Mental Health Care for Child Welfare Clients: Final Report
Mental Health Care for Child Welfare Clients:
Final Report July 2002

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Mental Health Care for Child Welfare Clients: Final Report

Executive Summary

Objective
The Agency for Health Care Administration (AHCA) contracted with the University of South Florida’s Louis de la Parte Florida Mental Health Institute (FMHI) during FY2001-02 to complete clinical case studies on currently open Department of Children and Families (DCF) foster care cases in the SunCoast region. Specifically, this study was designed to examine: (1) how demographic, behavioral, attitudinal, family and service system factors are related to service use patterns; (2) how foster care outcomes (child safety, permanence, child well-being and family stability) are supported through the mental health services received; and (3) whether interventions have been designed to include multiple systems (the child, foster parents, peers, school staff, behavioral and mental health professionals, and the broader community).

This study focused on twenty-one youth ages 10-17 years old who currently have an open case in the Department of Children and Families, have been in their foster care placement for at least six months, have undergone termination of parental rights (TPR), and reside in the DCF SunCoast Region of the state of Florida. Each child was Medicaid enrolled. The case studies consisted of a triad of semi-structured interviews with a youth, a caregiver, and a primary behavioral health service provider. The protocol for the interviews was specifically developed for this study to focus on service utilization, treatment plans and the nature of the mental health interventions. In addition to the interviews, standardized assessments of the child’s functioning were completed using the Child Behavior Checklist/4–18 (CBCL), Youth Self Report (YSR), and the Trauma Symptom Checklist for Children (TSCC).
Findings
The findings include descriptive data on the demographic characteristics of the participants, clinical assessment of mental health functioning and psychological distress among the youth, discussion of system level issues identified by providers, and presentation of case studies, which are representative of the challenges and successes in meeting the behavioral health needs of children in foster care.

Analysis of the clinical assessment profiles (CBCL, YSR, and TSCC) indicates that several youth are at a greater risk for a variety of problems, including disruptive behaviors and anger. Overall, the effect of problem areas assessed could have adverse consequences for long-term social adjustment, placement stability, and permanency options.

Youth, caregivers and providers described a broad range of therapeutic interventions provided to the child. Overall satisfaction with services was high; however, services tended to emphasize behavioral outcomes. Only a few providers reported goals specific to permanency outcomes or issues associated with loss and separation. Generally, caregivers and youth were involved in the development of treatment goals. The majority of providers sought the caregiver’s input to adapt services to conform to their belief system while fostering strategies to engage the caregiver in a partnership on behalf of the child’s treatment.

The majority of youth and caregiver respondents found that the location, time and frequency of services were convenient. Several families noted that services that were less structured and activity-based were most beneficial to the child’s functioning. Additionally, continuity of staff was important for investing the youth in the therapeutic relationship and providing a safety net from the repetitive loss of significant people in the child’s life. Overall satisfaction with services was high, although families need assistance in linking with appropriate services.
Qualitative data from provider interviews and six case studies highlight the behavioral health and child welfare issues identified in the study. Areas discussed include the value of therapeutic foster care, necessity of quality service providers, and importance of service continuity. Service coordination is needed to facilitate communication between the child welfare system and foster families and to follow-up after intensive services have ended in order to make sure necessary supports are in place. Youth and family need to be involved in defining needs and identifying solutions. Improvements could be made in planned, coordinated transition services for children so that funding mechanisms and caregiver supports are in place before the child is moved in addition to allowing the child some time for preliminary closure on their prior living arrangement and friendships. Additionally, funding mechanisms need to be examined to ensure that continuity in access to services is not adversely affected by evidence of progress toward treatment goals. Coordination of treatment goals with permanency planning is often lacking and more trauma-focused interventions are needed.

The findings of this study highlight the importance of a sense of belonging and connectedness for a child's long term functioning. While the foster care experience, combined with the abuse and neglect that resulted in foster care placement, can create barriers to promoting well-being in youth, the positive development of young people can be achieved through supports, stabilized care, and coordinated services. Child welfare goals of permanency and placement stability need to be incorporated into the behavioral treatment plan to help ensure that coordination of service delivery emphasizes common desired outcomes for the youth and includes transition planning.
Children in foster care have a myriad of socio-emotional needs which can adversely affect long-term adjustment, placement stability, and permanency outcomes. While abuse is not a disorder or syndrome, mental health problems are a common result (Finkelhor & Berliner, 1995). Among all children entering the child welfare system, individuals have been found at-risk for developmental, emotional, and behavioral problems that require intervention (Kendall, Dale, & Plakitsis, 1995; Putnam, 2000; Schneiderman, Connors, Fribourg, Gries, & Gonzales, 1998). Putnam reports that “approximately 30% to 40% of the children in out-of-home care have a serious emotional disorder and as many as 75% to 80% of the population in out-of-home care need mental health services” (2000, p. 3).

Many studies have attempted to identify factors that contribute to these emotional disorders, and combinations of factors have been noted which are disruptive to child functioning (Dore, 1999). The risk factors and high incidence rate of psychopathology among children in foster care placements necessitate concurrent attention to clinical needs and child welfare goals for permanency. This dual directive suggests that the mental health needs of children in care may be qualitatively and quantitatively different from the general population of children and necessitate specialized service delivery (Lyons, Libman-Mintzer, Kissiel, & Shallcross, 1998).

The suggested framework for mental health interventions for children in child welfare is a continuum of care that spans prevention, treatment, and maintenance services across treatment settings to address psychosocial effects of abuse and neglect. Ideally, this multi-systemic approach involves the child, current caregivers, birth parents, peers, teachers, mental health and medical professionals, and the local community (Armsden, Pecora, Payne, & Szatkiewicz, 2000).
In the past, barriers to meeting the needs of children in the child welfare system and the related needs of their families have been associated with the lack of formal policies to provide mental health services, the lack of timely assessments to identify psychosocial functioning of the child, and failure to communicate with multiple providers and caretakers (Stroul, Pires, & Armstrong, 1998). Although managed care systems have been devised to improve health care services by emphasizing primary and preventative care and system coordination, conflicts among the various child welfare and behavioral health managed care stakeholders can interfere with mental health service delivery. Barriers to quality service delivery include a lack of continuity of care (Macro International, 1992; Schulzinger, McCarthy, Meyers, Irvine, & Vincent, 1999), divergent values (e.g., child welfare's emphasis on safety, permanence and child well-being may diverge from managed care's short-term treatment focus), lack of providers with expertise in child welfare issues, insufficient family-focused services, and employment of providers who may not show their clients enough respect or sensitivity (Berliner & Conte, 1995).

The mental health treatment of abused children is further confounded by a historical paucity of empirically validated treatment models (Briere, 1996a). Traditionally, atheoretical and generic child treatment techniques have been implemented instead of interventions that are theoretically grounded and empirically validated (Friedrich, 1994). Outcome research is now establishing the effectiveness of directive, abuse-focused interventions that are goal-oriented and specific to the child and family dynamics. According to Berliner and Saunders, this type of trauma-focused intervention is designed to “ameliorate symptoms and prevent subsequent problems by helping children avoid the development of negative attributions and maladaptive coping” (1996, p. 295). Safety is paramount to successful outcomes, and from the perspective of a child the safety necessitates not only protection from further abuse, but also safety from further loss and separation.
Despite research that confirms a susceptibility to psychopathology among children in out-of-home care, we lack an in-depth assessment of the psychological and social functioning of children in the child welfare system. In addition, a comprehensive summary of the nature of these interventions has not yet been developed. In this study the project team assesses the mental health status of children in foster care using formal assessment measures. Specifically, the study explores issues related to process and effectiveness of service provision.

Based on a comprehensive review of treatment procedures and protocols recommended for use with abused children and their families, the project team has identified interventions with substantial scientific support, treatments with significant clinical acceptance, and procedures that are experimental or lack empirical support in the child abuse field (Saunders & Berliner, 2000). This review is designed to serve as a guide to assess service delivery and to identify clinical need.

The findings from this study have important policy ramifications for both the mental health and child welfare reforms taking place in Florida, since the entry into the child welfare system provides an opportunity for secondary prevention with regard to child mental health problems. One challenge is to better understand how to design both mental health managed care and child welfare privatization reforms so that early and comprehensive assessment of mental health needs takes place.
The project team completed twenty-one clinical case studies on currently open DCF (Department of Children and Families) foster care cases in the SunCoast region, focusing on former DCF Districts 5 and 6. Purposeful sampling was used in order to capture the richness and complexity of these cases. These two regions reflect the divergence and convergence of service delivery in one area of the state of Florida, which has implemented varying approaches for the provision of mental health and child welfare services.

Conceptual Models and Study Questions

Two conceptual models were developed. Figure 1 depicts a service model perspective in which services are hypothesized to be the organizing structure for addressing mental health and child welfare goals. Conversely, Figure 2 represents a goal-focused model in which services are based on identified needs. The contrasting models provided a foundation for the qualitative analyses of data, and reflect dual processes which can occur simultaneously in the service delivery system for children in foster care. The service driven model is based on observed practices which are often reported in the literature and within the child welfare field. It can be in conflict with the goal driven model which is more reflective of recommendations from guidelines for practice.

The primary research questions guiding this study were:

1. How are demographic, behavioral, attitudinal, family and service system factors related to service use patterns?

2. How are foster care outcomes (child safety, permanence, child well being and family stability) supported through the mental health services received?

3. Have interventions been designed to include multiple systems (the child, foster parents, peers, school staff, behavioral and mental health professionals, and the broader community)?
Figure 1
Service Model

Figure 2
Goal Model
Participants

This study focused on twenty-one youth ages 10-17 years old who currently have an open case in the Department of Children and Families, have been in their foster care placement for at least six months, have undergone termination of parental rights (TPR), and reside in the DCF SunCoast Region of the state of Florida. Each child is currently Medicaid enrolled. Respondents to interviews also included a foster caregiver and a mental health provider who are familiar with the services provided to the child.

Representatives from DCF SunCoast Region and Family Continuity Programs, Inc. each identified 21 (total 42) youth who met the participation criteria. A confidentiality certificate was obtained to meet DCF’s requirements for the protection of children’s identities and data. Caregivers were initially contacted by their caseworkers and subsequently by the research team to explain the study and identify interested participants. Following the initial phone contact, 28 of the identified youth met all of the criteria. Of those who were excluded: one was below the required age range, three were too cognitively delayed to meet the functional age demands of the tasks, three were siblings of another participating youth, four had experienced a change in placement within the past six months, one was a runaway, one was in detention, and one was placed out of county. Seventy-five percent of the eligible families agreed to participate.

Methodology

The case studies consisted of a triad of semi-structured interviews with the youth, a caregiver, and a primary behavioral health service provider. The protocol for the interviews was specifically developed for this study to focus on service utilization, treatment plans and the nature of the mental health interventions. The questions were guided by principles that include child-focused and family-centered services approach; individualized and strength-based assessment and intervention; prevention and early intervention focus; and non-duplicative service delivery. Few studies on child maltreatment have incorporated structured
interviews and qualitative methodology, despite the benefit of a more in-depth picture and rich detail that could not otherwise be gathered by quantitative means (Berliner & Conte, 1995). In addition to the interviews, standardized assessments of the child’s functioning were completed using the Child Behavior Checklist (CBCL), Youth Self Report (YSR), and the Trauma Symptom Checklist for Children (TSCC).

After human subjects research assent and consent forms were completed, the CBCL and service utilization data were obtained in an interview with the participants’ foster caregivers in their homes. The child completed the TSCC and youth version of the CBCL (Youth Self Report [YSR]) subsequent to a brief interview to get their feedback on their treatment services. For their participation, the foster caregiver received a $25 gift certificate and the youth received a $20 gift certificate. Maltreatment and treatment plan information were collected through interviews with the mental health provider.

**Instruments**

Despite an obvious trend for children within the child welfare system to demonstrate increased rates of behavioral and emotional disorders, only in the preceding decade have researchers really begun to apply standardized tests to evaluate levels of functioning (Clark et al., 1994; Dubowitz et al., 1994). Such tests are beneficial because they increase the likelihood of consistent and objective assessment, in addition to allowing for a comparison between a child’s test scores and a set of normed scores (Armsden, Pecora, Payne, & Szatkiewicz, 2000).

The Child Behavior Checklist (CBCL), developed by Achenbach and Edelbrock (1983), has been used by clinicians and researchers (Armsden et al., 2000; Berliner & Saunders, 1996; Borrego, Urquiza, Rasmussen, & Zebell, 1999; Clark et al., 1994; Cohen & Mannarino, 2000; Deblinger & Lippmann, 1996; Evans et al., 1994; Rosenblatt et al., 1998) to assess a child’s competence in play activities, work activities, social relations, and academics. The CBCL also evaluates problem behaviors on the following subscales: Withdrawn, Somatic Complaints, Anxious/Depressed, Social Problems, Thought Problems, Attention Problems, Delinquent Behavior, and Aggressive Behavior (Achenbach, 1991).
Specifically, the CBCL has been used in the past to demonstrate that children in foster care have significantly higher levels of clinically significant problem behavior than children within the general population. In addition, foster care children referred for mental health services tend to have more difficulties of an externalizing nature (sum of Withdrawn, Somatic Complaints, and Anxious/Depressed subscales), as opposed to internalizing (sum of Delinquent Behavior and Aggressive behavior subscales) (Armsden et al., 2000).

As Achenbach (1991) recommends, the CBCL should ideally be combined with other sources of observation and assessment. Children involved in this study were also given the Trauma Symptom Checklist for Children (TSCC; Briere, 1996b), which is a 54 item self-report instrument that measures psychological distress in children who have experienced traumatic events. The scale consists of six clinical areas: anxiety, depression, posttraumatic stress, sexual concerns, dissociation, and anger. Numerous studies support the idea that children 8 years of age and older are able to understand the terminology of the instrument, and the resulting data suggest that the TSCC is reliable and valid in both traumatized and nontraumatized samples (Elliot & Briere 1994; Cohen & Mannarino, 2000; Lanktree & Briere, 1995; Singer, Anglin, Song, & Lunghofer, 1995). Higher scores on each of the TSCC clinical scales and subscales reflect higher levels of symptoms.

Data Analysis
Qualitative data analysis techniques were applied in the present study to identify themes in the case study data and further elaborate on the narrative findings. Analysis included a description of the services provided, what services were provided to whom, how long children were spending in the various components, and the attainment of service plan goals and objectives. The identification of other predictors, including case characteristics and severity of harm, were examined to determine interactions among variables. Differences in CBCL, YSR, and TSCC scores were evaluated and compared to reference sample data. Linkages between service utilization and mental health functioning were examined to test the relationship between need and services provided.
Limitations

SunCoast Region DCF and Family Continuity Programs, Inc. identified youth in foster care and their caregivers for participation in this study. The inclusion criteria, however, restricted participation to (a) youth between the ages of 10–17 years; (b) children who have been in their current placement for at least six months; (c) youth who access mental health services; and (d) youth whose case has undergone termination of parental rights. Additionally, human subject consent to participate was signed by DCF and Family Continuity Programs, Inc. as the legal guardians of the child, by the foster caregiver and the provider. The child signed his/her assent to be interviewed. The participation criteria contributed to the study’s limitations in that the referral for participation by caseworkers at DCF and Family Continuity Programs, Inc. may have been based on the appropriateness of the youths’ experiences and high potential for reports of satisfaction. Similarly, the requirement of being with a consistent caregiver who could respond to the protocol certainly ruled out youth who experienced recent disruptions in their placements. Also, youth who were perceived to be emotionally fragile or severely delayed were not interviewed, based on caregivers assessment of their functioning. The use of self-report measures was further limited by intentional or inadvertent misreporting of socio-emotional functioning. As a result, the applicability of these findings to children with more intense symptoms is questionable. Additionally, the small number of cases restricts the power to detect significant interactions which reveal group differences and precludes the inclusion of more rigorous analyses.

These limitations notwithstanding, the results highlight issues associated with the process and effectiveness of service delivery to youth in foster care who present with diverse child welfare and behavioral health needs. Promising approaches are noted and alternatives to overcome existing barriers are suggested.
Results

This report details the findings from twenty-one participating triads. In addition to descriptive data on the demographic characteristics of the participants, themes related to the conceptual models are discussed, system-level issues identified by providers are explored, and case studies are presented which are representative of the challenges and successes in meeting the behavioral health needs of children in foster care.

Demographic Characteristics

These results are based on a triad of interviews and clinical assessments with 21 youth who were in foster care, their caregivers, and behavioral health providers. The cases of each participating youth have undergone termination of parental rights, and all respondents reside in Hillsborough, Pasco, or Pinellas counties in Florida.

Figures 3–5 summarize the demographic characteristics of the youth, caregivers, and providers. One-third (seven) of the children participating in the interviews resided in group homes, and 14 youth (67%) lived in foster homes at the time of the project. On average the youth were 13.6 years old and ranged from 10 to 17 years old. Whereas the majority of youth were male (62%); the participating caregivers and providers were primarily female (67% and 76%, respectively). Among the youth, 57% identified themselves as Caucasian, 24% African American, and 14% Hispanic-Latino. Of the caregivers, major racial/ethnic representations were Caucasian (57%) and African American (33%). The race/ethnicity of the providers was less diverse (90% Caucasian).
### Figure 4
**Gender**

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<td>Male</td>
<td>13</td>
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<td>Female</td>
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### Figure 5
**Race/Ethnicity**

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<th></th>
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<td>Caucasian</td>
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<td>Hispanic-Latino</td>
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<tr>
<td>Other</td>
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Clinical Assessment of Functioning

This section summarizes the findings regarding the clinical assessment of mental health functioning and psychological distress among the youth. The caregiver completed the Child Behavior Checklist (CBCL), and youth were administered the Youth Self Report (YSR) and the Trauma Symptom Checklist for Children (TSCC).

Child Behavior Checklist and Youth Self Report

The CBCL and YSR are parallel behavioral measures designed to obtain information about a child’s behaviors from different informants. The YSR and CBCL yield measures of internalizing behaviors, externalizing behaviors, and additional areas of problem behavior. Scores above the 98th percentile of the normative population indicate clinical levels. Results are summarized in Figures 6–8 and Table 1.

Figure 6
Clinical Assessment: CBCL/YSR
Internalizing Symptoms

- Clinical
- Sub-Clinical
- Normal

<table>
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<tr>
<th></th>
<th>Caregiver/CBCL</th>
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<tr>
<td>Clinical</td>
<td>52%</td>
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<tr>
<td>Sub-Clinical</td>
<td>29%</td>
<td>29%</td>
</tr>
<tr>
<td>Normal</td>
<td>19%</td>
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Figure 6: Clinical Assessment: CBCL/YSR Internalizing Symptoms.
Correlations between the scales were conducted to determine the agreement between the caregiver and the youth reports (i.e., inter-informant agreement). Different informants provide unique perspectives regarding children’s behaviors and problematic responses. Caregiver reports (CBCL) rated significantly higher rates of clinical level problem behaviors across all assessed domains. Overall youths reported engaging in more externalizing than internalizing behaviors.
with 38% noting clinical levels of behaviors related to aggression and delinquency. Internalizing behaviors were rated at a clinical level by 29% of the youth. Caregivers noted similar differences, with 67% rating externalizing behaviors at a clinical level and 52% reporting internalizing behaviors at this level. Overall, 76% of the foster children scored within the clinical range of the CBCL for internalizing, externalizing, or total behavior problems. On the YSR, 48% self-assessed within the clinical range. The somewhat higher perception of problems by caregivers, especially for aggressive behavior, indicates that caregivers are more prone to report disruptive behaviors as well as defiance and irritability among the youth than noted in the children’s self assessment. Although the youth did not always report lower levels of symptomatology than caregivers, the findings are consistent with other studies which suggest that children, particularly adolescents, tend to minimize the severity of their problems. Moreover, the higher incidence of externalizing disorders, including disruptive behaviors, aggression, and hyperactivity, is consistent with other research on children living in foster care (Marsenich, 2002).

### Table 1

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<td>28%</td>
<td>48%</td>
<td>24%</td>
</tr>
<tr>
<td>Total N</td>
<td>21</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Trauma Symptom Checklist for Children

In addition to emotional, behavioral, and developmental problems which are common in foster children, traumatic reactions may affect children who have experienced various forms of maltreatment (Marsenich, 2002). The Trauma Symptom Checklist for Children (TSCC) was developed as a standardized measure for symptoms of anxiety, depression, anger, post-traumatic stress, dissociation, and sexual concerns in traumatized children. The TSCC expands on more general measures such as the CBCL with sensitivity in the measurement of reactions to trauma. In addition to assessing post-traumatic difficulties, the TSCC appears to be sensitive to the effects of therapy for abused children (Cohen & Mannarino, 1992; Lanktree, Briere & de Jonge, 1993).
T scores are used to interpret each child’s level of symptomatology on the TSCC. The T scores have a mean of 50 and a standard deviation of 10. For all clinical samples except Sexual Concerns, T scores at or above 65 are considered clinically significant. T scores in the range of 60 to 65 are suggestive of difficulty and represent subclinical symptomatology. For the Sexual Concerns scale, T scores at or above 70 are considered clinically significant. The TSCC Underresponse and Hyperresponse scales detect extreme minimization or exaggeration of symptoms by a respondent. Based on these criteria, profiles were determined to be invalid for five respondents (three due to underresponse and two due to hyperresponse). These profiles were excluded from the analysis.

The results of the TSCC (Figures 9–10) suggest that anger, anxiety, dissociation (general, overt, and fantasy types), and sexual distress are the predominant areas needing intervention, with 25% of the youth scoring in the clinical range on these scales. Other problems noted included depression (13% rated at the clinical level), posttraumatic stress (clinically significant for 13%), and preoccupation with sexual concerns (19%). Although no single clinical syndrome characterizes the effects of maltreatment and child welfare involvement, overall findings from the clinical assessments (CBCL, YSR, and TSCC) indicate that several respondents are at a greater risk for a variety of problems, including disruptive behaviors and anger. Irritability, hostility or aggression may be evident among some youth, while others may internally reflect upon their resentment over previous maltreatment, abandonment or unfair experiences. Elevations on the dissociation scales suggest a tendency to emotionally detach and avoid negative affect. These responses may be part of a coping technique to reduce painful internal experience. Overall, the effect of problem areas assessed could have adverse consequences for long-term social adjustment, placement stability, and permanency options.
Figure 9
Clinical Assessment: TSCC

Figure 10
Clinical Assessment: TSCC Sexual
Behavioral Health Service Use

Interview responses were analyzed using qualitative techniques based on content analysis. The conceptual models for the research design were matched with emerging themes and triangulated with results from the clinical assessments. Responses were coded to match with preexisting categories derived from the research literature on behavioral health and children in the child welfare system. The congruity of responses was examined among the triad of informants to determine common issues across cases involving youth in foster care and to highlight specific strengths and barriers within the current system.

Service Activities

Nearly 40% of the caregivers indicated that linkage with the provider occurred through a professional referral while 6% received a referral from a friend or family member. The remainder of respondents reported that services were already in place prior to foster placement, and continuity of care was facilitated through collaboration with the foster caregiver, caseworker, and provider. Many of the current providers (38%) also indicated that they have linked the family to other service supports. Approximately 62% of the caregivers conferred that they were made aware of other beneficial programs within their community, and 57% were provided direct assistance by the provider in accessing these programs.

Among the youth interviewed, 82% reported meeting with a behavioral health service provider weekly. The majority of the youth (86%) were generally aware of the focus of the treatment, and 57% responded that they specifically discussed their needs regarding the goals of the treatment with their provider. Most of the caregivers (86%) and 95% of the youth described the services received from the primary behavioral health provider as talk therapy in which the youth focused on interpersonal problems and disruptive behaviors (Tables 2 and 3). Many youth (67%) also indicated engaging in other therapeutic activities (e.g., rehearsing behaviors; playing/making models/art projects; reading books together; role playing; practicing relaxation exercises; working on reading/writing skills). Providers described a broad range of therapeutic interventions, including mentoring and case management. Behavior management was considered a major focus of treatment by 43% of the providers, and 52% of the providers reported providing cognitive behavioral treatment.
Approximately 38% of the youth indicated that other significant people participate in their treatment sessions, including caregivers, siblings, and other family members. Additionally, 86% of the youth identified other individuals with whom they meet to assist them with problems and provide them support. These other “providers” included private therapists, little leagues coaches, school psychologists, teachers, social workers, school counselors, and group home staff. The caregivers and primary behavioral health providers also reported on the types of therapy received by the youth from all of the behavioral health service providers serving that particular child. Additional services not noted in Table 3 included psychological evaluations, attachment therapy, drop out prevention, and mentoring.

<table>
<thead>
<tr>
<th>Types of Therapy</th>
<th>Percent of Youth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Talk</td>
<td>95%</td>
</tr>
<tr>
<td>Play/Make Models</td>
<td>43%</td>
</tr>
<tr>
<td>Rehearse Behaviors</td>
<td>38%</td>
</tr>
<tr>
<td>Art</td>
<td>33%</td>
</tr>
<tr>
<td>Group Tx</td>
<td>33%</td>
</tr>
<tr>
<td>Relaxation</td>
<td>33%</td>
</tr>
<tr>
<td>Read Books</td>
<td>24%</td>
</tr>
<tr>
<td>Role Play</td>
<td>24%</td>
</tr>
<tr>
<td>Family Tx</td>
<td>14%</td>
</tr>
</tbody>
</table>

### Table 3
<table>
<thead>
<tr>
<th>Types of Therapy</th>
<th>Provided by Primary Behavioral Health Provider</th>
<th>Provided by All Behavioral Health Providers Serving the Youth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Talk or Individual Therapy</td>
<td>86%</td>
<td>76%</td>
</tr>
<tr>
<td>Play</td>
<td>29%</td>
<td>19%</td>
</tr>
<tr>
<td>Relaxation/Stress Management</td>
<td>19%</td>
<td>24%</td>
</tr>
<tr>
<td>Behavior Management</td>
<td>24%</td>
<td>43%</td>
</tr>
<tr>
<td>Substance Abuse Tx</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Sexual Abuse Tx</td>
<td>14%</td>
<td>24%</td>
</tr>
<tr>
<td>Medication Management</td>
<td>10%</td>
<td>5%</td>
</tr>
<tr>
<td>Family Tx</td>
<td>29%</td>
<td>38%</td>
</tr>
<tr>
<td>Group Tx</td>
<td>14%</td>
<td>24%</td>
</tr>
</tbody>
</table>
Service Plan Goals

As shown in Table 4, over half of the providers (67%) indicated that child protection issues were identified in the treatment referral for the child; however, only 28% of the treatment plans contained goals which were directly related to abuse or child welfare issues. Behavioral outcomes received primary focus in 48% of the treatment plans, and 24% of the plans contained goals addressing depression or coping skills. Only a few providers reported goals specific to permanency outcomes or issues associated with loss and separation.

<table>
<thead>
<tr>
<th>Focus of Goal</th>
<th>Percent of Treatment Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Outcomes</td>
<td>48%</td>
</tr>
<tr>
<td>Skill Development</td>
<td>38%</td>
</tr>
<tr>
<td>Abuse Issues</td>
<td>28%</td>
</tr>
<tr>
<td>Permanency Outcomes</td>
<td>14%</td>
</tr>
<tr>
<td>Pharmacological Intervention</td>
<td>5%</td>
</tr>
<tr>
<td>Loss</td>
<td>5%</td>
</tr>
</tbody>
</table>

Family Involvement

Other studies have found that foster parents are interested in being involved in efforts to meet the needs of children in their care. In order to gauge caregiver input and knowledge about treatment decisions for the youth, they were asked about the behavioral health service plan or treatment plan for the child. Approximately 71% reported that they were aware of a treatment plan and were involved in its development. They felt that their opinion had been sought regarding the types of services that were needed, and they had received an explanation of the plan. Nearly 62% of the caregivers indicated that they received a copy of the plan, and 81% noted that they received updates on the child’s progress as well as periodic explanations of the service goals and interventions provided. Among the caregivers, 76% reported that the provider made a special effort to learn about their values, attitudes and lifestyles, and half of the caregivers attended treatment sessions with the child. In the context of the treatment sessions, providers sought the family’s input to adapt services to conform to their belief system and fostered strategies to engage the family in a partnership on behalf of the child’s treatment.
The majority of behavioral health service providers reported that explanations regarding the treatment plan are provided to the child (81%) and the caregiver (86%). During this process 76% request the input of the youth and the caregiver before the plan is finalized. Many providers noted that they acquire the signature of the youth (86%) and caregiver (76%) on the completed plan to facilitate involvement of the family in treatment decisions.

### Convenience of Services

The majority of youth and caregiver respondents found that the location, time and frequency of services were convenient. Every caregiver had a contact phone number where the provider could be reached in case a crisis occurred, and the providers were easy to contact for 72% of the youth and 90% of the caregivers. The providers described visiting families at home, school, and work. Appointments were made around the family’s schedule, and caregivers were provided with the provider’s cell phone and pager number for after hours availability.

### Benefit of Services

The youth reported a range of feelings about the services that they receive from the provider, including positive emotions, embarrassment, anxiety, and anger. However, 76% expressed getting along very well with the provider, and the majority felt that the treatment was either somewhat (24%) or very helpful (67%). Similarly, 71% of the caregivers responded that they had seen a positive improvement in the child which they felt was a result of participation in treatment. Positive gains in family functioning were also noted by 57% of the respondents. The majority of caregivers (67%) responded that the services were very appropriate to the child’s needs, and an additional 29% described the interventions as somewhat appropriate. Several families noted that services which were less structured and activity-based were most beneficial to the child’s functioning. Additionally, continuity of staff was important for investing the youth in the therapeutic relationship and providing a safety net from the repetitive loss of significant people in the child’s life. Overall, 81% of the caregivers were very satisfied and 19% were somewhat satisfied with the quality of services received. Acquiring skills in anger management and learning to focus on strengths were especially critical to the success of many of the youth.
Funding

Funding for services primarily came from Medicaid (86%). Two cases involved creative efforts to sustain funding for service delivery, including using child protection program funds. However, these alternative resources were not considered viable as a long-term solution to meet the ongoing needs of the youth.

System Level Issues: The Provider Perspective

Children and caregivers were asked to identify the behavioral health provider most primary to their service provision. It was up to the individual informants to decide if the most primary provider was the one they saw the most often, the one they felt helped the child the most, or the provider they trusted the most. While respondents were allowed to identify their case managers as primary providers, the majority of caregivers identified a therapist or counselor that did not serve in a primary case management function.

As previously mentioned, the sample was drawn from Pinellas, Pasco, and Hillsborough Counties, all of which have been affected by the legislatively mandated privatization of child welfare services and a lead agency design. Community-Based Care (CBC) is a Department of Children and Families (DCF) initiative, designed to strengthen local communities’ support and commitment to children and families in state care (Paulson et al., 2002). CBC began with a pilot project in Sarasota County in 1997 and is expected to be fully implemented statewide over the next few years. DCF assigns local ownership and accountability for all children within a county to one lead agency. Pinellas and Pasco Counties’ lead agency is Family Continuity Programs, Inc. (FCP), and Hillsborough County’s lead agency is Hillsborough Kids, Inc. (HKI). Pinellas County began CBC implementation in 2000, Pasco County implemented their service centers in 2001, and Hillsborough County began implementation in 2002. These major systems changes should be kept in mind throughout the discussion of provider issues. Lead agencies have the option of either contracting out for all of the services children need, or both contracting out and retaining some service provision functions. Many of the providers interviewed work for provider network agencies that contract with the lead agency in their respective county. Others work directly for FCP as therapists. Providers in Hillsborough County either contracted directly with DCF or with HKI, depending on whether they had yet made the transition to CBC.
Providers were asked two types of questions: those that pertained to a specific child and those that related to their job and the greater child welfare system. Information that was child-specific was triangulated with responses from child and caregiver interviews and presented earlier in the results section. Additionally, information on the specific behavioral health issues of the participating youth are discussed in greater detail in the case study segment of the report. The following section summarizes non-child specific information gathered from providers. Examples of questions that providers were asked include: “List three things you do or strategies you use that from your perspective are the most beneficial for providing mental health services to children” and “Are there any specific barriers your agency faces in working with children and their families? Please describe them. How do you deal with these challenges?” Several themes emerged from provider responses: Professionalization of Staff, Family Engagement, Interagency Communication, Outcome Measurement, Discharge Criteria, and Funding.

**Professionalization of Staff: Education and Training**

Most providers were trained in social work or mental health counseling at the undergraduate and often the graduate level, resulting in many B.S.W., M.S.W., L.M.H.C., and L.C.S.W. degrees. Other related fields included Divinity, Educational Psychology, and Business Administration. Several providers specified certification in diverse areas such as sexology, child play therapy, and special education.

The majority of providers had been in their current position less than four years; however, many had attended trainings in the past two years. Training centered on child and family engagement, safety, specific therapeutic techniques, child welfare system issues, and trainings required by DCF and Medicaid. Several providers indicated that their individual agencies encouraged and financially supported their attendance at such events.

Several respondents highlighted the need for more qualified staff across all of the child-serving systems (i.e., DCF, DJJ, schools, mental health providers) to respond to the mental health needs of children. Some providers noted that their community is deficient in therapists who specialize in sex abuse therapy, resulting in long wait times for necessary services. Consequently, providers often indicated that they feel obliged to address sexual abuse if a child brings it up during
individual therapy; however, they often lack extensive training on specific interventions that might be very helpful to address this form of maltreatment.

**Caseload Size**

While the majority of providers (86%) interviewed had caseloads with no more than 20 children, two of the providers maintained caseloads of more than 41 children. It also should be noted that the lower caseload size among the majority of providers might be misleading, since several of the respondents worked part-time. Overall, providers reported that child welfare agencies are “overwhelmed” and felt that providers were not allowed enough time to spend with families due to heavy caseloads. Providers struggled with finding the time and resources to educate parents. One provider attempted to deal with this obstacle by “working overtime, letting non-crisis kids slide for a week, and finding resources to give parents to read.”

Large caseloads contribute to the frequent turnover of state workers. One provider mentioned that he knew of a child who had already gone through six case managers. Providers explained that it is difficult to get good information on a child with turnover rates as high as they currently are. In an effort to deal with this barrier, one provider indicated that he tries to do an extensive review of past charts, thoroughly updates new caseworkers as they come on, and mediates for both the child and the new caseworker. Another provider suggested hiring more caseworkers so that children could be seen on a more regular basis. There is also a concern that entry-level workers who are quickly promoted to supervisory roles need to be well trained in assessment and decision-making.

One provider hypothesized that caseload size may only be partially to blame for slow communications between families and caseworkers. She stated, “It remains somewhat a puzzle to me as to why DCF/FCP do not return phone calls. It is unclear whether it is because the caseloads are so high or whether it has become a culture of it being okay not to respond to calls.” This provider was very clear in her conclusion, however, that “The cases with the most progress [on behalf of the child] are the ones with the most frequent communication [by the workers].”

Another provider specifically addressed the unintended consequences of CBC implementation, stating that he had noticed that there has been an increase in worker stress as a result of the transition from DCF to HKI. He said that many workers are quitting, causing the remaining providers to
manage caseloads that have doubled. Providers are forced to meet unrealistic goals, which in turn leads to burnout and increased turnover. “Caseloads are humongous,” commented one provider. “We need the ability to do justice with the clients with whom we work.”

### Decrease in “Red Tape”

Providers explained that bureaucratic issues, legal considerations, standard procedures, and reporting requirements cause the system to move slowly, making it difficult to get things done to meet the needs of children and families. One provider estimated that two-thirds of his time was occupied with paperwork. Providers attempt to manage these systemic barriers by keeping organized, being consistent, getting to know the caseworkers, keeping in regular contact with caseworkers, trying to keep the focus on a team approach with caseworkers, and maintaining prompt communication. Despite these accommodations, policies and procedures sometimes delayed the service delivery process. For example, one provider stressed that she needed a more efficient way of getting psychotropic medication for the kids without the extensive and lengthy legal process involved. The provider explained that a judge in one case had sent the medical consent order to a parent who was incarcerated-for-life, and who refused to sign consent. Clearly, this example of “red tape” not only inconvenienced the provider, but also caused prolonged aggravation for the child.

### Family Engagement

The majority of families with whom providers work are mandated into the child welfare system. There is a standard level of opposition toward therapists, particularly at the onset of services. For example, one provider stated, “Sometimes the families themselves are the ‘barriers’ and will buck the system...particularly if they are court-ordered.” “Providers stressed the necessity of “develop[ing] as your main skill a way to break down resistance, and knowing how the child welfare system works and how to play the game.” Due to the fact that families are often forced into services, many are not yet ready to change. Before clinical activities can be introduced, the providers must take time to actively engage the families. Once families are engaged, maintaining momentum and motivation on the part of the caregivers is critical. Another provider reinforced, “Sometimes families are part of the problem...not the solution.” This provider shared that in situations where caregivers do not cooperate with a
child's therapy or treatment plan, there is a need to be “confrontational” and bring in assistance of other agencies (such as the abuse hot line, police, DCF, etc.).

Other comments related to engaging the family as a whole, particularly the significance of biological parents and the goal of reunification. “More attention is needed to have work done with birth families earlier on than exists currently,” stated one provider. It was suggested that a lot of reunifications could be successful if biological families were engaged immediately after the child’s removal. Providers explained that all too often a child will be in the care of the state for an extended period, and then the state will “go back to the family and see where the family is.” While services were focused on keeping the child safe, no one was helping the biological parents build on their strengths so that they could be reunited with their child. The provider concluded, “They [the birth families] have to have someone to help them.”

In addition to engaging families, there must also be tremendous effort on the part of the provider to engage each child. According to one provider, “often the child has a big attitude that is difficult to overcome.” Providers stressed that it was critical to establish a trusting relationship with the child. The providers valued openness and honesty. “I won’t lie to them,” stated a provider. Providers explained that in order for a child to begin to trust them, the child had to feel safe and validated. Providers try to learn what the youth wants to occur during and as a result of treatment. They then attempt to address priority issues of the child in the development of a treatment plan. Simply listening to the child and assuring them that his/her feelings and concerns are valid helped providers to develop a therapeutic alliance.

Once children are active in the therapeutic process, providers have to work to maintain their interest. Providers explained that Medicaid’s strict one hour billing was at times a drawback because children, particularly those with attention problems, have a hard time focusing for the full hour and want to do other things. Providers try to be creative in maintaining a child’s interest and make a point of varying therapeutic activities. Often this means an indirect and “noncontrolling” approach to therapy, which one provider referred to as “Gestalt techniques.” Many providers will work with parents and teachers to develop a very simple behavior management program that takes into account a child's cognitive limitations. One provider explained that she found adolescent males to be the most difficult to engage, the most likely to complain about
participating, and the most likely to drop out of therapy. Often clinical activities will need to be adapted to fit what an individual child is willing to do. An additional barrier to engagement was the mobility of children within the foster care system. Frequent placement changes for children make it difficult for the providers to maintain a therapeutic relationship or consistent communication.

Providers often found themselves in situations where the child and family had different points of view. Helping the child develop insight into the fact that he/she has problems and trying to assess and improve the relationships between child and caregiver were suggestions offered by providers. Many found it helpful to conduct joint therapy sessions with both parties, or some form of family therapy so that everyone could hear the other's feelings. One provider reflected, “Really, I think it's my style at being able to empathize ...in being able not to take sides...which helps level the playing field.” This provider found it helpful to incorporate a “reframing” strategy that aids individuals in seeing that each person is right to some degree. Once this understanding is reached, the provider helps families form common goals.

### Convenience and Accessibility of Services

Making services convenient is often a matter of location. Many providers make every effort to deliver services wherever their client feels most comfortable. Providers went to client's homes, schools, courtrooms, and/or places of employment. One provider stated, “Wherever the child and family is, that is where I go.” Another reiterated, “I go to wherever the major problem area is (e.g. school) to come to a solution.” Several providers interviewed worked on site at residential group homes, making a therapist available to children 24 hours a day, seven days a week. This ensures that services are convenient to children and easily accessible. Some providers found it helpful that they actually lived in close proximity to the children they served.

One provider explained that because there are very few Medicaid providers in the more rural area where she works, she frequently has to travel a long distance for available services for her families. She said that often families do not have adequate transportation to reach these services, and thus she must visit families in their homes and will meet with them before or after work, as needed. This provider gave one example where she had developed a special relationship with
a staff member at one of the schools and influenced the school staff member to accompany her to a family’s home to conduct the Individualized Education Plan (IEP) meeting (that is traditionally held on-site at the school) so that the family could be involved.

As previously alluded to, convenience of services is also a matter of timing. Families have busy lives, often struggling to meet basic needs. Children are also very involved with school and extracurricular activities. Providers find it necessary to maintain a very flexible work schedule in which they make themselves available for Saturday appointments if needed. One provider lamented that while she tried to work as many evenings and weekends as she could, she often “took flack” from coworkers for not being in the office during weekdays. Residential group home staff found it helpful to share calendars of each child’s activities and schedule therapy for after school accordingly. Many providers were adamant about seeing children after school hours so as not to interfere with achieving educational goals. In contrast, others welcomed the chance to visit children at school and attend multidisciplinary staffings. Another method of planning around the child was to attend other appointments a child may already have, such as medical visits. This is beneficial in that transportation is ensured and time spent transporting and waiting for services can be utilized to check on the child’s progress.

Consistency of appointment times was also mentioned as being helpful to engaging clients; however, one provider stressed that children often have special events that interfere with regularly scheduled therapy appointments. In these cases, the provider maintains an open policy of rescheduling whenever needed. Other helpful strategies included holding group sessions for adults in the evening and on a quarterly rather than monthly basis to increase attendance. Attempts were made to complete the intake within one week of referral, and to schedule the first therapy appointment within one month. “Standby” slots when no-shows occurred were offered to some clients. In addition, providers tried to avoid scheduling services during important family times, such as the dinner hour.

Providers, whether located on site or off, made sure to give clients a mobile phone and/or pager number. While having a contact number is the first step, providers stressed that it was crucial to make oneself available and able to return calls both quickly and during nontraditional office hours (evenings and weekends). Other providers tried to make it a
habit to schedule appointments for future meetings during the current therapy session so that the caregiver would not have to schedule at a later date via phone or voicemail.

#### Appropriateness of Interventions
Providers explained that sometimes the most appropriate service initially is to make sure a child's basic needs are being met. One provider stated, “I operate using Maslow’s hierarchy of needs; their shoes need to fit and they need to feel safe before [we] can address other higher level needs in therapy.” Next, providers found it helpful to provide a non-threatening, non-intrusive approach, working at the child’s pace because many children are not ready to address their specific abuse issues. One provider stressed a non-directive approach stating, “I express empathy and unconditional positive regard — sort of Rogerian.”

Many providers gave specific examples of children who did not benefit from traditional talk therapy. According to providers, younger children with ADHD and/or ODD respond much better to cognitive behavioral interventions in which they rehearse positive behavior. Solution focused treatment, incorporation of workbooks and physical activities, and a strength-based approach were also cited as helpful. One provider reiterated, “Most are young teens who don’t want to sit and talk for an hour, so I use worksheets and activities or go and do something; [I do] cognitive behavioral in the context of activity [and I] let kids tell me what they want to work on.” Other providers emphasized the extent to which most children they deal with have been physically, sexually and/or emotionally abused. One provider declared that approximately 95% of the children she worked with met the criteria for the diagnosis of PTSD. For this reason, she emphasized the need for trauma-focused interventions and play therapy for younger children who have been abused.

#### Empowerment and Informal Supports
Providers were aware of the need to create sustainable differences in clients’ lives. Several mentioned the need to prepare families and children for success beyond the child welfare system. Empowerment and teaching were often referenced as crucial techniques. One provider defined empowering kids as “teaching them to take responsibility for their actions; letting them know they are in control of what happens to them from now on.” Other providers found it helpful
to not only ask a child what they think they need, but also to involve them in all decisions related to their treatment. According to providers, kids responded best when the provider focused on the child's strengths and downplayed any weaknesses.

Teaching about specific disorders was a common suggestion. One provider gave the example, “I talk with children about ‘What is schizophrenia?’...and show them books about medications” to increase their understanding of these complex issues. Another provider found it helpful to always provide a rationale for positive behavior, stating, “I teach useful skills (e.g., anger management, coping, attachment), and I explain WHY certain behaviors are important.” Finally, providers find it necessary to educate families on aspects of the child welfare system so that they can better advocate for themselves. One provider stated, “I try to explain and demystify the system; it’s important for foster parents to understand such things as the court system and Medicaid.”

Providers expressed concern that children who have been in foster care for an extended period of time have a sense of learned helplessness in that many have not been connected with informal supports beyond the child welfare system. One provider confided, “Kids get labeled through the system, and they get lost in the cracks; they get moved too much, and they become institutionalized. They have no personal survival skills. Agency liability makes agency behavior too restrictive. Kids don’t know how to ask for help - they will call the police on themselves if they’ve left the grounds and aren’t sure what to do; These kids know how to play the system - that’s the only thing they know; These kids have no connections with anyone outside the system (agency).” Linking to community services such as summer camps and after school care was suggested. Many providers work to establish such connections for children, in addition to helping build on individual, family, and community resources, which may have already existed in a child’s life, as long as safety is ensured. One provider stressed, “they need connections...for the rest of their lives once they leave us.”

### Interagency Communication

#### A. Advantages of Communication

Providers perhaps had the most to say about communication or the lack thereof between colleagues, provider agencies, and different systems (i.e., child welfare vs. education vs.
The majority of providers agreed that interagency communication and collaboration directly benefit both the children and families to whom they provide services. Providers mentioned the need to share information, within limits of confidentiality, with each other to ensure appropriateness of services and nonduplicative services. For example, providers coordinated wraparound or home services with previous therapists; they shared client history information in order to understand current needs and past progress; they collaborated with DCF regarding case history and failed placements; they acquired previous school placement information; they communicated with DJJ for history with law enforcement, and they worked closely with physicians to ensure appropriate dosage of psychotropic medications. One provider stressed, “I make a lot of phone calls.”

Multidisciplinary treatment planning meetings were mentioned by several providers. These meetings are beneficial because they bring everyone who plays a different role in the child’s life to one table where issues and barriers can be discussed in a group format. Providers differentiated two types of team review meetings. The first was a more “in-house” meeting in which providers and case managers discussed ongoing clinical issues and progress related to a specific case. The second type of meeting was known as “ADM Meetings” in which “all the players” come together and focus on “big picture” issues such as length of stay. Participants in the ADM meetings include providers, representatives from Medicaid and the Health Department, DCF and lead agency staff, and foster parents. While children do not typically attend such meetings, they are represented on occasion. Quarterly reports on client progress and attendance are an additional form of communication between providers and their referring agency (DCF or CBC lead agency).

One provider acknowledged the fact that she did not always get invited to the group meeting she wanted to attend. This provider explained that an assertive approach of inviting oneself to team meetings was often necessary. For example, the provider recently attended a seminar put on for DCF workers about Master Trust Funds. She invited herself to attend this seminar because a child she provided services to has a trust fund, and she wanted to be better educated about constraints, etc. Another side benefit of attendance at these types of trainings is the networking that is accomplished.
CBC system theory emphasizes the need for interagency communication. One provider commented, “In the last two years when the system has been going to a community-based approach, it appears that agencies have become more collaborative.” This provider gave the example that before they place a child in an adoptive situation, there is a “Match Committee” that meets to determine appropriateness of fit between child and potential caregivers. Providers also noted increased inclusion of GALS (Guardian Ad Litems) at treatment plan meetings. “We’ve done a good job linking our kids up to outside agencies’ activities,” declared one provider. Others are maintaining a “wait and see” attitude towards the privatization of child welfare. Providers wondered how partnerships both between agencies and between agencies and families will look once CBC is fully implemented. One provider was anxious about how effective the point of entry will be for children. Another provider stressed that families needed to be kept up to speed about interagency changes, stating, “I’ve been a part of the privatization implementation since it started [and] communicate that to the families.”

B. Barriers to Communication

While providers shared several positive examples of interagency communication, many areas of frustration emerged. The most commonly cited problem was a lack of involvement and slow response time on the part of DCF and CBC lead agencies. Although most children are assigned a separate case manager, many providers found themselves performing case management activities rather than clinical interventions. This was very problematic for providers who had spent considerable time in school and training for a clinical career. As one provider stated, “[I] just have to do the liaison work necessary and [the] case management work needed — which is a lot of work.”

One provider gave an example of times where there is a critical placement issue for a foster child, and she cannot get the foster care worker assigned to return phone calls. This provider explained that while she makes every effort to schedule meetings at times convenient for caseworkers, the caseworkers often disregard mutually agreed upon appointment times. Providers cited several occasions that required them to consult supervisors of caseworkers and advocate on the behalf of children. In one provider’s words, “I just don’t play. I always remain positive, [but am] clear about the child’s needs.”
Another provider gave the example of being “handicapped” at ADM update meetings when FCP was not represented. A decision had been made for FCP to focus and follow-up on specific identified permanency issues. Follow-up meetings were held only to find out that no one from FCP had completed the agreed upon task. This provider mentioned that there was one case where the same issue had surfaced without resolution for as long as two years. Providers cited caseworker inexperience and high caseloads as potential reasons for their lack of involvement. However, this lack of involvement becomes detrimental to children if decisions about placement are not made with all of the information that could be available to a planning team.

Providers also described a frequent mismatch between goals set by DCF for the child and family and the treatment objectives set by the provider agency. It was not uncommon for agencies to get very short notice that a child they are working with is being returned home. This does not allow provider agencies enough time for an adequate termination process with the child with whom they have built a relationship. In addition, providers complained that DCF will often send them children with very little background information. Ideally, providers would like the opportunity to consult family members and review medical records. This gap was reported to disrupt a provider agency’s ability to develop appropriate interventions.

Providers also reported a particular sensitivity to relations with child protection investigators. One provider stated, “They claim we waste their time. They need more help to investigate reports. They need to be educated as to our mandate to report. We cannot make a determination, we only report.” This provider suggested that Protective Service Investigators needed to make better use of personnel in outside agencies to assist them with information.

**Measures of Clinical Progress and Client Satisfaction**

Providers were asked several questions regarding how their respective agencies measured client progress and satisfaction. There was a noticeable lack of knowledge surrounding outcome measurement. This may in part be due to the fact that over half (52.9%) of providers were not given any formal feedback from their agency related to the children they worked with, beyond what they shared anecdotally with colleagues at
team meetings. One provider acknowledged, “This is a weak area for us; measuring clinical goals is fairly subjective.” Other providers expressed a disregard for outcome measures, stating, “They [name of agency] generate a lot of reports...although I don’t really pay much attention to them. I see them [the children] all the time, so I know what is happening with them.” Another provider supported this informal outcome measurement by stating, “we [just] check in with the family at each meeting.”

The majority of providers were aware of some type of satisfaction survey distributed to clients. Many clients fill out evaluations after services end. Some statistics are kept, which provide an analysis over a five-year period on topics such as reoccurrence of abuse. Some agencies randomly call clients to follow-up, and solicit feedback on unidentified cases. The agency compiles the positive and negative feedback, and there is a general internal summary of these surveys provided to staff. One provider explained that these surveys are not formatted in an “individualized” manner, and without more program specific feedback staff are unable to tell whether it is one of the rural or urban child programs that is being addressed. In addition, one provider noted that it had been his/her experience that individuals who had had negative experiences more characteristically completed these surveys.

Several providers were able to describe very specific measures for clinical progress and client satisfaction. Satisfaction surveys where clients grade providers confidentially are done after 30 days and then six months later. There is a grievance mechanism in place at some agencies to bring information to the attention of supervisors and administration. “Monitor calls” are made to caregivers regarding the child’s progress. The monitor will assign a point value based on answers and measured against treatment goals. Other providers utilized a “status profile” checklist upon intake, admitting, and discharge.

Some agencies have a series of more formal reviews with treatment plans and goal attainment being reviewed every three to six months or as needed. Discharges are reviewed annually at some agencies and percentage of goals met is calculated. One provider gave an example of the incorporation of child focus groups, stating, “We make changes in accordance to kids’ needs and wishes. They have focus groups. For example, the kids complained that the cafeteria workers weren’t wearing hairnets or gloves. This was addressed [immediately]. They definitely have a voice.”
Outcome measurement would not be advantageous to service provision reform were it not for dissemination efforts. One provider mentioned a Continual Quality Improvement (CQI) initiative, taking some specific indicators and measuring them over time. Another provider described a bi-monthly task force that studied and created strategies for client services. One agency’s division director reported back to providers six times a year. Other efforts at dissemination included staff meetings, group (team) supervision, individual supervision, and an outpatient division meeting. Providers stressed that it was critical that they receive as much client-specific feedback as possible.

Discharge Criteria: Knowing When to End Services

“We start the discharge process as soon as the client is admitted,” one provider stated. This is done by establishing realistic steps for the client to achieve treatment plan goals and measurable objectives. Discharge often depends on how well the goals are achieved. Some clinical judgment is also involved in that providers try not to discharge children who still have significant unmet needs. In addition, a child must continue to meet the criteria for remaining in the treatment program. One provider added that the family often contributes to the discharge decision. If goals have been met for at least six months, the family is stable, and the family feels they can “do it on their own,” discharge may occur. Other discharge criteria included adequate functioning across all environments, lack of hospitalization, 30 to 60 days without physical restraints, resolution of symptoms for an individualized period of time, linkage to community supports, adequate safety planning, demonstration of an ability to apply skills in “real life”, and consumer satisfaction. Ideally providers liked to make the discharge decision when the child had worked through his/her issues, was no longer acting out, everything at school was stable, and established relationships with family and friends were in place.

“Permanence is the ultimate goal [for discharge],” explained another provider. Agencies also base discharge on availability of an appropriate foster or adoptive home. “If we don’t have a family for them to go to, then discharge becomes more challenging,” explained one provider. “Even though a typical stay is no longer than 12 months, there are a limited number of people coming forward [as possible placements].” Providers also mentioned that children are monitored post discharge: “They overcome some problems and may be
therapeutically ready, but we follow them, and they can still come back if there is a need for treatment free of charge after their adoption.” Another reiterated, “We stay with the child as long as they are in foster care. They know how to return, and why.”

Unfortunately, many children are discharged who have not met their treatment goals and/or found a permanent home. Providers explained that the type of funding for a case might also have some influence on discharge decisions. With Title XXI, non-Medicaid cases, providers only “have a year’s contract.” For this reason, “less services” may be offered to the child than in foster care cases and cases funded through ADM. One provider explained that the foster care and ADM cases are theoretically on a two-year contract, but are frequently renewed. Loss of Medicaid funding was cited by some providers as being influential in a discharge decision. Additional reasons for discharge include a child moving out of the service area, a child reaching the age of 18 years, lack of family cooperation with a child’s treatment, and a child running away. One provider confided, “rarely are [they actually] reunified.”

### Funding

Many of the problem areas discussed in this section could benefit from either an increase in funding or a reallocation of funds. The majority of providers interviewed were emphatic that DCF, CBC lead agencies, and all of the provider network agencies were understaffed and under-funded in many areas. Specifically, providers reported a need for more investment in identifying placement options, supporting foster parents, providing individualized therapies, and providing transportation.

#### A. Placements

Since this study focused on adolescents whose parents had had their rights terminated, many of the children fell into a specific subpopulation of foster care children who have been in the system for several years without being adopted. Many of these children reach adulthood before a placement is found. One provider warned that there were simply not enough residential programs for severe kids and that as a result, “kids can fall through the cracks.” Providers struggled with the reality that many children they work with do finish treatment, but there is simply nowhere for them to go. Providers are faced with trying to develop creative strategies to motivate people in the community to take children into their homes. One
residential group home has assigned a staff member the primary responsibility of community outreach and “home finding.” Another provider is advocating for increased use of minorities in the recruitment efforts, believing that it is possible that more people would respond to someone representing their own race or ethnicity.

In addition, once foster parents are found, they must be adequately supported. Providers wanted more funding for counseling and for foster parents to use so that they could provide additional options for youth (e.g., scouting and its associated expenses). Providers suggested mandatory respite for foster parents because they tend to get overwhelmed and deny their own needs. Providers also wanted to ensure that foster parents receive mandatory training every six months on the needs of their children.

B. Services and Supports
Many funding suggestions related to hiring more social workers and Guardian Ad Litems so that caseload sizes could remain small and case managers and therapists were less likely to quit. Another common suggestion was increasing providers’ salary in order to provide a financial incentive to match the strain of their workload. Other respondents indicated that more resources should be put into child protective investigations and staff training. “Good training is expensive,” commented one provider. This provider tried to use her membership in professional organizations to get free training for her agency. She also mentioned that it was helpful when agencies collaborated on training events and shared in the costs. Yet another request for resources had to do with the expansion of play therapy facilities. Often providers take children off-site because the current facilities do not allow for much privacy.

Providers were concerned about a lack of resources for specific interventions. For example, a provider had recently started to work with a child diagnosed with Reactive Attachment Disorder. The provider was told that there were limited resources to deal with this type of issue and that there was a question of how to fund the necessary interventions. In general, providers were concerned that DCF and FCP may stop covering behavioral health services before a child is ready. In this case, it is up to the provider to write letters requesting continuation of funding. One provider acknowledged, “Advocating for a child yields rare success.” Some providers turn to foster and adoptive parents for funding
in order to maintain the therapeutic relationship. Another provider mentioned a rash of new cutbacks and the necessity of keeping up-to-date on what paperwork needs to be submitted to various funding streams. Another provider suggested that better assessments of children when they first enter the system might lead to more appropriate services and better use of existing resources.

C. Transportation

Even if funding for services is in place, there is still the more basic need of making sure children and families can get to services. Many families live in more rural areas, making it a much longer trip to reach the provider and agency. Providers reported that as a result, many needs go unmet or are not adequately attended to, such as medical care. Another problem cited was that some facilities and group homes are not located on bus routes so that cheaper methods of transportation were ruled out.
The following six cases highlight behavioral health and child welfare issues identified in the study.

**Case Study I: Brian**

Brian is a 15-year-old Caucasian male in the 9th grade. Brian likes to fish, is somewhat involved in a church group, and would someday like to be a mechanic. Brian has no close friends but believes he could be a good friend to someone. Brian's overall school performance is below average, according to both Brian and his caregiver. The caregiver interviewed is Brian's foster father. The foster father works with Brian on anger management, engagement in household responsibilities such as lawn care and making his bed, and reported that Brian has a good sense of humor. Brian meets with his provider in the foster home weekly to work on his problems with anger (per Brian). According to Brian, “I just get angry when people yell at me or when they tell me to do things I don’t want to do.”

**Brian: Clinical Assessment**

Brian's YSR score was in the clinical range for Total Competence and Social; however, Brian's Total Problems, Internalizing, and Externalizing scores were all in the normal range for boys aged 11 to 18. Brian's CBCL scores were in the borderline clinical range for Activities/School, Social Problems, and Total Problems. This indicates that Brian's foster father reported more problems than are typically reported by parents of boys aged 12 to 18, particularly problems in social relationships. Brian's TSCC score was in the clinical range for the Sexual Distress subscale (SC-D). For example, Brian reported often yelling, arguing, “wanting to say dirty words,” “wishing bad things had never happened,” and “getting upset when people talk about sex.” Clearly, Brian's problems with anger and social situations correlate with his lack of peer engagement; however, Brian seemed aware of his problems (cross-informant agreement was above average) and concurrently expressed positive self-worth in that he believes he has the potential to be a friend.
Case Study I:

Brian

Brian: Services

Brian receives Medicaid-funded individual therapy/behavior management, medication management, and is currently placed in a therapeutic foster home. Brian has been working with a counselor for six months who provides intensive in-home counseling and behavior management to children with SED. There is much uncertainty surrounding Brian's prior treatment. Brian wonders how his former therapist is doing, and the new provider does not know why Brian was initially referred to the program or what precipitated his involvement in the child welfare system. A clear disconnect in terms of critical information that might help Brian is present and perhaps intensified by staff turnover.

Brian reported that he gets along with the provider somewhat well, and while he's easy to get a hold of and easy to understand, the provider does not help Brian at all. According to Brian, “I'm still having anger; I'm always going to, it's a part of me.” However, Brian later revealed, “I want my behavior to be perfect...I wish I didn't get mad.” Brian expressed anxiety around his perception that the provider has not helped him in the past and does not have the ability to help him. This stress may be instrumental in exacerbating Brian's tendency for self-abusive behavior. The provider does, however, engage both foster parents in the talk therapy/behavior management sessions.

Brian's foster father indicated that while the provider provides convenient and accessible services and is skilled at providing Brian with positive reinforcements, the most helpful service Brian has received is therapeutic foster care. However, the foster father noted, “Once a child starts making improvements they get stepped down from therapeutic foster care and have to be moved. Kids get bounced around, ‘punished’ for improving. They get moved out of therapeutic foster care, don’t do well and continue to be moved to other homes. They're looking to move Brian now, and he’s probably not going to do well in regular foster care, especially with too many other children. This happened before with a child we had and he is doing badly now.” The provider agreed that the most beneficial aspect of services for Brian was living with one family for an extended period of time in a therapeutic foster home. According to the provider, “He has been bounced a lot due to his behavior.”
**Brian: Unmet Needs**

The provider indicated challenges faced with Brian include: “no specific permanency plan, and [the fact that] funding for treatment services ended with the step-down so [foster care agency] is covering the charges on a month-to-month basis, which cannot be continued.” Due to the uncertainty over funding, the provider expressed that the ultimate frustration is that “We can’t get clear information on whether he will be able to stay [in current placement], which is what he would like.” In addition, when the foster father was asked if he had been made aware of additional programs within the local community from which Brian might benefit, he responded, “they are trying to cut back on services since Brian has been stepped down.” This reflects a major deficit in service provision. At a time when continuity of funding for Brian’s most beneficial formal support is tenuous, linkages to informal community supports such as local YMCAs, sports teams, and faith-based organizations is critical, particularly with a child who lacks friends and is trying to improve his social skills.

**Brian: Conclusion**

Aspects that are working in Brian’s case include establishing positive expectations for the child and maintaining a strength-based orientation. It should be noted that it is quite possible that medication management is critical in order for Brian to control his outbursts and relate positively to others; however, this service was not highlighted by those interviewed. Providing multimodal therapeutic interventions seems to be beneficial to Brian. Aspects of Brian’s case that need improvement include stability and consistency within the foster family system; planned, coordinated transition services for children; and linkages to informal, local supports and community resources.
Case Study II: Katie

Katie and the Exemplary Service Provider

Katie is a 13-year-old Caucasian female in the 7th grade. Katie is a very social teenager with many friends. She enjoys talking on the phone, watching television, and shopping. Katie’s biological mother has a substance abuse problem that resulted in her parental rights being terminated when Katie was nine. Katie has been in foster care since this time, both in a residential setting and relative placement. Katie has a biological younger sister who she does not live with, but misses very much. The caregiver interviewed was Katie’s grandmother who currently has custody and is applying to be a licensed foster parent. Katie’s grandmother explains that Katie is still mad at her mother and acts out frequently in an attempt to control situations. Katie indicated that she meets with her behavioral health provider “because everybody thinks I have problems.” Everyone interviewed identified an egregious generation gap between the grandmother and granddaughter.

Katie: Clinical Assessment

Katie’s YSR produced an Externalizing score in the subclinical range. Katie’s profile of problems on the YSR was significantly similar to the Delinquent profile type. For example, Katie reports swearing often, sometimes “not feeling guilty when I’ve done something wrong,” and sometimes “liking to hang out with older kids” and/or kids who often get into trouble. CBCL scores were all in the normal range. The cross-informant agreement was average. Both Katie and her grandmother reported that Katie was failing several subjects in school and that this was not due to her incomprehension of the material, but rather her dislike of doing schoolwork. Katie’s TSCC was in the clinical range for the Sexual Preoccupation subscale (SC-P). However, Katie fell into this clinical range because of often “wanting to say dirty words,” and given the otherwise normal scores could have more to do with her acting out behavior than specific sexual concerns.
Katie: Services
The provider is a family support specialist at a foster care agency. The primary goal of services is to help families stabilize upon reunification and to work for placement permanency. The behavioral health provider is in the home weekly with a service plan goal of long-term foster placement. Katie’s grandmother remarked that the provider “helps with conflicts, takes Katie shopping, out to eat, helps with meeting doctor appointments, and is helpful in mediating communications [between grandmother and Katie].”

While it is suggested that this case be viewed as a “success” fostered by an involved and motivated provider, Katie is still struggling with trusting her provider. Katie enjoys activities such as going to the mall with her provider; however, she is hesitant to divulge personal information because “I don’t know if she really cares about me because it’s her job. With friends you can share personal stuff and they can share with you. [Provider] doesn’t share any personal stuff.” The provider acknowledges Katie’s “incredible resistance to talking about her feelings.” Despite this challenge, which is common to most child welfare cases, Katie’s grandmother reported, “Katie’s attitude about counseling has improved. Katie is happier now - people such as her teachers say her attitude is greatly improved. Defiance has decreased. Katie’s more polite and better behaved in school.”

Katie: Family Involvement
According to Katie’s grandmother, “The system just dropped Katie off. She didn’t [even] have a chance to say good-bye to her friends. I had no backup from the system, such as how to get Medicaid or services. [The provider] stepped in to help get things done that the system was unresponsive to.” In addition, the provider described Katie’s situation in the following words: “Katie feels like she needs to be really grown up; grandmother is not aware of the impact of her own behavior & attitudes on Katie’s behavior [grandmother’s ambivalence toward child].” Due to this problem, the provider has attempted to link Katie with other community programs and children her age, such as a summer wilderness camp. This works to supplement the inevitable gap Katie currently feels with her grandmother, whom the provider is monitoring for lack of overall involvement with Katie.
It is important to point out that a frequent criticism of the child welfare system is that staff, due to low pay, long hours, and high turnover rates, are often too young and inexperienced to handle matters of child safety and permanency. In this particular case, while the family specialist is young and new to the agency, she capitalizes on her age to relate better with Katie and brings a fresh approach to the therapeutic relationship that both the grandmother and Katie appreciate. The provider reported that in an attempt to engage families, she will, “go to them and whatever I need to do to develop a relationship with them — I approach the process from [asking the child] ‘what are you interested in?’” According to the provider, “I let Katie subtly know that I wasn’t trying to force her into traditional therapy because she was very against it.” The grandmother remarked that the most helpful out of all the services has been receiving “talk therapy in the context of activities instead of a structured treatment hour; less formal is better.”

**Katie: Conclusion**

Aspects of Katie’s case that seem to help include linking families with appropriate services and coordination of treatment goals with permanency planning. Improvements could be made in planned, coordinated transition services for children so that funding mechanisms and caregiver supports are in place before the child is moved, in addition to allowing the child some time for preliminary closure on their prior living arrangement and friendships. While excellent communication occurred between the provider and family in this case, effective communication between families and the larger system is still required. Supporting young providers with trainings on innovative therapeutic techniques/strategies, in addition to encouraging them to use their youthful attitude to their advantage in developing a trusting relationship with children is recommended. As Katie’s grandmother emphasized, the system could stand to benefit from many more providers like this, whom kids respond to and interact with during more informal meetings.
Carlos and Self-Preservation Among Failed Adoptions

Carlos is a 16-year-old Hispanic male in the 10th grade. Carlos is a good athlete and enjoys playing football. His school performance is average, and he is involved in the Boys and Girls Club, ROTC, and a career prep course at school. Carlos came into the child welfare system as the result of child protection issues, with a possibility of sexual abuse. Carlos was placed in a foster home with his biological brother; however, he misses his biological sister who was adopted and stayed with the family where the adoptions failed for the two brothers. The caregiver interviewed is Carlos's foster father, and the provider interviewed sees Carlos weekly for talk therapy/behavior management. It was reported that Carlos has been bounced around a lot from placement to placement and has experienced many failed adoptions due to his behavior problems. Carlos reported that he feels counseling is “to let out all the stuff I’ve done in the past — so it isn’t bottled up.” Carlos also asserts that services have helped him realize, “I can be good and can do anything I put my mind to.”

Carlos: Clinical Assessment

The YSR score for Total Competence was in the clinical range, but scores for Activities and Social were normal. Carlos has at least one close friend and sees him on a regular basis. Total Problems and Externalizing fell into the subclinical range and were most significantly similar to the Social Problems profile. The CBCL Total Problems and Externalizing fell into the subclinical range for boys aged 11 to 18, but Internalizing and all other syndrome scales were normal. Informant agreement between Carlos and his foster father was average. Scores on the TSCC were normal with the exception of a subclinical score on Dissociation and a clinical score on Dissociation — Fantasy. Carlos reported frequently “pretending I’m somewhere else” and “going away in my mind and trying not to think.” This dissociation correlates with provider reports that Carlos has put up a hard shell and won’t let anyone get close to him because he has been forced to change placements so often. The disassociation may also be indicative of the sexual abuse that the provider has only recently “started to address.”
Carlos: Services

Carlos receives Medicaid-funded talk therapy from a male provider on a weekly basis. The provider tries to incorporate some behavior management and cognitive behavioral techniques, while engaging Carlos on an informal basis. The provider plays ball at the park with all of the kids in the foster home and then talks to Carlos and his younger brother off to the side. The provider also serves as a positive role model and mentor for Carlos. Mentors are often scarce for adolescent boys of minority status, thus the provider is filling a much-needed gap. Informal family therapy occurs to the extent that the provider includes the foster parents in talk therapy sessions. Carlos’ foster father reported, “we tell him things that need to be addressed and the provider addresses it with Carlos.” While the potential for permanent placement is bleak for Carlos, he reports that the services he receives help him a lot. According to Carlos, he feels he has improved “my attitude — learning to control it; being more positive; I don’t care what others think about me.”

Carlos: Unmet Needs

Carlos has been moved too many times to facilitate healthy attachment and any development of trust. According to the provider, “Carlos is very closed emotionally. [He has been] rejected so many times he has a shell around him. The boys believe they will [be] hurt if they open up. Carlos has almost given up on a permanent family. He is pretty much just in a self preservation mode.” Carlos is also aware of multiple courtroom battles for custody of himself and his brother. The biological mother had at one time filed for custody, and the caregiver in the home in which Carlos was previously placed is also in the process of trying to regain custody. Carlos’ current foster family’s friendship with the previous foster family further intensifies Carlos’ refusal to get close to anyone. These long and drawn out court proceedings have proved detrimental to Carlos’ emotional stability. While the provider theoretically tries to engage Carlos in identifying the kind of home he wants, the provider struggles to maintain a balance between all of the competing parties and “what is probably going to happen” despite anyone’s expressed desires. The provider acknowledged that the placement instability exacerbates Carlos’ behavior problems and openly stated, “the fact that we did not resolve that has created a problem.”
Carlos’ foster father stated, “Carlos’ needs are not being met. There were two failed adoptions, and another family wanted to adopt but the children were removed — Carlos has issues related to that. The provider is good with the kids, but there are [more important] things that need to be addressed.” While the child welfare system may have kept Carlos safe, they have provided neither a stable nor permanent placement for Carlos to thrive. In addition, both the foster father and the provider acknowledged the problem of staff turnover stating, “This only hurts the kids more.” The provider stated, “The biggest thing that hurts us is staff turnover, there are not enough benefits to our jobs to retain workers.”

**Carlos: Conclusions**

Carlos is fortunate in the sense that he seems to have a high level of resiliency and the provider works to positively reinforce these qualities. The provider is well matched to Carlos in terms of gender and willingness to conduct therapy sessions during ball games. However, Carlos seems to have gone from an unsafe but permanent and intact biological family to being safe but separated from loved ones and in a series of unstable living environments.
Greg and the Benefits of Informal Supports

Greg is a 14-year-old African-American male in the 8th grade. Greg is involved in a Little League football team in addition to enjoying basketball and drawing. Greg is very social and maintains several close friendships with peers. Greg’s foster mother, interviewed for this case study, engages Greg in several household responsibilities such as laundry and dishwashing. Greg was originally referred for services by the school system because his behavior was found to be overly disruptive. Greg received a DSM-IV diagnosis of Oppositional Defiant Disorder (ODD). Greg was also classified as Emotionally Handicapped (EH) and receives special services at school. Both Greg and his foster mother rated his overall academic standing as slightly below average. Greg reported that he receives behavioral health services to deal with his “bad behavior; [when I’m] mad and unhappy.”

Greg: Clinical Assessment

Although informant agreement was calculated to be average, Greg did report fewer problems through the YSR than Greg’s foster mother reported as part of the CBCL. For example, Greg’s YSR Total Competence score and Total Problems score were both in the normal range for boys age 11 to 18 years, and all syndrome scales were in the normal range. Greg’s score on the CBCL Total Competence was normal, as well as the Activities and Social scales; however, his CBCL School scale score was in the borderline clinical range. This correlates with the foster mother’s accounts of Greg having continual problems in school since the age of seven years. In addition, on the CBCL problem scales, Greg’s Total Problems and Externalizing scores were both in the clinical range, and his Internalizing score was in the subclinical range. Specifically, his scores on Withdrawn, Somatic Complaints, Anxious/Depressed, Social Problems, Delinquent Behavior, and Aggressive Behavior domains were all normal, while his score on the Thought Problems and Attention Problems were borderline clinical. The emphasis on thought problems is often found in children with ODD. Examples of specific problems that Greg’s foster mother reported include impulsivity, fighting, hanging out with children who get into trouble, temper tantrums, teasing others, and disobedience at school.
scores were all normal with the exception of the Anger subscale in the clinical range. Greg fell into the clinical range because he expressed often having trouble with “getting mad and calming down,” arguing, fighting, and “wanting to yell and break things.”

**Greg: Services**

Greg received Medicaid-funded talk therapy both in home and at school that incorporated aspects of play therapy, stress management and relaxation therapy, anger management, cognitive behavior strategies, and family therapy. Greg got along well with his provider and felt that she helped him a lot. Specifically, Greg reported that the best part of services was “having someone to talk to” about events that have happened and planning for the future. Greg reported feeling better about himself as a result of services and learned that “to succeed in life you have to be good.” Greg’s foster mom stressed the provider’s role in providing Greg with positive reinforcement: “She said little things that had big effects to make him feel better about himself.” According to the provider, “I learned that Greg and his foster family value honesty, respect, and achievement” and that it was important to build on these strengths. In addition, the provider felt that the most helpful aspect of her services was to “tell Greg that teachers cared for him and to instill a sense of self value.” The provider also worked as a mediator between the case manager and the foster mother when medication was suggested as a way to control Greg’s outbursts. The foster mother felt that Greg should not be on medication, and the provider supported her decision by offering additional information to Greg’s foster family regarding behavior modification and the stages of developmental recovery from trauma.

Initially Greg saw the provider once a week; however, Greg has been phased off of these formal supports. At the time of interview, Greg had not seen the provider in six months. Both Greg and his foster mom wanted the provider’s involvement in Greg’s life to continue. Greg’s foster mother commented, “If I had my way, he would still be seeing the provider once a month. She would still be involved. She could help motivate him at school. She served as valuable support for me. So, yes, they listened some on a day to day basis, but cut us off from services before I was ready.”
Greg: Informal Supports

Somewhat fortuitously, the provider’s supervisor began coaching the Little League team on which Greg played. Greg reflected on this transition from formal to informal supports by stating, “She was good, but after she quit coming, my coach at Little League [provider’s supervisor] helped me a lot with my attitude and working toward goals.” The coach served as a mentor to Greg, and for the first time in three years, Greg was not kicked out of Little League due to behavior problems. This informal support was critical in maintaining Greg’s engagement in positive activities during the time his formal supports were withdrawn. However, it should be noted that follow-up may need to be provided when informal supports are put into place. For example, the foster mother had no knowledge until the time of this interview that Greg’s coach had clinical training and was a strong influence in Greg’s life. In addition, this sports team only met in the fall, leaving Greg without informal support or mentoring for the rest of the year.

Greg: Conclusions

Aspects that worked in Greg’s case were the strength-based approach to service provision, the provider’s support of the family’s decision not to medicate Greg, and the informal support who was a “perfect match” for Greg in that he had significant clinical experience, could serve as a male role model, and shared a common interest (sports) with Greg. Aspects of this case that could be improved include communication between the child welfare system and foster families and follow-up after intensive services have ended in order to make sure the necessary supports are in place.
Ramona and the Residential Group Home

Ramona is a 15-year-old multiracial and multiethnic female in the 9th grade. Ramona likes to wrestle, do artwork, is somewhat involved in a church group, and volunteers at an animal hospital. Ramona has several close friends and spends time with them on a weekly basis. Ramona’s overall school performance is below average to average, with the exception of fine arts. According to Ramona, “I hate school because it takes the fun out of life.” She has been classified as emotionally handicapped and diagnosed with PTSD. Ramona was unable to share anything she liked about herself; however, her primary caregiver at the group home noted that she was “kind and warm-hearted.” As for a reason why she saw a therapist, Ramona explained that it was simply standard procedure for every child at the group home.

Ramona: Clinical Assessment

Ramona’s YSR score was in the subclinical range for Total Problems, Internalizing, and Thought Problems scales. Ramona’s YSR Scores were normal in all other areas, and informant agreement with the caregiver’s report was above average. Ramona’s caregiver reported CBCL scores in the clinical range for Total Problems, Internalizing, and School scales. The results of the CBCL indicate that Ramona’s caregiver reported more problems than are typically reported by parents of girls aged 11 to 18, particularly withdrawn behavior, somatic complaints, problems of anxiety or depression, thought problems, and attention problems. Ramona scored in the clinical range on the TSCC for Anxiety, Post Traumatic Stress, Disassociation, Disassociation-Overt, Disassociation-Fantasy, and Sexual Distress (SC-D). For example, she reported almost always having trouble with “scary ideas or pictures popping into my head,” “feeling scared of men,” and “pretending I am someone else.” What is not represented in these scores is that Ramona went to great lengths to express on the TSCC form that the “Almost all of the Time” category was not frequent enough to reflect her ongoing experiences of “remembering things that happened that I didn’t like” and “wishing bad things had never happened.” Clearly, Ramona has experienced one or more traumatic events during childhood and/or adolescence.
Ramona: Services

Ramona first came to the attention of DCF due to physical abuse, sexual abuse and neglect. Ramona and two younger biological brothers were placed together in a residential group home. While one brother is now being adopted, the other sibling lives with Ramona in the same cottage. The caregiver and provider reported that due to previous abuse, Ramona was forced to parent both younger siblings. Group home staff members now work with the children to establish more appropriate bonds. Ramona has a male primary caregiver assigned to her cottage, who is present eight hours a day, seven days a week. The provider interviewed has known Ramona for four years and is an individual therapist assigned by the group home. This primary provider offers talk therapy sessions more than once a week in which sexual concerns are brought up, but no specific sex abuse therapy is done. Ramona sees another counselor for family therapy once a week and a psychiatrist and nursing staff for medication management every six months.

Ramona: Unmet Needs

Despite these Medicaid-funded services, Ramona, her caregiver, and her provider all indicated that the caregiver serves the most therapeutic role in Ramona’s life. The provider reported that this caregiver helps Ramona with stress and behavior management activities. Ramona clarified that the one person she really speaks to about her problems is her caregiver because she trusts him and considers him to be “like a father” to her. In reference to her provider, Ramona simply stated, “I don’t get any help from her.” The provider acknowledged that the biggest challenge she faces with Ramona is her belief that the provider “doesn’t really understand anything about teenagers and particularly doesn’t understand anything about sex.”

While it is clear that Ramona’s caregiver feels comfortable in his role as primary caregiver and trusted friend, he expressed strong frustration that Ramona’s clinical needs were not being met. The caregiver was much more aware of Ramona’s past history of “severe physical assaults and sexual abuse” than the provider. The caregiver believes that Ramona is not fully disclosing her concerns and that she is not being “forced” to deal with these issues in her therapy sessions. While Ramona’s caregiver did not attribute any positive improvement to her interactions with the provider, he did believe that his relationship with Ramona has led to “more
normalized behavior and less negative attention-seeking.” As a result of therapy, Ramona would like to “not have PTSD;” however, her treatment plan only attempts to decrease symptoms and Ramona explained that her provider doesn’t adequately address the sexual issues. Ramona would also like to leave the group home for a permanent family, but the provider explained, “There is no family for her to go to.”

**Ramona: Cultural Competency**

Ramona described her ethnic background as “Black, White, Chippewa Indian, Irish, German, and Cuban.” Ramona’s provider explained that she focuses her efforts on “what Ramona thinks about her culture” rather than what other family members believe or what ethnicity peers assign to Ramona. Ramona’s caregiver explained that he and group home staff make an effort to be sensitive to cultural issues that exist. For example, when Ramona turned 15, they held a “quinceañera” for her birthday, which is a Spanish celebration for a young woman’s transition to the age of 15. It should also be noted that despite the fact that Ramona’s therapist is Hispanic and female, Ramona benefits the most from time spent with the person she trusts: her male, Caucasian caregiver.

**Ramona: Conclusion**

Ramona’s treatment plan goals need to be revised to incorporate placement and permanency issues and a plan for the future if Ramona is not adopted. In addition, it may be beneficial for the primary caregiver to attend some therapy sessions with Ramona due to the fact that Ramona is very reserved and only trusts her caregiver. With this extra support present, Ramona may be able to examine some of the deeper problems she faces on a nearly constant basis, and the provider may be able to introduce more trauma-focused interventions.
Jennifer and the Advantages of Service Continuity

Jennifer is a Caucasian female in the 6th grade. Jennifer enjoys skateboarding, swimming, and reading. She described herself as “smart and creative,” and her African-American foster mother reported that Jennifer’s performance in school is above average. Jennifer’s foster mother described her as “loving, intelligent, family-oriented, and very outgoing.” Jennifer’s biological mother is deceased, and Jennifer came into the child welfare system due to physical abuse. Jennifer has acted out sexually in the past and been a victim of alleged sexual abuse while in foster care. The foster mother is most concerned about Jennifer’s anxiety, depression, and attachment disorder. Although Jennifer has moved through many foster care settings, Jennifer’s primary provider has stayed with her over the last five years and has a close bond with the child. Jennifer explained that she sees her provider “because of my past with my biological parents and my many foster homes...and it’s fun.”

Jennifer: Clinical Assessment

While Jennifer’s Total Competence score and Activities and Social scales were all in the normal range, her scores on Total Problems, Internalizing, and Externalizing were all in the clinical range. Jennifer reported more problems than are typically reported by girls aged 11 to 18, particularly problems of anxiety or depression, problems in social relationships, thought problems, attention problems, and problems of an aggressive nature. Jennifer’s foster mother tended to rate her behavior as more severe, with informant agreement recorded as below average. One example of disagreement was that Jennifer reported having four or more friends, while the foster mother reported that Jennifer had no close friends. The foster mother reported additional problems with rule breaking behavior, and Jennifer’s profile of problems on the CBCL was significantly similar to the Social Problems profile type. Jennifer’s responses on the TSCC placed her in the normal range for Depression, Post Traumatic Stress, and Sexual Concerns; however, she met clinical criteria for Anxiety, Anger, Disassociation (both Overt and Fantasy), and subclinical for Sexual Distress. For example, Jennifer reported often having trouble controlling her anger, worry, and fear, but “trying not to have any feelings” and “feeling like things aren’t real.”
Jennifer: Services

Jennifer receives Medicaid-funded medication management via a psychiatrist every few months. Medicaid has stopped funding Jennifer's therapy; however, Family Continuity Programs has continued to pay for Jennifer to receive weekly individual therapy with the same counselor she has had on and off for the last five years. The provider incorporates aspects of play therapy, behavior management, sexual abuse therapy, and cognitive behavioral therapy. Group therapy has also been introduced on a weekly basis with the intention of decreasing individual sessions. The provider cited that the most beneficial aspect of services provided to Jennifer has been the continuity of the provider’s contact with Jennifer. The provider explained, “The foster care system repeats the pattern of abandonment, which is the central problem in these kids lives. Kids are faced with the loss of counselors and multiple placements.”

Jennifer reported that working with the provider “helps me a lot with my problems, helps [me] to confront my problems and to control my anger.” Jennifer’s self-esteem has improved in that she has “learned what a good person I am, what a good personality I have and how to improve myself.” Jennifer gave an example of a coping skill she adopted from therapy: “If someone is rude to me, I substitute [provider’s name] for that person and ask myself how I would react if she did that behavior.” Both Jennifer and her foster mother felt they have had input into the services Jennifer receives and the goals of her treatment plan. The foster mother emphasized the goal of placement stability and permanency for Jennifer, adding that she had “sabotaged” two adoptions in the past. “This is the longest continuous placement Jennifer has ever lived in [14 months]. She has started to admit and face issues so that she can finally work on them. We could not have kept her without [provider’s] help.” In sum, the family felt that this provider “always listens, addresses the needs and goals, gets to the root of actions, and is very on target.”
Jennifer: Medication Management

In contrast, the foster mother expressed significant dissatisfaction with the psychiatrist that provides medication management to Jennifer. “They are awful, arrogant, and not user friendly. They are not responsive, and dismiss our concerns. Left up to them, this placement would have failed. We want to change providers. Their line is ‘we are the doctors.’ That makes me feel like they don’t care about us or Jennifer’s needs.”

Jennifer: Conclusion

In cases where attachment and behavior problems often disrupt or abruptly end foster placements, the attention of one provider over the long term can be extremely helpful, providing continuity in an otherwise unstable childhood. Clearly, all service providers, including physicians, should strive for adherence to standards of family engagement and respect for clients.
Highly effective interventions for children have some common attributes. They are designed to be comprehensive, flexible, and responsive to the specific needs of the child. They work with the child in the context of a family unit. They focus on the family as part of the community and link with informal supports in the neighborhood. They are guided by a clear mission and continue to evolve over time as emerging practices and evidence-based treatment advance. They value the maintenance of high quality standards and evaluate the efforts of the organization and staff to achieve its shared purpose. The staff are competent, committed and invested in ongoing growth and development of their skills. The provider actively engages the family and other child serving professionals/organizations into a collaborative partnership, which is based on mutual trust and respect.

For children in the foster care system, critical areas of well-being can be overlooked, including mental health and socio-behavioral functioning. Problems can also be exacerbated by multiple placements, lack of continuity of interventions, and access restrictions on services. Continued instability increases risks for long-term socio-emotional difficulties. While the foster care experience, combined with the abuse and neglect that resulted in foster care placement, can create barriers to promoting well-being in youth, the positive development of young people can be achieved through supports, stabilized care, and coordinated services.

**Behavioral Health Issues**

Although there has been limited empirical evidence focused on mental health treatment of children in foster care, guidelines identifying promising interventions for the treatment of sexual and physical abuse and associated symptomatology are emerging (Marsenich, 2002; Saunders & Berliner, 2000). Cognitive behavior therapy, identified as a preferred intervention by many of the providers, has demonstrated improved outcomes for traumatic responses; however, aggression and anger have responded better to anger control therapy provided in the context of wraparound services, therapeutic foster care, and/or multisystemic therapy (Marsenich, 2002).

There are a wide variety of traumatic events to which youth in the child welfare system have been exposed during their childhood. This trauma has been associated with adverse mental health outcomes, such as post-traumatic stress, dissociation, anxiety, depression, anger, and aggression.
Anger and aggression seem to dominate as issues among the youth in this study. Trauma specific reactions also included dissociation which may be exhibited as a lack of empathy, difficulty defining or acknowledging feelings and an avoidance of emotional closeness.

For optimal service effectiveness, service providers need a working understanding of the child welfare system, family dynamics, realistic behavioral/achievement expectations for youth, impact of separation/loss on a child’s behavior, and emerging evidence for effective treatment. Treatment plans must promote the active involvement of foster parents and involve youth in the decision-making process. Youth and caregivers expressed a preference for engaging and creative services which provide realistic strategies for mediating aggression and disruptive behaviors. Natural supports in the community also are critical to providing ongoing support to the youth and family.

Child welfare goals of permanency and placement stability need to be incorporated into the behavioral treatment plan to help ensure that coordination of service delivery emphasizes common desired outcomes for the youth. Improvements in the child’s behavior and socio-emotional functioning will facilitate increased placement stability. Funding mechanisms need to be examined to ensure that continuity in access to services is not adversely affected by evidence of progress toward treatment goals.

**Child Welfare Issues**

The Adoption and Safe Families Act (ASFA) has emphasized the need for permanency among children in the child welfare system, and has impacted child welfare practice by mandating time limits on the process of making and sustaining permanency decisions. The issues of safety and permanency are paramount for successful implementation; however, finding permanent homes for adolescents in foster care can be especially challenging and confounded by the difficulties of mental health issues. While socio-emotional problems often contribute to instability of placements, lack of continuity among caregivers has a simultaneous adverse impact on the functioning of youth. To comply with ASFA, children in foster care must be provided with quality services that protect their safety and well-being.
Several goals identified under ASFA for effective implementation are salient to meeting the needs of children in foster care who require mental health services. Engagement, the process of developing and maintaining a collaborative partnership with the family, is necessary to invest caregivers and the youth in the process of change. Engagement activities include shared decision-making and involvement in the development of the treatment plan. Engagement is facilitated by attending to unique cultural practices, beliefs and traditions of the family and youth which can serve as a catalyst to involvement in service delivery and successful placements. It can be especially challenging to find providers who reflect the diversity of the youth served, so sensitivity to culture and values is critical.

Youth and family need to be involved in defining needs and identifying solutions. The child and caregiver should be approached with respect and cooperation. Engagement of the youth is dependent on creating safe and stable supports, which can sustain periods of struggle. Safety issues shift from a focus on physical safety to an emphasis on emotional safety, i.e., security from further loss and separation. Ideally, continuity in staff can evolve into a trusting relationship. Given the reality of staff transitions, goals which address relationship loss provide a context for assisting youth with recurrent attachment disruptions, allow the child to debrief, and foster closure before learning to reengage with others.

Under ASFA, assessment also plays an important role in developing and implementing services appropriate to the child’s needs. Ongoing assessment at regular intervals provides useful information on the needs and strengths of the youth as permanency options are explored and skills are developed for long-term well-being.

The ASFA goal of evaluation emphasizes the process of monitoring progress towards goals and desired outcomes. It is important to regularly assess the child and caregiver’s views of progress to determine if services are appropriate. Existing barriers need to be identified and revisions to the treatment plan or referrals and linkages with other services in the community should be pursued. Mental health outcomes can be monitored by measuring satisfaction with services, evaluating fidelity of treatments, monitoring care compliance, and tracking adherence to procedural requirements.
The findings of this study highlight the importance of a sense of belonging and connectedness for a child's long term functioning. The results suggest that youth placement stability is highly correlated with caregiver satisfaction. To achieve this stability, individualized service plans which reflect comprehensive and coordinated care are needed.

Goals of treatment should be associated with permanency outcomes. Foster families and the youth require ongoing services which can address complex and interrelated problems. For example, the disruptive and aggressive behaviors which were common among the participating youth in foster care also negatively affect the success of placements and options for permanency.

Despite the importance of permanency outcomes and its association with mental health issues, only one provider in the study reported services focusing on transitions for independence. Based on feedback of the youth, caregivers, and providers, services did not address preparation for the workplace, self-sufficiency, or economic independence, which can all be important issues in the permanency planning process.

The challenges of permanency for adolescents are confounded by years of unstable placements, the scars of lost relationships, and the demands of transitioning into adulthood. Yet permanency is critical for teens to mediate the risks for long-term social and emotional problems. Permanency for adolescents can take a variety of forms, including sustaining connections with extended family or important adults in their lives. The nurturance of relationships with siblings, foster caregivers, mentors, other relatives, etc. can mediate the sense of loss of connection with others.

Whether permanency is focused on adoption, placement stability, or connection with significant others, the infusion of planned placement goals into interventions needs to be considered and transition planning is an important component. Activities to foster successful transitions may include youth training for independence, guidance in pursuing higher education opportunities, and preparation for employment. Additionally, the foster family can benefit from family preparation activities, financial assistance, and linkage with resources to support the youth's transition into adulthood.
References


