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**PRACTICE PARAMETER FOR THE ASSESSMENT AND MANAGEMENT OF
YOUTH INVOLVED WITH THE CHILD WELFARE SYSTEM**

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ABSTRACT

This Practice Parameter presents principles for the mental health assessment and management of youth involved with the child welfare system. Important definitions, background, history, epidemiology, mental health care utilization and functional outcomes are described. Practical guidance regarding child welfare-related considerations for evaluation and management are discussed. **Key Words:** practice parameters, practice guidelines, child and adolescent psychiatry, foster care, placement, child welfare.

DEVELOPMENT AND ATTRIBUTION

This Parameter was developed by Terry Lee, MD, George Fouras, MD, Rachel Brown MBBS, MPhil, and the American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Quality Issues (CQI): Heather J. Walter, MD, MPH and Oscar G. Bukstein, MD, MPH, co-chairs, and Christopher Bellonci, MD, Scott Benson, MD, Allan Chrisman, MD, John Hamilton, MD, Munya Hayek, MD, Helene Keable, MD, Carol Rockhill, MD, Ulrich Schoettle, MD, Matthew Siegel, MD, and Sandra Stock, MD.

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

The AACAP develops both patient-oriented and clinician-oriented Practice Parameters. Patient-oriented Parameters provide recommendations to guide clinicians towards best

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1 assessment and treatment practices. Recommendations are based on the critical appraisal of
2 empirical evidence (when available) and clinical consensus (when not), and are graded according
3 to the strength of the empirical and clinical support. Clinician-oriented Parameters provide
4 clinicians with the information (stated as principles) needed to develop practice-based skills.
5 Although empirical evidence may be available to support certain principles, principles are
6 primarily based on clinical consensus. This Parameter is a clinician-oriented Parameter.

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

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

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6

7 **INTRODUCTION**

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

19 In this Parameter, the terms “child” and “youth” are used interchangeably, except where
20 otherwise specified. The term “family” is used in a broad sense to include relatives, close family
21 friends, and non-traditional families, and the term “caregiver” includes “family” and when
22 specified, other childcare providers in out-of-home placements.
23

24 **METHODOLOGY**

25 The list of references for this Parameter was developed by systematically searching a
26 variety of electronic databases: Cochrane, PubMed, PsycINFO, Social Services Abstracts, and
27 Social Work Abstracts. The search was conducted in February 2012. There were no limits set in
28 terms of age or date. The search was limited to American studies and English language. The
29 search used only controlled vocabulary terms (i.e., MESH for PubMed, Thesaurus terms for
30 PsycINFO and Social Services Abstracts). In the case of PubMed, a clinical queries filter was
31 applied with a narrow scope to capture specific results.

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1 Child welfare was combined with a range of subjects to thoroughly encompass the topic.
2 Because foster care is a key component of child welfare, the term was used synonymously in the
3 search. A sample search strategy for PubMed followed this pattern: (Child welfare [MESH] OR
4 Foster home care [MESH]) AND Child abuse [MESH]. The combination search terms included
5 adoption, child abuse, child advocacy, child behavior disorders, child care, child custody, child
6 development, child health services, child rearing, developmental disabilities, group homes,
7 mental disorders, mental health, Munchausen syndrome by proxy, and parenting. This resulted in
8 2,635 PubMed references. A similar combination of search terms was repeated in PsycINFO
9 (2,172 references), Social Services Abstracts (1791), and Social Work Abstracts (166). This
10 resulted in 6,729 unduplicated references. Abstracts and/or titles of all 6,729 references were
11 reviewed. The search was augmented by a review of articles nominated by expert reviewers and
12 further search of article reference lists, relevant books, and pertinent websites. A total of 314
13 articles were selected for full-text review based upon their relevance to the topics addressed in
14 this Parameter. The most pertinent of these 314 articles were selected for inclusion in the
15 reference list for this Parameter.

16

17 **DEFINITIONS**

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

22 • **Child Welfare System:** A group of services designed to promote the well-being of
23 children by ensuring safety, achieving permanency, and strengthening families to care for
24 their children successfully. The child welfare system is not a single entity and involves
25 many organizations. Some child welfare services are provided by state and local
26 departments of social services, while others are contracted to private child welfare
27 agencies and child service providers.

28 • **Child Maltreatment:** There is no single accepted definition of child maltreatment. Each
29 state provides its own definitions of maltreatment within civil and criminal statutes. The
30 Federal Child Abuse Prevention and Treatment Act reads “child abuse and neglect
31 means, at a minimum, any recent act or failure to act on the part of a parent or caretaker

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1 which results in death, serious physical or emotional harm, sexual abuse or exploitation,
2 or an act or failure to act which presents an imminent risk or serious harm.” In addition to
3 physical, emotional, and sexual abuse/neglect, child maltreatment can also encompass a
4 broader array of exposures such as a child’s experience of domestic violence or parental
5 substance abuse. Any form of child maltreatment can lead to traumatic responses.

- 6 • **Child Protective Service (CPS):** The social service agency that receives reports,
7 conducts investigations and assessments, and provides initial intervention and treatment
8 services to children and families when child maltreatment is suspected to have occurred.
9 This umbrella term refers to any state or county social service agency that responds to
10 and investigates reports of possible child abuse, and makes a disposition based on the
11 findings.
- 12 • **Foster Care:** A service for children who cannot live with their custodial parents or
13 guardians for some period of time; sometimes termed “out-of-home” care. The range of
14 placements can include kinship care, non-relative foster care, treatment/therapeutic foster
15 care, group home, residential group care, secure residential treatment, and supervised
16 independent living. Foster care is intended to be short-term with a focus on returning
17 children home as soon as possible, or providing them with permanent families through
18 adoption or guardianship.
- 19 • **Child Welfare Worker:** The person who is responsible for the case management of the
20 youth in question. The worker coordinates services to the child and family including
21 referrals to appropriate agencies and services and monitors the youth’s placement. The
22 child welfare worker also prepares documentation for the courts and represents social
23 services in any juvenile court proceedings.
- 24 • **Dependency Court:** The portion of juvenile court presiding over child welfare matters.
- 25 • **Dependent Child:** A child placed in the custody of a child welfare system by
26 dependency court, typically because of maltreatment by caregivers. During dependency,
27 the youth may remain at home with court oversight, or be placed out-of-home. A court
28 plan will be generated. The plan will indicate when the child may be reunified if the
29 youth was placed out-of-home, and under what circumstances the case may be dismissed
30 from dependency court.

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- 1 • **Permanency:** A concept based on the value that youth grow up best in a family
2 environment that is durable, nurturing and stable. This is supported by policies and
3 practices in the dependency court and foster care systems. Permanent placements include
4 return to the biological family, adoption, and legal guardianship.
- 5 • **Kinship Care:** Placements of children with relatives or close family friends, also known
6 as fictive kin. Kin are preferred for children removed from their birth parents because it
7 maintains the children’s connections with their families. Kinship care may be informal,
8 e.g., the family makes the decision for youth to live with kin or formal, e.g., the state
9 removes a youth from parental custody and places the youth with kin. The latter involves
10 training, licensure, and more resource support.
- 11 • **Guardianship:** Caregivers can assume legal guardianship of a child in out-of-home care
12 without termination of parental rights. Guardianship removes the youth from the child
13 welfare system, allows the guardian/caregiver to make important decisions on behalf of
14 the youth and establishes a long-term caregiver for the youth. Relative caregivers who
15 wish to provide a permanent home for a child and maintain relationships with extended
16 family members most frequently use guardianship.
- 17 • **Treatment (Therapeutic) Foster Care:** Family foster care designed for children with
18 severe emotional and behavioral problems. It provides additional support, including
19 supplemental finances, supervision, and training. Treatment foster care standards vary in
20 different jurisdictions.
- 21 • **Court Appointed Special Advocate (CASA):** A person, usually a volunteer, appointed
22 by the court who seeks to ensure that the needs and interests of a child in dependency
23 court proceedings are protected. The CASA is a party to the case and advocates for
24 safety, permanency, and well-being. CASAs are given certain powers and can speak on
25 the youth’s behalf in court. They cannot consent for treatment, but may function as an
26 educational surrogate for special education purposes, if specifically tasked.
- 27 • **Guardian ad Litem (GAL):** A lawyer or layperson appointed by the court to handle the
28 affairs of, or act or speak on behalf of someone involved with the court. In dependency
29 court, this typically involves representing the youth’s best interests in maltreatment cases.
30 It may involve a variety of additional roles, including independent investigator, advocate,
31 advisor, or guardian for the child. A layperson who serves in this role is sometimes

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1 known as a CASA. Not all cases will have a GAL appointed. It is up to the individual
2 bench officer to decide whether to do so or not.

3
4 **BACKGROUND**

5 The child welfare system is a group of services designed to promote the well-being of
6 children by ensuring safety, achieving permanency, and strengthening families to care for their
7 children successfully.² Significant numbers of youth and families have contact with the child
8 welfare system, with considerable social and fiscal consequences. In 2011, approximately
9 681,000 children were confirmed to be victims of maltreatment, and approximately 400,000
10 youth resided in foster care daily.³ The total annual cost of child abuse and neglect has been
11 estimated to be \$80.2 billion.⁴

12 Child and adolescent psychiatrists and other mental health professionals can play an
13 important role in the lives of many youth in foster care. Upwards of 80% of youth involved with
14 the child welfare system have developmental, behavioral, or emotional concerns requiring
15 mental health treatment.^{5,6,7,8} Compared to other Medicaid-eligible youth, youth placed in foster
16 care have 5 to 8 times the rate of mental health service utilization, 8 to 12 times greater mental
17 health expenditures, and 2 to 8 times the rates of various psychotropic prescribing practices (e.g.,
18 any psychotropic medication, antipsychotic medication, polypharmacy).^{7,9,10,11,12,13,14,15,16,17,18}

19 Increasing attention has focused on the high rates of psychotropic prescribing to youth in
20 foster care. Wide geographic variations in prescribing rates suggest psychotropic medications
21 may be both over- and under-prescribed, and that factors other than clinical need influence
22 prescribing practices.^{19,20,21,22} Foster youth have higher rates of mental health disorders, which
23 may be due in part to the effects of maltreatment, trauma, removal from home and family,
24 multiple placements, disrupted attachments, poverty, gestational exposures, and genetic
25 vulnerability. In addition to higher rates of mental health disorders, factors potentially
26 contributing to appropriately higher rates of prescribing include gaining access to Medicaid
27 insurance, systematic screening and assessment, and child welfare advocacy for indicated
28 treatments. While higher rates of mental health disorders support higher psychotropic prescribing
29 rates, it is not clear whether the current magnitude of higher prescribing is appropriate. Factors
30 contributing to potentially inappropriate psychotropic prescribing may include insufficient time
31 and information for clinicians to properly evaluate and reassess, limited support for collaboration

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1 among providers and stakeholders, under-recognition of trauma etiology in case formulation of
2 complex presenting problems, limited access to effective and specifically targeted psychosocial
3 treatments, clinician workforce insufficiently trained in effective psychosocial and
4 psychopharmacologic treatments, poor continuity of care, limited integration of care, ineffective
5 advocacy, unrealistic hope that medication will stabilize a complex psychosocial situation, lack
6 of commitment to indicated parent skills training (especially when permanency is unclear), lack
7 of commitment to or confidence in psychotherapy for complex problems, and responding to
8 behavioral crises and urgent requests with pharmacologic interventions. Addressing many of
9 these concerns will require reorganizing the mental health and child welfare systems, and how
10 they interface. This restructuring goes beyond the scope of this Practice Parameter, but provides
11 opportunities for public policy advocacy.

12 While there is no definitive evidence to determine the appropriateness of higher rates of
13 psychotropic prescribing to youth involved with the child welfare system, various stakeholders
14 are concerned. In a survey of state child welfare agencies, the United States (US) Government
15 Accountability Office (GAO) found that 15 states identified the overprescribing of psychiatric
16 medication to youth involved with the child welfare system as one of the most important
17 emerging issues facing their child welfare system.²³ One study of child welfare and mental
18 health professionals' view of the quality of psychiatric services received by consumers of the
19 child welfare system revealed concerns about the overuse of psychotropic medications and
20 overmedication of youth. The overuse was in part attributed to a lack of clinical feedback from
21 child welfare partners to psychiatrists.²⁴ A survey of 47 states and the District of Columbia on
22 psychotropic medication oversight in foster care found that over half the states rated their level
23 of concern about psychotropic medication use as "high". A majority of these states reported an
24 increasing trend in the use of psychotropic medications, specifically increased use of
25 antipsychotics, antidepressants, and ADHD medications, increased polypharmacy, increased
26 medication use among young children, and increased reliance on "prn" medications in residential
27 facilities.¹⁶

28 As a result of these concerns, a number of guidelines and protocols for the oversight of
29 psychiatric medication use in the child welfare system have been developed and
30 catalogued.^{16,17,25} In 2005, the AACAP published a Position Statement on Oversight of
31 Psychotropic Medication Use for Children in State Custody: A Best Principles Guideline,²⁶

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1 which is a set of oversight recommendations for child welfare jurisdictions and state agencies. In
2 summary, the Position Statement *Minimal Standards* call for jurisdictions to:

- 3 • Identify the parties empowered to consent for treatment of youth in state custody in a
4 timely fashion,
- 5 • Obtain assent from minor youth for psychiatric medication when possible, and
- 6 • Establish guidelines for the use of psychiatric medications for youth in state custody.

7 *Recommended Standards* include:

- 8 • Provide psychoeducational materials to facilitate the consent process,
- 9 • Maintain an ongoing medical record with medical and psychiatric history, and
- 10 • Establish a child psychiatry consultation program for:
 - 11 ○ Persons who are responsible for consenting for psychiatric medication treatment,
 - 12 ○ Physicians working with youth involved with the child welfare system, and
 - 13 ○ Face-to-face evaluations of youth at the request of child welfare stakeholders who
14 have concerns about a specific youth’s psychiatric medication regimen.

15 *Ideal Standards* include:

- 16 • Establish training requirements for child welfare workers, court personnel, and/or foster
17 parents to promote more effective advocacy for youth in their custody regarding
18 behavioral health care, psychiatric medications, and monitoring,
- 19 • Establish programs administered by child psychiatrists to oversee and evaluate the
20 utilization of medications for youth in state custody, at both the individual youth and
21 population levels, and
- 22 • Create a Web site to provide stakeholders easy access to pertinent policies and
23 procedures governing the use of psychiatric medications and useful information about
24 child psychiatric diagnoses and psychotropic medications.

25 In 2011, the GAO recommended that the US Department of Health and Human Services
26 (HHS), the federal agency overseeing child welfare, endorse further guidance to states on best
27 practices for oversight of psychotropic prescribing to youth involved in the child welfare system.
28 HHS agrees with this recommendation.¹⁸ In a survey of key informants from child welfare and
29 affiliated agencies in 47 states and the District of Columbia¹⁶ four-fifths of states had or were
30 developing a written policy or guideline regarding psychotropic medication use. Two-thirds of
31 states had adopted at least one “red flag” marker signaling a need for heightened scrutiny (the

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1 nature of which varied across states). The most commonly utilized red flags were use of
2 psychotropic medications in young children (defined variously as age 3-6 years), endorsed by
3 nearly one-half of states; use of multiple psychotropic medications concurrently (defined
4 variously as 3-5 medications), endorsed by two-fifths of states; and use of multiple medications
5 within the same class for longer than 30 days, endorsed by two-fifths of states. Dosage exceeding
6 maximum recommendations (e.g., manufacturer, professional, federal, or state) and medications
7 inconsistent with current recommendations (e.g., professional or state guidelines) were endorsed
8 as red flags by over one-quarter of states. These state actions were congruent with the 2012
9 federal guidelines pertaining to oversight of psychotropic medication for children in foster care
10 (<https://www.acf.hhs.gov/sites/default/files/cb/im1203.pdf>), which identified three potentially
11 problematic psychotropic prescribing practices designated as “too many” (polypharmacy), “too
12 much” (dosages exceeding recommendations), and “too young” (prescribing to young children).

13

14 **HISTORY**

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

22 The potential conflict between parents’ rights to raise their children without government
23 interference and children’s rights to be raised free from maltreatment is a societal dilemma.
24 Debate continues over the relationship between the rights of parents and the best interests of the
25 child, including safety and developmental needs. When considering the rights and interests of the
26 state, parents, caregivers, or youth, differences of opinion may arise. More than fifty years ago,
27 the courts did not recognize that a child in state custody had any rights. Over the years,
28 dependency court principles shifted first to the “tender years” concept, which acknowledged the
29 developmental needs of young children, and then in the 1970s to the concept of “the best
30 interests of the child.” All states have statutes requiring that the child’s best interests be
31 considered in at least some aspect of child welfare decision-making, but application of this

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1 concept varies significantly. No standard definition exists for “best interests of the child,” but the
2 term generally refers to the primacy of the child’s safety and well-being.

3 The history of foster care in the US includes examples where the rights of parents in
4 certain ethnic and racial groups have been inappropriately overridden. For example, American
5 Indian youth have been, and continue to be, removed from their families at high rates. As a
6 result, the Indian Child Welfare Act (ICWA) of 1978 mandates that, if possible, a tribal court
7 will hear all child welfare cases involving American Indian children. The ICWA also sets
8 specific guidelines for the placement of American Indian children into foster care in order to
9 preserve the child’s cultural identity.

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

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

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

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

6 The Foster Care Independence Act (John H. Chafee Foster Care Independence Program)
7 was signed into law in 1999, and provides states with more funding and greater flexibility in
8 carrying out programs designed to help youth transition from foster care to self-sufficiency.
9 Chief provisions of this law are an expansion of a state’s ability to provide services for youth up
10 to the age of 21, including housing assistance and Medicaid eligibility. The act also expands
11 opportunities for providing education, training, and employment services and financial support to
12 foster youth preparing to live on their own.

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

21 The Child and Family Services Improvement and Innovation Act (PL112-34), signed into
22 law in 2011, requires states to develop plans for oversight and coordination of health care
23 services for foster youth. It specifically requires states to outline the monitoring and treatments
24 of emotional trauma associated with a child’s maltreatment and removal from home and to
25 develop protocols for the appropriate use and monitoring of psychotropic medications. The law
26 calls for states to describe activities to reduce the length of time youth under age 5 are without a
27 permanent family, and to identify which populations are at greatest risk of maltreatment and how
28 services are targeted to the highest risk populations. The law also requires peer-to-peer
29 mentoring and support groups for parents and services and activities designed to facilitate
30 visitation of children by parents and siblings.

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1 Although not specifically relating to child welfare, the Affordable Care Act (ACA) of
2 2010 (PL 111-148) allows youth aging out of the foster care system to remain eligible for
3 Medicaid until age 26 years, beginning in 2014.

4
5 **PRINCIPLES**

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

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

18 Situations meeting local CPS criteria for safety and/or risk concerns will be assigned to
19 an “urgent” or “regular” response. The time frames depend on risk level and state and federal
20 regulations, and may be modified according to local rules or specific situations. At the end of the
21 investigation, CPS personnel typically determine whether maltreatment allegations are
22 “substantiated” or “unsubstantiated.” Some states have additional categories, such as “unable to
23 determine.” For cases of substantiated maltreatment, the 2011 national frequencies of the types
24 of maltreatment were: neglect (78.5%), physical abuse (17.6%), sexual abuse (9.1%),
25 psychologically maltreated (9.0%) and medical neglect (2.2%) (Note: percentages add up to
26 more than 100% because a youth can experience more than one type of maltreatment).³

27 Depending on the level of assessed risk, the case may be closed, referred to voluntary
28 services, or referred to dependency court oversight through the filing of a dependency petition.
29 Additional options exist in some jurisdictions. When allegations of maltreatment are
30 substantiated, CPS immediately decides whether the child is safe to remain at home, or should be
31 taken into CPS custody. Each open case is reviewed in dependency court. A child made

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1 dependent by the court may be “placed” at home, or in out-of-home care. When placed out-of-
2 home, CPS prioritizes placing youth in kinship care when possible, in order to maintain a youth's
3 family connections. When more formal placements are used, child welfare workers seek the least
4 restrictive setting. On a given day in 2011, youth in out-of-home placements were mainly placed
5 in non-relative foster care (47%) and relative’s homes (27%). The remaining youth were in
6 institutions (9%), group homes (6%), trial home visits (5%), pre-adoptive homes (4%), runaway
7 (1%) and supervised independent living (1%).²⁷

8 Youth in dependency court will have a permanency plan, which specifies the plan for the
9 youth’s exit from the child welfare system, and a service plan. Depending on the jurisdiction and
10 characteristics of the situation, youth may be assigned a CASA or GAL to represent the youth’s
11 best interests in dependency court. CPS develops a service plan after assessing a youth and
12 family’s strengths and needs. Service plans typically address basic needs (e.g., housing, food),
13 barriers to effective parenting (e.g., substance use, parenting skills), and the youth’s medical,
14 emotional and behavioral needs. The child welfare worker supports and monitors progress, and
15 reviews the case status at regularly scheduled court hearings. When the court determines that the
16 service plan has been successfully completed, it dismisses the petition. In situations where
17 families do not make sufficient progress despite “reasonable efforts” made to support them, each
18 jurisdiction has statutes providing for the termination of parental rights by a court. Termination
19 of parental rights may be voluntary or involuntary. When considering involuntary termination of
20 parental rights, most jurisdictions require the court to determine whether the parent is unfit by
21 clear and convincing evidence and whether termination is in the child’s best interests.
22 Termination of parental rights ends the legal parent-child relationship. At that point, the
23 preferred permanent plan is adoption. Under child welfare principles, family settings are
24 preferred over long-term group or residential placements because family settings offer youth an
25 opportunity for enduring and nurturing attachments, a sense of belonging, long-term
26 commitment and a shared future. In some cases, intermediary solutions such as guardianship
27 may become the permanent plan.

28 Some child welfare systems use structured decision-making in their determination and
29 decision processes. In this approach, fundamental child welfare objectives, values and problems
30 are defined and analyzed from multiple stakeholder perspectives to develop clearly defined
31 decision-making criteria. Jurisdictions using structured decision-making seek to promote

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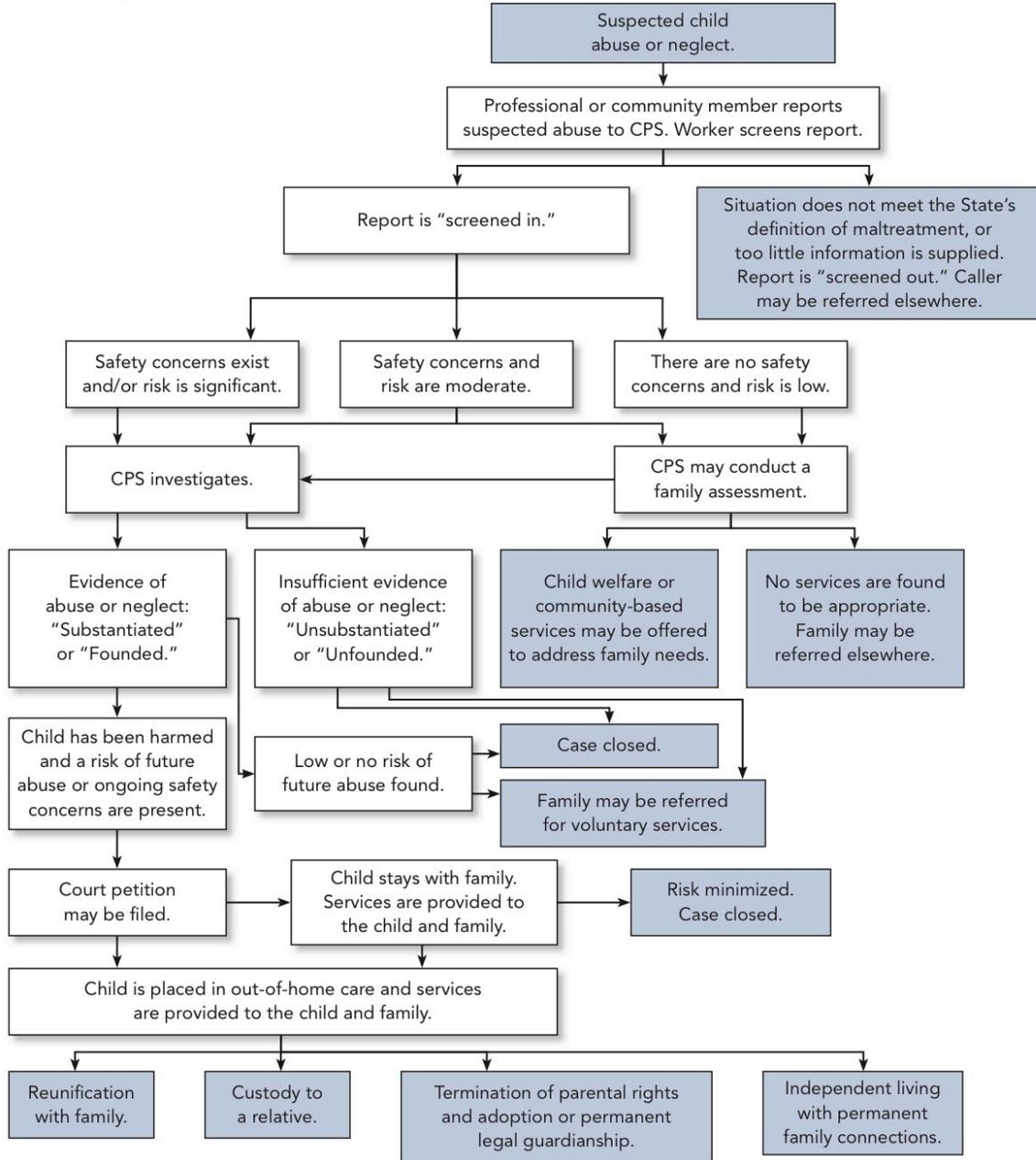
1 consistent, transparent and objective decision-making at key points of the child welfare process
2 and to produce positive outcomes for youth and families.

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

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Appendix A: The Child Welfare System



- 1
- 2 **Principle 2. Clinicians should be familiar with child welfare system core values and**
- 3 **principles.**

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

15 Child welfare systems value strengths-based approaches and resilience orientations.
16 Masten defines resilience as a class of phenomena characterized by good outcomes in spite of
17 serious threats to adaptation or development, and emphasizes that resilience is a common, rather
18 than extraordinary, characteristic of individuals.²⁹ Resilience highlights the tendency of a human
19 being towards typical development, rather than assuming inevitable pathology. A resilience
20 orientation portends a strengths-based approach that identifies and enhances protective factors in
21 a youth’s ecology. The Center for Study of Social Policy’s Strengthening Families framework
22 organizes and addresses protective factors around parental resilience, social connections,
23 knowledge of parenting and child development, concrete support in times of need, and social and
24 emotional competence of children.³⁰

25 Clinicians using a culturally informed approach attempt to understand youth and families
26 in the context of their culture. Some minority groups, including African-Americans and
27 American Indians, are overrepresented at each decision point of the child welfare system.^{31,32} At
28 the same time, youth of color in foster care are underrepresented in accessing mental health
29 services.^{33,34} Lesbian, gay, bisexual, transgender and questioning their gender identity or sexual
30 orientation (LGBTQ) youth are also overrepresented in the child welfare system. In addition to
31 the maltreatment, traumas, disrupted attachments and losses experienced by other youth in the

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1 child welfare system, LGBTQ youth in foster care face additional challenges. These include
2 homophobia or transphobia, and the need to assess safety in their schools, social networks,
3 communities and homes in order to decide whether, and to whom, to disclose their LGBTQ
4 identity.³⁵ Clinicians should be aware of and responsive to a youth and family’s culture,
5 ethnicity, race, language, sexual orientation, gender identity, and spirituality. Provider sensitivity
6 to cultural differences will facilitate engagement with youth and families, enhance the quality of
7 services, and promote culturally acceptable decision-making. Clinicians should elicit and attempt
8 to understand a youth’s and/or family’s perspective and explanatory model of behavioral health
9 concerns and child welfare system involvement. This will help facilitate culturally appropriate
10 treatment planning. A diverse provider workforce inclusive of providers from the cultures of the
11 families being served will improve cultural literacy and fit. When placed out-of-home, a youth’s
12 cultural identity should be promoted and nurtured. Readers are referred to the Practice Parameter
13 for Cultural Competence in Child and Adolescent Psychiatric Practice and the Practice Parameter
14 on Gay, Lesbian, or Bisexual Sexual Orientation, Gender Nonconformity, and Gender
15 Discordance in Children and Adolescents for more information.^{36,37}

16 Many stakeholders endorse a trauma-informed approach; however, there is no single
17 accepted definition of trauma-informed care. The term generally refers to an organizational
18 approach and commitment to recognizing the manifestations of trauma in youth, caregivers, care
19 providers and stakeholders and to addressing trauma effects. Trauma awareness will permeate all
20 aspects of organizational functioning, including incorporating trauma knowledge into policies,
21 and addressing the impact of vicarious and/or secondary trauma on clinicians and other
22 stakeholders. In addition, trauma-informed service systems routinely screen for trauma exposure
23 and symptoms, support youth and families in understanding traumatic experiences, emphasize
24 safety and resiliency, and stress CASSP principles. Clinicians should have specific training on
25 the impact of maltreatment and other forms of trauma and recognizing trauma responses,
26 including complex trauma responses. The National Child Traumatic Stress Network (NCTSN)
27 Web site provides a Child Welfare Trauma Training Toolkit³⁸ for teaching basic knowledge,
28 skills and values for working with youth in the child welfare system who have experienced
29 traumatic stress. Clinicians sufficiently trained in, and committed to, trauma-informed
30 approaches are better poised to advocate for the integration of this orientation with day-to-day

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1 practice, and to advocate for the types of public health policies and clinical practice needed to
2 provide good care.

3

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

6 Every child and adolescent in foster care has a representative of the state’s child welfare
7 agency responsible for managing his or her case. Consents should be addressed prior to the first
8 appointment. Each specific step in the child welfare process (e.g., placed but not a court
9 dependent, court dependent, legal guardianship, shared social services/juvenile justice custody,
10 etc.) has different implications for consent, release of information, and treatment. The child’s
11 biological parents may retain certain rights and, in some circumstances, courts require their
12 consent for evaluation and/or treatment. The individual with physical custody of the child may
13 not be able to provide consent because legal custody and/or authority for consent may rest with a
14 child welfare agency, biological parent, or some other party such as the court or a state-appointed
15 consent agent. Most jurisdictions also have specific laws and procedures for prescribing
16 psychiatric medications to youth involved with dependency court. Psychiatric medications
17 should not be prescribed without first obtaining consent from the designated consenting
18 authority, although exceptions may apply in emergencies. Questions about a child’s legal status,
19 as well as requests for consent for evaluation and treatment, informed consent, release of
20 information, and coordination of treatment, should be directed to the child welfare worker.

21

22 **Principle 4. *Prior to accepting a referral, the clinician should clarify the circumstances and***
23 ***goals of the referral, and the limits of which services can and cannot be provided.***

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

- 28 • **Assessment.** Multiple guidelines and federal statutes call for early universal mental
29 health screening of all youth entering the child welfare system, followed by a more
30 comprehensive mental health evaluation for youth who screen positively.^{39,40,41}

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1 Screenings and evaluations must include assessments of trauma exposure and trauma-
2 related symptoms using assessment techniques with adequate reliability and validity.

- 3 • **Treatment and Teamwork.** As indicated, clinicians may provide ongoing psychiatric
4 care to youth involved with the child welfare system. When providing clinical care,
5 clinicians join the child and family team. Child and family teams are family members,
6 their community supports and other pertinent stakeholders that come together to keep
7 children safe and promote children’s permanency and well-being. Receiving feedback
8 from other team members, coordinating care, providing psychoeducation when
9 appropriate, and communicating with other stakeholders can improve outcomes. The
10 camaraderie of a team with strengths-based and solution-focused approaches is likely to
11 buffer some challenges and enhance a clinician’s capacity to work with youth involved
12 with the child welfare system. Mental health clinicians working with youth in the child
13 welfare system should coordinate care with caregivers, primary care providers, educators
14 and other stakeholders. Some youth may be involved with other pediatric providers, other
15 mental health providers, special education services, and/or the juvenile justice system.
- 16 • **Level of Care Recommendations.** Clinicians are sometimes asked to provide a
17 recommendation for the level of mental health care and/or treatment intensity to address a
18 youth’s mental health needs. This may be for a youth a clinician is working with, or a
19 specific role in system of care oversight for multiple youth. For all youth, but especially
20 for those with a history of maltreatment, clinicians must carefully consider the effects of
21 more restrictive placements and interventions, including seclusion and restraint.
- 22 • **Consultation.** Child welfare agencies and departments increasingly turn to mental health
23 clinicians to provide consultation and/or evaluations for youth in state care and their
24 families. In various child welfare systems, child and adolescent mental health clinicians
25 consult with and/or oversee aspects of the child welfare system. They may provide
26 consultation to child welfare agency personnel and treating clinicians, case-specific
27 and/or systemic oversight of psychotropic medication use, and education for
28 stakeholders.²⁵
- 29 • **Psychiatric Medication Consent and Oversight.** Some jurisdictions place psychiatric
30 medication consent for youth in foster care within a central or regional authority, made
31 up of expert clinicians. Review and consultation may accompany the psychotropic

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1 medication consent. Some jurisdictions monitor child welfare psychotropic medications
2 with specific programs. Examples of programs include second opinions, tracking
3 compliance with pertinent policies, and/or expert review of behavioral health care.

- 4 • **Forensic Assessment.** It is critical that clinicians understand the distinction between
5 therapeutic and forensic roles when working with dependency court, and the differences
6 between a fact witness and an expert witness. Some professional organizations have
7 ethical guidelines addressing the distinction between clinical and forensic activities.
8 Clinicians must be aware there is no known method to determine the veracity of a child's
9 statements, so care must be taken to not overstate one's opinion. For more information
10 and guidance, readers are referred to the AACAP Practice Parameter for Child and
11 Adolescent Forensic Evaluations.⁴²
- 12 • **System Advocacy.** Clinicians should advocate for the development of systems that
13 facilitate and promote effective behavioral health care; and for the safety, permanency
14 and well-being for youth involved with the child welfare system.

15
16 ***Principle 5. Clinicians should communicate with the referral source and the child welfare***
17 ***worker to obtain the information needed to proceed with the evaluation.***

18 Prior to the initial appointment, the clinician should communicate with the person making
19 the referral to ensure that relevant information arrives before or at the time of the initial
20 appointment. The clinician should ask that the youth be accompanied to the appointment by
21 persons familiar with the youth and the youth's recent functioning, and by whom the youth feels
22 supported. Clinicians should only proceed when there is sufficient information and access to
23 persons with suitable familiarity with the youth. Sources of additional information that the child
24 welfare worker can provide include dependency court documents, court evaluations, initial and
25 subsequent pediatric/developmental/trauma/mental health/substance use screens required by
26 most states, pediatric evaluations after initial placement required by most states, previous
27 behavioral health evaluations and treatment notes, school evaluations and notes, and evaluations
28 and documents from juvenile court. Federal legislation provides for additional sources of
29 information. The Fostering Connections to Success and Increasing Adoptions Act of 2008 directs
30 states to develop plans to oversee and coordinate health care services and establish a medical
31 home with prescription medication oversight. The Child and Family Services Improvement and

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1 Innovation Act of 2011 requires states to develop plans for oversight and coordination of health
2 care services for foster youth.

3

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

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

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

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

25

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

28 Evaluations should consider the youth’s developmental stage and associated common
29 health, developmental and mental health issues. Evaluators should consider the history of
30 maltreatment and trauma, the complexity of maltreatment and trauma responses, the effects of
31 separation from family, the effects of disrupted attachments, the effects of separation from other

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1 community/school supports, the youth’s developmental trajectory, current youth functioning, and
2 risk and protective factors in the youth’s ecology. The history obtained from informants should
3 include the specific circumstances surrounding the youth’s entry into care, the number of
4 placements, the circumstances and qualities of each placement, reasons for transition from one
5 placement to another, youth response to transitions, and current and longitudinal contact with
6 parents, siblings and extended family. The child welfare worker usually provides much of the
7 information, with input from other informants, including biological and foster parents when
8 available. Clinicians may hear multiple and sometimes disparate perspectives from various
9 stakeholders. This requires sensitivity to all perspectives and a level of comfort with ambiguity
10 and lack of certainty. Descriptions of current youth functioning may also vary, based on the
11 reporter’s relationship to the youth. Given the potential multiple viewpoints, motivations and
12 interests, collecting information from multiple collateral contacts and domains is essential. Areas
13 for special consideration in the evaluation and management of youth involved with the child
14 welfare system include:

- 15 • **Establishing Trust.** Trust is a critical component of the therapeutic relationship. Youth
16 with a history of maltreatment, trauma, and disrupted attachments should not be expected
17 to trust unfamiliar clinicians. Caution in developing new relationships is appropriate and
18 respecting and speaking to a youth’s caution can help develop the therapeutic
19 relationship. Clinicians can promote engagement through open and authentic
20 communication and developing youth-identified treatment goals. Techniques facilitating
21 alliance-building include attending to non-verbal cues, active listening, validation,
22 warmth, empathy, acceptance, and a non-judgmental stance.
- 23 • **Youth Experience of Child Welfare System Involvement.** In addition to the facts of
24 their history, clinicians should attend to the youth’s perceptions, reactions, emotions, and
25 cognitions related to the experience of being involved with the child welfare system. This
26 can include exploring the youth’s beliefs and feelings regarding why the child welfare
27 system is involved, why they are placed out-of-home, views of the child welfare system,
28 desired outcomes, and how helpful or unhelpful their experience has been. Evaluators
29 should consider typical manifestations of grief, loss, and trauma in children and
30 adolescents, as well as the potential range of reactions to separation from attachment

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1 figures. Youth may feel ambivalent about separation from parents who have maltreated
2 them.

- 3 • **Typical Development and Attachment, and Disruption.** Knowledge of normative child
4 and adolescent development, parent-child attachment, and specific trauma-focused
5 training will enhance clinician recognition of the diverse and complex effects of
6 maltreatment, trauma, separation, out-of-home placement, and other aspects of child
7 welfare system involvement. During an initial assessment, the clinician should consider
8 whether, and to what extent, a youth's symptoms are related to a long-standing concern,
9 problems with attachment, separation from caregivers, separation from familiar ecology,
10 grief and loss, out-of-home placement, and/or maltreatment and trauma. Clinicians can
11 provide important information to other stakeholders regarding the potential effects of
12 these factors.
- 13 • **Trauma.** Clinicians should recognize that maltreatment and trauma can be complex and
14 chronic, leading to a confusing clinical presentation that may be difficult to differentiate
15 from other mental health conditions. Readers are referred to the AACAP Practice
16 Parameter for the Assessment and Treatment of Children and Adolescents with
17 Posttraumatic Stress Disorder (PTSD)⁴³ for more information on the effects and
18 manifestations of trauma. This Parameter acknowledges that youth with a history of
19 trauma may present with emotional, physical, and/or interpersonal dysregulation but not
20 meet full criteria for a diagnosis of PTSD, but recommends considering trauma effects in
21 the differential diagnoses of other psychiatric disorders. The PTSD Practice Parameter
22 also discusses the potential for other psychiatric disorders and physical conditions to
23 mimic PTSD. The trauma histories of youth involved with the child welfare system will
24 generally include abuse and/or neglect and the traumatic stress of removing youth from
25 their primary caregivers and familiar social ecology.
- 26 • **Adjustment to Placement.** An individual youth's adjustment to placement depends on
27 numerous factors. The factors include pre-removal functioning, individual youth
28 characteristics, the circumstances of removal, the stability and supportiveness of the
29 current placement, access and connections to support from previous ecologies, and the
30 youth's perceptions of current circumstances.

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- 1 • **Collaboration.** Clinicians assessing and managing youth involved with the child welfare
2 system must collaborate and coordinate with medical providers and stakeholders from
3 other child-serving systems. The provision of health care and coordination of health care
4 services is mandated by federal child welfare guidelines. Youth involved with the foster
5 care system should have a primary care provider. In addition to mental health concerns,
6 youth in foster care face medical challenges at significantly higher rates than other
7 children, sometimes as a consequence of the circumstances that led to their removal from
8 their home and sometimes exacerbated by their experiences in foster care.⁴⁴
- 9 • **Functioning in Multiple Domains.** Information on academic, social, behavioral and
10 emotional functioning in school, and comparing school and home functioning will inform
11 assessment and treatment planning. Youth involved with the child welfare system are at
12 increased risk for involvement in other child-serving systems, such as juvenile justice or
13 special education. Clinicians must understand the youth’s status in these other systems
14 and collaborate with providers and stakeholders in order to coordinate care and receive
15 feedback on youth functioning and response to services. Clinicians should also attend to
16 youth functioning in multiple domains (such as school, peers, home, and community)
17 because prior disruptions place the youth at greater risk for problems in these domains
18 and problems in one of these domains may disrupt the current placement. Emerging
19 evidence indicates that youth problem behaviors place foster youth at risk for disrupted
20 placement, and that multiple placements increase the likelihood of youth disruptive
21 behavior.^{45,46}
- 22 • **Movement in the Child Welfare System.** Clinicians must understand the youth’s status
23 in the child welfare system, promote youth understanding of the process, and address
24 issues associated with movement through the child welfare system. Clinicians will often
25 work with more than one placement and system of care. Permanency plans may change
26 as the child’s and family’s circumstances change. Clinicians who elect to work with
27 youth in the child welfare system must be willing to accept that placement decisions
28 ultimately rest with dependency court judges and hearing commissioners. However,
29 clinicians can effectively advocate for youth involved with the child welfare system by
30 working as a member of the child and family team and presenting clear reasoning for
31 their recommendations. Clinicians should advocate for consistency, stable and nurturing

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1 placements, clinically appropriate transitions, minimal disruptions, maintenance of
2 supportive relationships and familiar settings, permanency, and well-being. Clinicians
3 must also consider and address a youth’s development and transition to adulthood.

- 4 • **Clinician Self-Awareness.** The circumstances surrounding youth involved with the child
5 welfare system (such as abuse, neglect, family functioning, child-rearing beliefs, and
6 disrupted attachments) may give rise to strong emotions and differences of opinion;
7 clinicians should be conscious of transference and countertransference issues.

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

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

17 Clinicians must pay particular attention to record keeping and be aware of the possible
18 tensions between the need for detailed records, and confidentiality issues or privacy concerns
19 that may arise for youth involved with the child welfare system. On one hand, continuity of a
20 child’s treatment may rely heavily on the accuracy and details of records passed from one
21 clinician to another. On the other hand, clinician copies of medical records provided to child
22 welfare workers and other stakeholders will be read by many different individuals. During active
23 CPS investigations in most states, all records may be subject to disclosure. Clinicians must be
24 mindful that their records may become part of court proceedings, including the prosecution of an
25 alleged maltreating parent, without the knowledge or consent of either patient or clinician.
26 Clinicians should clearly attribute sources of information and indicate when information is
27 obtained second- or third-hand, so that hearsay does not appear to be fact.

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

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

Studies using a variety of methods of population ascertainment and assessment have consistently found that relative to the general population, youth involved with the child welfare system have significantly higher rates of developmental, physical, emotional, behavioral, and substance use disorders. Among preschool-aged children in the child welfare system, 30%-65% have developmental and/or behavioral health concerns.^{47,48,49,50} Fifty to 80% of youth in foster care have behavioral health concerns with high rates of comorbidity, including elevated rates of depressive, anxiety, posttraumatic stress, disruptive behavior, attention-deficit/hyperactivity, learning, and substance use disorders, and suicide attempts.^{6,51,52,53,54,55,56} Children who remain with their family of origin or are placed with kin also have high rates of developmental and behavioral health concerns.^{6,48,57,58,59} In adulthood, elevated physical, mental health, and substance use risks persist, along with increased rates of low academic achievement, unemployment, low income, disability, poverty, lack of health insurance, homelessness, and engagement in illegal behavior.^{56,60,61,62,63,64,65}

Despite guidelines for screening and evaluating youth entering the child welfare system for behavioral health needs, well-documented high rates of behavioral health needs and multiple reports of disproportionately high rates of mental health utilization and expenditures by youth involved with the child welfare system, significant unmet or underserved behavioral health needs exist. The National Surveys of Child and Adolescent Well-Being (NSCAW), two national longitudinal studies of youth and families referred to the child welfare system, provide valuable information regarding behavioral health needs and underutilization of services. In the second NSCAW, it was found that among a subgroup of 12-36 month-olds with mental health needs, only 2.2% received any type of mental health service. The percentage went up to 19.2% when parent skills training were included.⁶⁶ In the first NSCAW, among children less than 6 years old with developmental and behavioral needs, fewer than 25% were receiving services. Remaining in the biological home and age less than 3 years of age were factors associated with underutilization of services.⁴⁸ For youth 2-14 years of age, only approximately 25% of youth with strong evidence of clinical need received any care in the previous 12 months. Severity of need and living outside of the biological home increased the likelihood of receiving specialty mental

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1 health care for all ages. Among school-aged children, African-Americans were less likely to
2 receive services, while adolescents who have a parent with severe mental illness were more
3 likely to receive mental health care.⁶ Evaluating a subset of youth 2-15 years of age who had
4 been in out-of-home care for about 12 months, approximately 25% of youth with high rates of
5 mental health needs had not received mental health services. Severity of need, older age, and
6 history of sexual abuse were associated with accessing mental health services, while history of
7 neglect and African-American ethnicity were associated with decreased use of services.⁵⁸ Thus,
8 additional advocacy is needed to assure that youth who are known to be at risk of being
9 underserved—including African-American youth, young children, youth remaining at home or
10 placed in kinship care, and victims of neglect—get the help they need.

11 Given that 50%-80% of all youth in the child welfare system have behavioral health
12 treatment needs, and only 19%-50% of youth in need of mental health services receive
13 services,^{6,66,67} clinicians should advocate for appropriate mental health screening and evaluation
14 in their local child welfare system and in primary care settings. Multiple guidelines^{39,40,41,68} and
15 the Fostering Connections to Success and Increasing Adoptions Act (PL-110-351) call for youth
16 in foster placement to receive initial and follow-up mental health screenings. Screenings should
17 include assessment of exposure to trauma and related symptoms. The use of validated,
18 developmentally appropriate and feasible instruments for screening and assessment is
19 recommended.⁶⁹ Guidelines generally call for initial screening within 24-72 hours of entering
20 foster care by trained personnel. Initial screening should focus on identifying youth at high risk
21 for safety concerns, running away from placement, and/or in need of mental health or substance
22 abuse service needs. Initial and subsequent screenings should also determine whether further
23 assessment or immediate intervention is needed. One recent guideline⁴¹ calls for a second and
24 more complete screen within 30 days to evaluate mental health and substance use service needs
25 and assess functioning in multiple relevant domains, such as school and community. Within 60
26 days, or sooner as indicated, youth who screen positively should receive an individualized,
27 comprehensive mental health evaluation. The mental health evaluation will help inform
28 treatment and permanency planning. Ongoing screening should include informal screening
29 during each child welfare worker visit. More formalized screening using standardized
30 instruments should occur at least annually and whenever there is a change in functioning or
31 environment. Youth should be screened prior to exiting the child welfare system. Given their

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1 increased risk to have unmet behavioral health needs, youth remaining at home or placed with
2 kin should receive similar screenings and evaluations. Collaborating with primary care and other
3 health care providers and advocating for universal behavioral health care screenings in primary
4 care settings will also help identify behavioral health needs.

5

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

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

11 There have been a number of recent reviews of the effectiveness of various psychosocial
12 interventions for youth involved with the child welfare system and youth who have been
13 maltreated.^{55,70,71,72,73,74,75,76} The review formats vary, and different rating criteria lead to
14 differences in the ratings of individual treatments, but all the reviews are informative. A number
15 of these reviews include discussion of the definition of evidence-based practice, dissemination of
16 evidence-based and expert consensus best practices, and various barriers to dissemination. Some
17 “best” and “most promising” practices are described below, but represent only a portion of
18 empirically supported treatments for youth involved with the child welfare system. At the same
19 time, the range and effectiveness of treatments must be enhanced.

20 Parent-Child Interaction Therapy (PCIT) is an evidence-based treatment for disruptive
21 behavior disorders that focuses on improving the quality of the parent-child relationship and
22 changing parent-child interaction patterns. The two main components of the skills training are
23 organized around Child Directed Interactions and Parent Directed Interactions. Live coaching is
24 provided. PCIT was originally developed for children aged 2-7 years with disruptive behavior. It
25 has been adapted for physically abusive parents and their children up to 12 years of age, and
26 supplemented with an additional motivational enhancement module. In one trial, at median
27 follow-up of 850 days, families receiving the child welfare-adapted PCIT had a re-report rate of
28 19% for physical abuse, compared to 49% for the standard community control group.⁷⁷ In a
29 subsequent study, trained community providers were used, and the study design dismantled the
30 motivational enhancement versus services as usual orientation module and PCIT versus usual

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1 parent training. A significant reduction in future child welfare reports was found for caregivers
2 receiving combined motivation enhancement orientation and PCIT, which was synergistic.⁷⁸

3 Alternatives for Families: Cognitive Behavioral Therapy (AF-CBT) (formerly Abuse-
4 Focused Cognitive Behavioral Therapy) is an evidence-based treatment for improving
5 relationships between children and caregivers in families involved in physical coercion/force and
6 chronic conflict/hostility. The treatment emphasizes intra- and interpersonal skills training to
7 reduce individual youth, parent, and family risk factors for, and the consequences of, physical
8 abuse or coercive behavior. AF-CBT is comprised of two components: individual child and
9 parent cognitive behavioral therapy (CBT) and family therapy (FT). In comparing the separate
10 components to treatment as usual, at one-year follow-up, both individual CBT and FT were
11 associated with lower child-to-parent violence and child externalizing behavior, parent distress
12 and abuse risk, and family conflict and cohesion. Abuse recidivism rates were: individual CBT
13 (5%), FT (6%), and treatment as usual (30%).⁷⁹

14 Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is an evidence-based
15 treatment originally developed for posttraumatic stress symptoms (PTSS) resulting from
16 childhood sexual abuse, which has been applied to PTSS related to other traumas. Individual
17 youth and parallel non-offending parent sessions are provided initially, progressing to conjoint
18 sessions. The treatment utilizes psychoeducation, parent management skills, relaxation, affective
19 modulation skills, cognitive coping, trauma narrative, exposure, and enhancing personal safety.
20 Youth treated with TF-CBT, relative to youth receiving alternative treatments, have greater
21 reductions in posttraumatic stress, depressive, anxiety and behavioral symptoms, while
22 caregivers report less abuse-specific parental distress.^{80,81,82}

23 Multidimensional Treatment Foster Care (MTFC) is an evidence-based intensive
24 community-based treatment originally developed for youth involved with the juvenile justice
25 system, which has been adapted for multiple populations, including youth involved with the
26 child welfare system in need of out-of-home placement. MTFC provides behavioral parent
27 training and intensive support for MTFC foster parents, family therapy for biological family,
28 skills training and supportive therapy for youth, and school-based behavioral interventions and
29 academic support. An adaptation of MTFC for child welfare—Keeping Foster Parents Trained
30 and Supported (KEEP), was evaluated in a randomized controlled trial, and found to reduce child
31 behavior problems, increase reunification with biological families, and decrease foster home

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1 disruptions.^{83,84} MTFC has been adapted for preschoolers involved with the child welfare system
2 (MTFC-P) and is also called Early Intervention Foster Care (EIFC). EIFC has been shown to
3 increase the likelihood of permanent placements (90% compared to 64% for regular foster care
4 control),⁸⁴ and alter cortisol activity to more closely resemble that of non-maltreated community
5 comparison youth.⁸⁵

6 Multisystemic Therapy (MST) is an empirically supported intensive community-based
7 treatment originally developed for youth involved with the juvenile justice system, which has
8 been adapted for multiple populations, including physically abused youth and their families. In
9 one trial with 16 month follow-up, Multisystemic Therapy for Child Abuse and Neglect (MST-
10 CAN) was more effective than enhanced outpatient services in reducing youth mental health
11 symptoms, parent psychiatric distress, parenting behaviors associated with maltreatment, youth
12 out-of-home placements, and changes in youth placement. Youth receiving MST-CAN were less
13 likely to be re-abused, but base rates were low and the difference did not reach statistical
14 significance.⁸⁶

15 In addition to being knowledgeable about effective treatments, clinicians should also be
16 aware of interventions with risk of harm. The AACAP Policy Statement on Coercive
17 Interventions for Reactive Attachment Disorder highlights the danger, lack of evidence of
18 effectiveness, violation of fundamental human rights, and growing number of deaths associated
19 with so called “rebirthing techniques” or “holding therapy,” and calls for cessation of the use
20 these interventions.⁸⁷

21

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

25 The authority to consent for psychiatric medications varies by jurisdiction and the youth’s
26 status in the child welfare process. The authority to consent may reside with a youth, biological
27 parents, child welfare agency, court or other party, and there may be further oversight by another
28 state supported agency with expertise in mental health treatment and psychopharmacology.
29 Clinicians need to be aware of the local laws and standards prior to prescribing medication. In
30 addition to obtaining proper legal consent, clinicians should obtain youth assent if youth do not
31 have authority to consent for themselves. In developmentally appropriate language, the clinician

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1 should discuss the clinician’s findings, the role of medication in the treatment of the youth’s
2 symptoms, potential positive and negative effects of the medication including how medication
3 may help, and alternative treatment options. The clinician should also address any questions and
4 concerns the youth may have. Many youth feel they have little control or influence over child
5 welfare decisions.^{88,89,90} Involving a youth in the decision to try medication affirms the youth’s
6 role in his or her treatment and can enhance engagement in the trial, and treatment in general.
7 Youth-oriented toolkits may assist older youth in mental health and psychiatric medication
8 decision-making.⁹¹ The youth’s caregivers should be involved in a similar manner, when
9 appropriate.

10 Requests for psychiatric medication prescriptions may present as urgent or emergent, but
11 before prescribing, clinicians need sufficient information to support psychiatric evaluation and
12 treatment planning. Clinicians should also determine whether there are appropriate levels of
13 structure, supervision and stability in a youth’s current living situation to manage psychiatric
14 medications. Psychotropic medication is just one element of a comprehensive plan and must be
15 coordinated and integrated with psychosocial interventions. Evidence-based treatments for youth
16 often require the participation of caregivers, especially when addressing youth disruptive
17 behavior. If youth placement is transitory, including when permanency has not been achieved,
18 foster parents or kinship caregivers may be less likely to participate in parent skills training.
19 Clinicians can play an important role in advancing the importance of psychosocial interventions,
20 either as first-line treatments or in coordination with the initiation of psychotropic medications.
21 Failure to provide effective psychosocial treatments may lead to an inappropriate emphasis on
22 prescribing psychotropic medications. Clinicians are referred to the AACAP Practice Parameter
23 on the Use of Psychiatric Medications for Children and Adolescents⁹² for general prescribing
24 principles, and should be aware of “red flag” monitoring in their state. Psychotropic prescribing
25 should be based upon the best available evidence of safety and efficacy, and should be
26 coordinated with a youth’s primary care providers.

27

28 **PARAMETER LIMITATIONS**

29 AACAP Practice Parameters are developed to assist clinicians in psychiatric decision
30 making. These Parameters are not intended to define the sole standard of care. As such, the
31 Parameters should not be deemed inclusive of all proper methods of care or exclusive of other

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1 methods of care directed at obtaining the desired results. The ultimate judgment regarding the
2 care of a particular patient must be made by the clinician in light of all of the circumstances
3 presented by the patient and his or her family, the diagnostic and treatment options available, and
4 available resources.

5

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