support group for parents involved in the child welfare system that can benefit anyone in a parenting role. A professionally trained facilitator and a parent run each group. Groups for parents are held weekly for 1.5-2 hours, with a concurrent child and youth program.

Contact Information

Augusto Minakata
Sr. Program Coordinator
Parents Anonymous® Inc
675 W. Foothill Blvd. Suite 220
Claremont, CA 91711-3475
Phone: (909) 621-6184 ext 218
Fax: (909) 621-0614
E-mail: aminikata@parentsanonymous.org
Web site: www.parentsanonymous.org

Training Information:

An agency must be accredited before agency workers can be trained in Parents Anonymous. To become accredited, please contact Parents Anonymous.

After accreditation, there is a 2.5-day training in a "train-the-trainer" model. The training is didactic and interactive, and includes role-plays, video clips, and discussions of different kinds of scenarios. Training is held for Parents Anonymous group facilitators, parent group leaders, and human service workers who will run the youth groups.

After accreditation and initial training, there is ongoing evaluation through bi-annual 1.5-hour consultation calls.

Additional Information:

The cost of training varies depending on the size of the organization being trained and how many PA groups the agency will open.

Parent Engagement and Self-Advocacy (PESA) Program[111]

PESA aims to improve the mental health of children in child welfare by teaching birth parents, foster parents, and agency workers how to work together to advocate for the mental health and educational needs of children in care.

Contact Information

Lisa Hunter Romanelli, PhD
Director of Programs
The REACH Institute
708 Third Avenue, 5th Floor
New York, NY 10017
Phone: (212) 209-3871
Fax: (212) 209-7123
E-mail: lisa@thereachinstitute.org

Training Information:

Training for PESA group facilitators is available through the REACH Institute. Initial training is 24 hours, followed by bi-weekly consultation calls for one year. Training is provided at the REACH Institute or at agency sites.

Parent Mentoring Program

The Parent Mentoring Program is a manualized program developed in Washington State. Specially trained foster parents who mentor birth parents on issues related to why their child came into care form the core of the program.[88]

Contact Information

Ross Brown
DCFS
PO box 9809
Vancouver, WA 98666
Phone: (360) 993-7956
Fax: (360) 993-6939
E-mail: rosb300@dshs.wa.gov

Training Information:

Training is currently available to in-state agencies. Training involves phone consultation to prospective agencies, then a 2-day on site training once foster parents have been identified. Service providers and foster parents are trained during this time. If you are located outside of Washington State, please call Ross Brown or Peggy DeVoy to discuss training options.

Additional Information:

Peggy DeVoy, the co-developer and co-coordinator, can be reached at (360) 993-7819 or depe300@dshs.wa.gov. Dr. Maureen Marcenko, project evaluator, can be reached at mmarcenk@u.washington.edu

Shared Family Care

Shared Family Care places a parent and one or two children in a community home where they are offered support and mentorship by a trained host family.[112] The program works to establish a relationship between the foster and birth parents, and improve the life and social skills of birth parents.[113] The program goals are focused on child safety, well-being, and permanency.

Contact Information

Saundra Marshall, Program Supervisor

3350 Clayton Rd.

Concord, CA 94519

Phone: (925) 602-1750

Fax: (925) 602-1754

E-mail: smarshall@familiesfirstinc.org

Web site: www.familiesfirstinc.org/community_services_sharedfamily.html
aia.berkeley.edu/information_resources/shared_family_care.php

Training Information:

Training is provided on site in Concord, CA. Occasional workshops are presented at regional conferences. Training can be completed on site in one day, during which program procedures, guidelines, and handouts are provided. A short video is also available.

Powerful Families[114]

Powerful Families focuses on parent empowerment by improving family stability and reducing economic hardship. The program provides parents under stress, whose children have been removed from their homes, with a network of peer supports. The program teaches birth parents, kinship parents, and youth in the child welfare system how to advocate for their needs and those of their family. The program occurs over nine 2-hour weekly sessions. In these sessions, parents and their children are encouraged to arrive up to an hour early to network with others. After a meal, daycare or youth activities are provided for the children. At the end of each session, parents are given a task or a topic to discuss with their family.

Contact Information

Casey Life Skills Program

1300 Dexter Avenue North, Floor 3

Seattle, WA 98109-3542

Phone: (206) 282-7300

Fax: (206) 282-3555

E-mail: asktau@casey.org

Web site: www.caseylifeskills.org

Training Information:

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

Building Bridges[115]

Building Bridges focuses on forming helpful collaborations between the child welfare systems and the communities they serve, targeted to four groups: youth in foster care/alumni of foster care, birth parents, foster parents, and kinship caregivers. The program encourages meaningful partnerships, learning and understanding the perspectives within these partnerships, exploring culture, and troubleshooting case needs by identifying the barriers and bridges to partnerships.

Contact Information

Casey Family Programs

1300 Dexter Avenue North, Floor 3

Seattle, WA 98109-3542

Phone: (206) 282-7300

Fax: (206) 282-3555

Web site: www.casey.org

Training Information:

Training is offered in two formats: a 2-day interactive core workshop and the 4-hour Introduction Workshop. Workshops are facilitated by teams comprised of a child welfare staff person and two people who represent the group participants.

Youth Empowerment and Support

Youth aging out of foster care are often reliant on human services such as public financial assistance, state unemployment, and homeless shelters.[116] However, the implementation of effective youth empowerment programs within foster care can help prevent or minimize these negative outcomes. Youth empowerment programs aim to increase the sense of control youth have over their own lives by giving them opportunities to:[117, 118]

- Assume responsibility for making important life decisions.
- Learn life-enhancing skills.
- Obtain social and problem-solving peer support from others who are dealing with or have surmounted similar life challenges.
- Participate in important community affairs.

This section of the toolkit contains the following:

Youth Empowerment and Support Guidelines (page 122)

The seven guidelines presented in this section identify recommendations to enhance the engagement and empowerment of youth in foster care. Each guideline is supported with information underscoring its importance, in addition to tips on how to implement it at your agency.

Youth Empowerment and Support Tools & Resources (page 133)

The Tools & Resources section provides information about youth empowerment and support programs in the following areas:

- General youth empowerment programs (page 129)
- Court-Related Services (page 137)
- Academic remediation services (page 139)
- Mentoring programs (page 139)
- College education attainment services (page 142)
- Employment preparation services (page 144)

Guidelines

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

Child welfare agencies and their partners (courts, mental health, education, health, etc.) incorporate the objective of empowering children and youth in their missions, values, and practices in order to enhance the mental health and functioning of children and youth. To empower youth in child welfare settings, assessments of child and youth services needs and the planning and implementation of these services are strengths-based and focus on engaging children and youth to enhance their mental health and functioning in multiple domains. These domains include school attendance and performance, employment education and experience, post-high school educational and vocational training, preparation, and attainment. In addition, youth will be provided, while in care, with opportunities to enhance their peer and family relationships and recreational and spiritual participation and accomplishments.[119]

Rationale: Why is this Guideline important?

- Empowerment is a vital process for youth in foster care and involves giving youth opportunities to test and assert themselves beyond the foster care system. Youth empowerment helps develop emotional regulation, a sense of control over their own lives, and provides an opportunity for youth to plan for their own future; these are the key components in healing from past traumatic stress and lead to healthy adult development.
- The Foster Care Independence Act of 1999 recognized the importance of youth empowerment and requires that youth in care be given the opportunity to participate in the development of their transition plan.

Implementation: How can I incorporate this Guideline at my agency?

- Educate caseworkers about the concept of youth empowerment.
- Agency policies should contain multiple methods of informing youth about their rights, should ensure that youth are included in decision making about each of the domains, and should invite and encourage youth to come to meetings and to court hearings. For example, participation on a Youth Advisory Council can provide youth with an opportunity to develop peer relationships while advocating for the needs of others.
- Develop ongoing relationships with the youth in your agency and involve them in the planning and implementation process of all future programming. For example, ask an alumnus or alumna of foster care to mentor youth in care.
- Give youth the opportunity to lead their own planning efforts while keeping in mind that, given their trauma history, some youth may have difficulty doing this or engaging with supportive adults (e.g., caregivers, caseworkers, and agency staff).
- Speak to youth within the agency about what would help them feel more empowered.
- Identify and partner with youth empowerment programs in your community.
- Consider connecting youth to some of the empowerment programs mentioned in the Youth Empowerment and Support Tools & Resources section (pages 133-145).

Guideline 2.
Legal Advocates for Children and Youthw

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

Rationale: Why is this Guideline important?

- Having an attorney with training in child and youth mental health issues and services helps ensure that a child's legal rights are protected, that he or she receives the appropriate mental health services if needed, and that he or she has an opportunity to be heard in court. A child's wants are likely to receive greater consideration if a legal advocate is present.
- The benefits of having youth heard in court include:[120]
  - Enhancement of youth's sense of control
  - Increased understanding of the legal process by youth
  - Provision of additional information to the Court.

Note: Representation by an attorney and the opportunity to be heard in court does not mean that a child's stated wishes should or will override the legal standard. The Court's decision will always be guided by what is in the best interest of the child.[121]

Implementation: How can I incorporate this Guideline at my agency?

- Link youth to court-related programs that help to empower youth in foster care by increasing their satisfaction with the judicial system.[122] Some of these programs include:
  - Court Appointed Special Advocate & Guardian Ad Litem Programs (CASA/GAL)
  - State Court Improvement Programs (CIPs)
  - Law Guardian Interdisciplinary Teams
  - More information on these programs can be found in the Youth Empowerment and Support Tools & Resources section (pages 133-145)
- Work together with courts, GALs, and lawyers for children to conduct cross-training on adolescent empowerment and development. Include youth and alumni in the planning and execution of the training.
- Agencies should ensure that every child has an attorney for his or her case.

Guideline 3.
Youth Advocate Involvement in Child Welfare Agencies

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

Rationale: Why is this Guideline important?

- Youth in child welfare face unique life circumstances that may be best understood by older youth in care who are dealing with similar issues or alumni of care who experienced these issues in the past. Such youth advocates offer not only the support and empathy that youth in care need but also strategies for handling difficult circumstances that are unique to the foster care experience.
- Youth advocates who are in care or alumni of care can serve as supervised mentors to younger youth in care. Mentoring is an important strategy for youth empowerment and provides youth with a support system, meaningful roles, and the opportunity to learn new skills.[123]
- Long-term, supervised mentoring has shown several positive youth outcomes including fewer school absences, increased academic competence, and decreased depressive symptoms.[124]

Implementation: How can I incorporate this Guideline at my agency?

- Identify youth advocates who are willing to volunteer or work for the agency in an advisory capacity. Some examples include California Youth Connection (CYC), Foster Care Alumni of America (FCAA) (operating nationally and in five states), the Mockingbird Network in Washington State, or UFOSTERsuccess. Refer to the Youth Empowerment and Support Tools & Resources section for more information (pages 133-145).
- Youth advocates must receive training and support to ensure that they are able to support youth in care while not having their own personal trauma histories reactivated.
- Review what services are available through the National Child Welfare Resource Center for Youth Development. The NCWRCYD provides training and technical assistance to child welfare agencies; to access these services, contact your Administration for Children and Families federal regional office. Please visit: http://www.nrcys.ou.edu or call (918) 660-3700 for more information.
- Ask caseworkers, judges, attorneys, and others to identify alumni who could provide valuable advice or mentorship.
- Consider linking youth in care with a foster care alumni mentor through one of the mentoring programs in the Youth Empowerment and Support Tools & Resources section (pages 133-145).

Guideline 4.
Multicultural Competence

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

Rationale: Why is this Guideline important?

- Of the estimated 513,000 youth in foster care in 2005, 41% were white, 32% were black, 18% were Hispanic, and 8% were of other races or ethnic origins.[125] Given this diverse population, it is important for agency staff to have multicultural competence in order to assist these youth in developing a healthy sense of racial and ethnic identity.
- Multicultural competence involves:
  - Awareness about personal biases, assumptions, attitudes, and world views
  - Specific knowledge of cultures, history, world views, languages, and diverse experiences
  - The ability to effectively intervene in personal and professional domains with individuals of diverse cultural backgrounds

Implementation: How can I incorporate this Guideline at my agency?

- Provide staff with multicultural competence training. Consider using the program Knowing Who You Are developed by Casey Family Programs.
  - Knowing Who You Are is a three-part curriculum that includes a video, online course, and in-person training to help social workers and other adults and professionals in the child welfare system develop awareness, knowledge, and skills around the importance of working with youth on developing their racial and ethnic identity.
  - For more information, please visit: http://www.casey.org/Resources/Projects/REI.
- Encourage and support youth to become engaged in cultural and religious activities through various organizations within your community. Invite speakers and host events in your own organization to introduce youth to cultural/religious events and opportunities.
- Ensure that foster parents are trained to understand the importance of this guideline and provide guidance and support to incorporate it in their work with the children in their care.
- Establish relationships with community groups that involve people of various ethnic, cultural, and religious traditions and promote youth involvement in the activities of those groups.

Guideline 5.
Youth Understanding of Their Rights and Entitlements

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

Rationale: Why is this Guideline important?

- Helping youth to understand their rights, entitlements, and opportunities, and providing them with concrete assistance in accessing child welfare agencies and their partners can increase the likelihood of a successful transition to adulthood.

Implementation: How can I incorporate this Guideline at my agency?

- Provide education and training to your staff in foster care youth rights, entitlements, and opportunities.
- Provide written material in easy-to-understand language about rights, entitlements, and opportunities to youth at your agency; require your staff to discuss youth rights, entitlements, and opportunities with youth in care on a regular basis.
- Provide materials through a number of venues (brochures in court, on youth-friendly agency Web sites, through caseworkers, etc.)
- Have youth advocates develop materials (reviewed by professionals) to inform youth in care about their rights and entitlements when they enter the system and repeatedly thereafter.
- Create a forum within your agency for youth in care to get assistance in gaining access to services and completing required applications.
- Consider connecting youth to academic remediation services in the Youth Empowerment and Support Tools & Resources section (page 139).
- Consider connecting youth to college education attainment services in the Youth Empowerment and Support Tools & Resources section (pages 142-143).
- Consider connecting youth to employment preparation services in the Youth Empowerment and Support Tools & Resources section (pages 144-145).

Guideline 6.
Adequate Support for Youth Aging Out of Care

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

Rationale: Why is this Guideline important?

- The Casey Northwest and National Foster Care Alumni studies found that placement stability, educational supports, and employment experience were all associated with adult success.[126, 127]
- Given the significant medical and mental health needs of youth who age out of foster care, all states should extend foster care services, adoption support, and Medicaid coverage for transitioning youth until age 21, as allowed by federal law. Independent living services should be provided to youth as early as age 13 and continued through their early-to-mid 20s.[128]

Implementation: How can I incorporate this Guideline at my agency?

- Connect youth to academic remediation services in the Youth Empowerment and Support Tools & Resources section (page 138). Youth should be referred to these services prior to the age of 21.
- Connect youth to college education attainment services in the Youth Empowerment and Support Tools & Resources section (pages 142-143). Youth should be referred to these services prior to the age of 21.
- Connecting youth to employment preparation services in the Youth Empowerment and Support Tools & Resources section (pages 142-143). Youth should be referred to these services prior to the age of 21.
- Work with youth and your community to obtain necessary health and housing benefits prior to aging out of care.
- Work to ensure that your state is fully taking advantage of aging-out resources allowed under the Foster Care Independence Act and the Fostering Connections Act.
- Advocate with the state legislature to implement transitional benefits for older and former youth from foster care, in concert with the Fostering Connections federal legislation.
- Start planning for the aging-out process with the youth earlier than is currently standard practice.
- Identify mentors whom the child can link with who can be a permanent adult resource after the child ages out of care.

Guideline 7.
Accountability for Youth Empowerment Outcomes

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

Rationale: Why is this Guideline important?

- National, State, and local data intended to measure outcomes for children connected to the child welfare system should include data relating to youth empowerment in order to identify what kinds of empowerment-related programs and interventions benefit youth in foster care and assist them in making successful transitions into adulthood.

Implementation: How can I incorporate this Guideline at my agency?

- Include in the Child and Family Services Review (CFSR) (as well as State and local quality service reviews) measures of the rates of youth involvement with a youth advocate and/or mentor and engagement in youth empowerment programs.
- Track empowerment-related outcomes of youth in and formerly in care to at least age 21, including how many pursued vocational training or enrolled and remained in a higher education institution, how many were employed and had stable housing arrangements when exiting the system and at appropriate timeframes after leaving care, how many had access to healthcare services and are connected with caring adults, etc.

Evidence-Based Practice Rating Scale:

1 = Well-Supported by Research Evidence 2 = Supported by Research Evidence
3 = Promising Research Evidence 4 = Emerging Practice

Program	Leadership/ Developer	Description	Ages	EBP Rating
General Youth Empowerment Programs				
California Youth Connection (CYC)	T. Hightower, President	Guided by youth in care to promote alumni policy, development, and legislative change	14-24	N/A
Foster Care Alumni of America (FCAA)	W. Stanton, Chair, Board of Directors	Brings the voices of alumni from foster care to public policy and program design	18 and older	N/A
The Taking Control Program	M. Habib, S. Sunday, A. Turnbull, V. Labuna, et al.	Educates youth in foster care, in a group setting, on various skills and topics, such as coping skills, interpersonal skills, and mental health	12-18	4
The Getting Beyond the System (GBS) Model	B. Krebs & P. Pitcoff, Co-Founders	Strengths-based self-advocacy training program teaches skills for the improvement of intellectual, career, and lifelong learning	14-24	4
Voices of Youth	United Nations Children's Fund	Includes youth in all aspects of child welfare practice and policy development and operation	10 and older	N/A
Youth Communication	K. Hefner, Publisher/ Executive Director	Provides reading and writing skills through training in journalism and publications	14-19	N/A
uFOSTERsuccess	Former youth from foster care	Strives to educate foster care professionals, get youth in foster care and alumni involved in helping improve child welfare, and advocate for foster care issues based on experience	—	N/A

Program	Leadership/ Developer	Description	Ages	EBP Rating
Court-Related Services				
Court-Appointed Special Advocates (CASA)	Michael Piraino, CEO	Judge-appointed volunteers serve as advocates or guardians for children in foster care and provide direction within the court system	Up to 18	N/A
Guardian Ad Litem (GAL) Programs	Theresa Flury, Executive Director	Volunteers appointed by the court provide assistance gathering information and advocating for children within community and court settings	Up to 21	N/A
State Court Improvement Programs (CIPs)	Program-based	Focuses on the timeliness and quality of decisions made by courts in cases of maltreatment	Up to 21	N/A
Law Guardian Interdisciplinary Teams	Program-based	Teams of attorneys (law guardians) represent foster care youth in judicial proceedings and work together as members of interdisciplinary teams.	Youth in care and alumni	N/A
Academic Remediation Services				
Foster Youth Services (FYS) Program	Federal government	Provides academic remediation services including tutoring and vocational training for the improvement of educational performance and achievement	Up to 18	N/A

Program	Leadership/ Developer	Description	Ages	EBP Rating
Mentoring Services				
Adoption and Foster Care Mentoring	M. French, Executive Director	Identifies, trains, and supervises mentor-mentee relationships, both one-on-one and in groups	7-14	N/A
AmeriCorps Foster Youth Mentoring Project (FYMP)	Chancellor's Office of the California Community Colleges	AmeriCorps students from state colleges mentor youth in foster care	14-18	N/A
Fostering Healthy Connections	Child Welfare League of America (CWLA)	Supports alumni from foster care ages 21 and younger in mentor-mentee relationships with current youth in care	Up to 21	N/A
New York City Administration for Children's Services (ACS) Mentoring Program	NYC Children's Services	Matches mentors with youth aging out of foster care to help youth develop practical independent living skills	14-21	N/A
College Education Attainment Services				
General College and Vocational Preparation Programs: Casey Life Skills	Casey Family Programs	Serves high school students through preparatory services and apprenticeship or internship attainment	8 and older	N/A
Scholarship Programs: The Living Classroom	J. Bond, President and CEO	Involves collaboration with state foundations to offer scholarships to youth in foster care	16-19	N/A
Community Collaborations: Washington State Puget Sound Pathways Network (PATHNET)	Federal government	Public school and community college collaborations provide high school mentoring, career counseling, and tutoring opportunities to youth in foster care prior to and during college admission	18 and older	N/A
Orphan Foundation of America (OFA)	J. Rivers, Founder	Provides college scholarships, online mentoring, internships, and other supports to college students while administrating several state Chafee Educational and Training Voucher (ETV) programs	Under 25	N/A

Program	Leadership/ Developer	Description	Ages	EBP Rating
Employment Preparation Services				
School-to-Career Partnership of United Parcel Service (UPS) and the Annie E. Casey Foundation	Annie E. Casey Foundation	Provides business-training opportunities along with transportation assistance	Up to 21	N/A
Project H.O.P.E.	Federal government	Collaboration between youth advocacy programs and the Alameda County Independent Living Skills Program in Alameda County, California, to provide youth in foster care with career and education opportunities	16-18	N/A
Job Corps Programs	Federal government	Federal programs that provide education and training services focused on employment, education, and military attainment	16-24	N/A

Youth Empowerment and Support

General Youth Empowerment Programs

California Youth Connection (CYC)

CYC is an advocacy program developed for, and guided by, current and former youth in foster care, age 14-24, who seek to improve the foster care system through involvement in policy development and legislative change. CYC members take part in a variety of tasks, including collaborating to identify local issues and initiate positive change. They also attend local and statewide meetings (i.e., Summer Leadership and Policy Conference, CYC Day at the Capitol) to share youth-in-care perspectives.[129]

CYC's newsletter, EMPOWER!, gives youth in foster care a voice on individual and systemic needs.

Contact Information

CYC Statewide Office
604 Mission Street, 9th Floor
San Francisco, CA 94105
Phone: (415) 442-5060 / (800) 397-8236
Fax: (415) 442-0720
Web site: www.calyouth.org/site/nyc

Foster Care Alumni of America (FCAA)

FCAA is an advocacy organization designed to bring the voices of alumni to public policy issues by providing a forum for discussing current issues. A result of the growing alumni from foster care movements, FCAA seeks to provide those who share the foster care experience with opportunities to connect and advocate for change, as well as to transform foster care practice and policy, educate professionals and care providers, influence laws, and change the stereotypes held about this population.

FCAA maintains an online newsletter, Connecting Today…Transforming Tomorrow, which includes members' highlights and stories, opportunities for involvement, and organizational updates.[130]

Contact Information

Foster Care Alumni of America
118 South Royal Street
2nd Floor
Alexandria, VA 22314
Phone: (703) 299-6767 / (888) ALUMNI(0)
E-mail: admin@fostercarealumni.org
Web site: www.fostercarealumni.org

Taking Control

Taking Control, an adaptation of the Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS) program, is a 6-session group program designed to help youth in foster care, age 12-18, develop the self-awareness and skills to advocate for themselves and get their emotional, psychological, and social needs met. The group, led by a clinician and alumni from foster care, provides an engaging and informal learning environment where youth members can learn new skills, support each other, and work together on a meaningful group project. The sessions focus on helping youth members learn new ways to handle the difficult situations that many of them face on a regular basis.[131]

Contact Information

Lisa Hunter Romanelli, PhD
Director of Programs
The REACH Institute
708 Third Avenue, 5th Floor
New York, NY 10017
Phone: (212) 209-3871
Fax: (212) 209-7123
E-mail: Lisa@thereachinstitute.org

Mandy Habib, PsyD
North Shore University Hospital
2100 Community Drive
Manhassett, NY 11030
Phone: (516) 562-3276
Fax: (516) 562-4786
E-mail: mhabib@nshs.edu

Training Information:

The 2-day training includes the participation of mental health clinicians and alumni co-leader pairs.

Getting Beyond the System (GBS)

GBS is a strengths-based, self-advocacy training program for teens and young adults developed by the Youth Advocacy Center, located in New York City. A trained facilitator conducts the GBS Self-Advocacy Seminar that covers self-advocacy and other important skills (i.e., career preparation) that are necessary for youth to take control of their lives. The seminar meets for 2.5 hours a week over a 12-week period and is intended to complement transitional and educational programming provided by agencies.[132]

Contact Information

Youth Advocacy Center, Inc.
281 Sixth Avenue
New York, NY 10014
Phone: (212) 675-6181
Fax: (212) 675-5724
E-mail: sross@youthadvocacycenter.org
Web site: www.youthadvocacycenter.org/model/beyond.html

Training Information:

The 2-day GBS Philosophy and Approaches [Facilitator] Training Workshop costs $300 per attendee with 10% off for each additional attendee from the same organization. The workshop is held at a conference center in New York City.

Voices of Youth

Voices of Youth is an Internet site created by the United Nations Children's Fund (UNICEF) that advocates for the inclusion of youth in all aspects of child welfare practice, policy development, and operation through the sharing of personal stories and perspectives of youth in foster care.

The online site includes three sections: 1) Explore – to foster knowledge of children's rights and the latest developments, 2) Speak Out – to promote communication utilizing discussion boards, and 3) Take Action – to spur initiatives and elicit involvement in current projects.[133]

Contact Information

Voice of Youth
2 United Nations Plaza
New York, NY 10017
Phone: (212) 326-7000
E-mail: voy@unicef.org
Web site: www.unicef.org/voy

Youth Communication

Youth Communication uses training in journalism and the publication of magazines to increase the ability of youth in foster care to make important life decisions.

Youth Communication publishes one magazine, *Represent*, written by foster youth, and another, *Rise*, written by the parents of children in care or families receiving preventive services.[134] These magazines provide a forum for these youth (and parents) to share issues, perspectives, experiences, and common concerns. The program also provides education outreach programs for schools and foster care agencies.[135]

Contact Information

Youth Communication
NY Center, Inc.
224 W. 29th Street
New York, NY 10001
Phone: (212) 279-0708
Fax: (212) 279-8856
Web site: www.youthcomm.org

uFOSTERsuccess

uFOSTERsuccess is a non-profit organization in Utah that was established by a group of alumni from foster care. They give voice and affiliation to the youth and alumni of foster care by creating opportunities through advocacy, partnerships, education, programs, tools, and leadership. The organization's three objectives are (1) educate and motivate foster care professionals, (2) get current youth in foster care and alumni directly involved in helping improve child welfare, and (3) advocate for foster care issues based on experience.[136]

Contact Information

uFOSTERsuccess
P.O. Box 1386
Sandy, UT 84047
E-mail: ufostersuccess@gmail.com
bafeaster@hotmail.com
Web site: www.ufostersuccess.org

Court-Related Services

Court-Appointed Special Advocates (CASA)

Court-appointed special advocates serve as advocates or guardians for children in foster care. CASA volunteers are appointed by the judge and provide advice and direction about the court system to ensure that the youth and their families do not become overburdened by the legal and social service systems.[137]

Contact Information

100 West Harrison
North Tower, Suite 500
Seattle, WA 98119
Phone: (800) 628-3233
E-mail: staff@nationalcasa.org
Web site: www.nationalcasa.org

Guardian Ad Litem Programs (GAL)

Guardian Ad Litem Programs provide volunteers appointed by the court to serve as advocates or guardians for children in foster care within court and community settings. Advocates meet with children and families to gather information about a child's needs, wishes, and his or her family, and then they convey this information to the judges. They also monitor cases and facilitate communication among the children serving agencies, parents, foster parents, and attorneys involved in the child's life.[138]

Contact Information

Statewide Guardian ad Litem Office
The Holland Building
600 South Calhoun Street, Suite 154
Tallahassee, FL 32399
Phone: (850) 922-7213
Fax: (850) 922-7211
Web site: www.guardianadlitem.org

State Court Improvement Programs (CIPs)

Court Improvement Programs (CIPs) focus on the timeliness and quality of decisions made by courts in cases of maltreatment.

The Permanency Planning for Children Department of the National Council of Juvenile and Family Court Judges (NCJFCJ) provides technical assistance and training to CIPs.[139]

Contact Information

National Council of Juvenile and Family Court Judges
P.O. Box 8970
Reno, NV 89507
Phone: (775)784-6012
Fax: (775)784-6628
Web site: www.ncjfcj.org/content/view/82/146

Law Guardian Interdisciplinary Teams

Teams of attorneys (law guardians) represent youth in foster care in judicial proceedings and work together as members of interdisciplinary teams.

Lawyers of Children, Inc., is an example of a program that represents children in foster care in the New York City Family Courts using such an approach.[140]

Contact Information

Lawyers for Children
110 Lafayette Street
New York, NY 10013
Phone: (800) 244-2540
Web site: www.lawyersforchildren.com

Academic Remediation Services

Foster Youth Services (FYS)

FYS programs are based in California and provide academic remediation and the coordination of instruction, tutoring, vocational training, counseling, mentoring, and training for independent living. FYS programs strive to increase placement stability and improve the educational performance and achievement of youth in foster care.[141]

Contact Information

Jackie Wong
Foster Youth Services Program State Coordinator
Counseling, Student Support and Service-Learning Office
California Department of Education
1430 N Street, Suite 6408
Sacramento, CA 95814
Phone: (916) 327-5930
Fax: (916) 323-6061
E-mail: jawong@cde.ca.gov

Mentoring Services

Adoption and Foster Care Mentoring (AFC)

AFC Mentoring is a Boston-based program that identifies, trains, and supervises mentor-mentee relationships between adults (over 18) and youth (7-14) in foster, kinship, residential, or adoptive care.

Two programs developed to bring adults and youth together include AFC Mentors (one-on-one mentoring) and Team AFC (group mentoring). AFC Mentoring program volunteers, mentors, and staff provide youth with confidence, friendship, and guidance to assist them in reaching their various goals. Mentors meet with their mentees for at least eight hours, twice a month, for a minimum of one year. The relationships created through this program are often the first source of consistency that many youth in care experience while enduring numerous placements.[142]

Contact Information

AFC Mentoring
727 Atlantic Avenue, 3rd Floor
Boston, MA 02111
Phone: (617) 224-1300
Fax: (617) 451-1025
Web site: www.afcmentoring.org

AmeriCorps Foster Youth Mentoring Project (FYMP)

The AmeriCorps FYMP was formed through the Chancellor's Office of the California Community Colleges and is a collaborative effort between the state of California and ten community colleges throughout the state. The program teams community college students/AmeriCorps members with youth in foster care, age 14-18, for one-on-one mentoring. Through the mentoring relationship, youth in care work on improving their social, academic, vocational, and independent living skills. The program also reaches out to youth (age 18-21) who have aged out of the system to provide them with mentoring and continued support. Mentors meet with mentees for approximately 10 hours per week over 9-12 months.

The following community colleges participate in the FYMP: Bakersfield College, Butte College, Compton Community College, Citrus Community College, LA Harbor College, LA Southwest College, Modesto Junior College, City College of San Francisco, Santa Ana College, and Yuba College.[143]

Contact Information

FYMP
1102 Q Street, 3rd Floor
Sacramento, CA 95811
Phone: (866) 325-3222
Fax: (916) 325-0844
Web site: www.foundationccc.org/home/tabid/36/default.aspx

Fostering Healthy Connections

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

An initial pilot site for the program, Father Maloney's Boys' Haven, located in Kentucky, has reported successful six-month outcomes and has demonstrated the potential for this program to be replicated across the nation.[144]

Contact Information

Kerrin Sweet
Foster Care Program Manager
Child Welfare League of America
2345 Crystal Drive, Suite 250
Arlington, VA 22202
Phone: (703) 412-2400
Fax: (703) 412-2401
E-mail: ksweet@cwla.org
Web site: www.cwla.org/programs/fostercare/peermentoring.htm

New York City Administration for Children Services Mentoring Program

The ACS Mentoring Program pairs mentors (over the age of 21) with youth aging out of foster care (age 14-21) to help youth develop the practical living skills and maturity needed to survive on their own. Mentors meet with mentees 2-3 hours per week for a minimum of one year.

ACS offers a Mentor Symposium for youth from care and their mentors that covers important information, such as GED preparation, job training, and money management. It features presentations by successful youth and youth alumni on their career paths.[145]

In addition, ACS has developed a list of Best Practice Guidelines for Foster Care Youth Mentoring, which covers organizational development and various considerations for working with mentors, mentees, and caseworkers.[146]

Contact Information

Administration for Children's Services (ACS)
ACS Mentoring Program
Office of Youth Development
2 Washington Street, 20th Floor
New York, NY 1004
Phone: (212) 341-0914
Web site: Home2nyc.gov/html/acs/html/become_mentor/referral_service.shtml

College Education Attainment Services

Casey Life Skills Program

General college and vocational preparation programs provide high school youth with preparatory services and opportunities to obtain educational and vocational internships. The Casey Life Skills Web site addresses this area of concern and covers topics applicable to transitioning youth, which range from educational skills and resources to employment seeking and maintenance tips.[147]

Contact Information

Casey Life Skills Program
1300 Dexter Avenue North, Floor 3
Seattle, WA 98109
Phone: (206) 282-7300
Fax: (206) 282-3555
E-mail: aclsa@casey.org
Web site: www.caseylifeskills.org

Additional Information:

Three training levels are available including the End User one-day training, the Certified User two-day training, and Certified Trainer three-day training.

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

Living Classrooms Foundation/UPS School to Career Partnership

The Living Classrooms Foundation/United Parcel Service (UPS) School to Career Partnership provides youth in foster care (age 16-19), recruited from group homes in Baltimore, with UPS job training and entry-level employment. UPS provides scholarships for participating youth to cover community college tuition costs. This collaboration is funded by the Annie E. Casey Foundation and the State of Maryland.[148]

Contact Information

Christine Truett
Living Classrooms
802 S. Caroline Street
Baltimore, MD 21231
Phone: (410) 685-0295
E-mail: christine@livingclassrooms.org
Web site: www.livingclassrooms.org

Chafee-Funded ETV (Education/Training Voucher) Program

The Chafee ETV Program provides financial resources for postsecondary education and training for youth aging out of foster care who are enrolled in a qualified higher education program.[146]

Contact Information

The Chafee Educational and Training Voucher (ETV) Program
National Foster Care Coalition
1776 I Street, NW, 9th Floor
Washington, DC 20006
Phone: (202) 756-4842
Web site: www.statevoucher.org

Orphan Foundation of America (OFA)

OFA provides 350 college scholarships through various sponsors (e.g., Casey Family Scholars Program). OFA also provides online mentoring, internships, and other supports to college students in all 50 states, while administering Chafee Education and Training Voucher programs in Alabama, Arkansas, Colorado, Indiana, Maryland, Missouri, New York, North Carolina, and Ohio. Approximately 68% of OFA scholarship recipients have been cited as remaining in, and completing, higher education programs.[149]

Contact Information

Orphan Foundation of America
21351 Gentry Drive, Suite 130
Sterling, VA 20166
Phone: (571) 203-0270
Fax: (571) 203-0273
E-mail: scholarship@orphan.org
Web site: www.orphan.org

Employment Preparation Services

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

This partnership supports youth in foster care through the provision of business training opportunities along with transportation assistance during and after high school graduation to aid in the successful transition from school to employment.[150]

Other FORTUNE 100 companies utilizing this model include Marriott Hotels, Home Depot, and Bank of America.

Contact Information

The Annie E. Casey Foundation
701 St. Paul Street
Baltimore, MD 21202
Phone: (410) 547-6600
E-mail: webmail@aecf.org
Web site: www.aecf.org/ChildFamilyServices/SchoolToCareer.aspx

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

Project H.O.P.E. is a youth employment program, based in California, which was formed through a collaborative effort between the Alameda County Workforce Investment Board (ACWIB) and the Alameda County Department of Children and Family Services. The program encourages self-sufficiency through leadership development and career and educational preparation by connecting youth in care, age 16-18, to various employment and community resources provided in the community.[151]

Contact Information

Thou M. Ny
Youth Empowerment Program Consultant
Alameda County Independent Living Skills Program
2647 International Boulevard, Suite 312
Oakland, CA 94601-1596
Phone: (510) 268-2843
Fax: (510) 434-2438
E-mail: nyt@acgov.org
Web site: www.alamedacountyilsp.org/Services/Employment/HOPE/index.htm

Job Corps

Job Corps is a federally-funded program, which provides education and employment training services to at-risk youth age 16-24. Services assist youth in attaining education, vocational training, or entering the military.

Approximately 60,000 youth are served by 122 Job Corps Centers nationwide. Evaluations of Job Corps have revealed positive youth outcomes, including reduced involvement with the juvenile justice system and increased levels of employment and educational attainments.[152]

Contact Information

U.S. Department of Labor
Frances Perkins Building
200 Constitution Avenue, NW
Washington, DC 20210
Phone: (877) 889-5627
Web site: www.jobcorps.dol.gov

References

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