

Evidence-Based Practices with Families Involved in the Child Welfare System



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Note. We have no financial conflicts to disclose

Overview



- This presentation draws primarily from three sources of information:
 - The California Evidence-Based Clearinghouse (CEBC) for Child Welfare (<http://www.cebc4cw.org/>).
 - The 2007 Best Practices for Mental Health in Child Welfare Consensus Conference (<http://www.aecf.org/KnowledgeCenter/Publications.aspx?pubguid=%7BF9-2E5C-4D63-8584-73205D3B7CA4%7D>).
 - The Hood Study (http://160.109.101.132/icrhps/prodserv/docs/Executive_Report_09-07-10_348.pdf).
 - The AACAP Practice Parameters for Mental Health Disorders <http://www.aacap.org/>.

Learning Objectives



1. Understand the characteristics of children and youth in child welfare custody.
2. Learn about the evidence-based interventions for children and parents who are child welfare-involved.
3. Understand the need for parent engagement and support and develop strategies to achieve goals.
4. Understand implications for youth serving systems.



**LEARNING
OBJECTIVE 1**

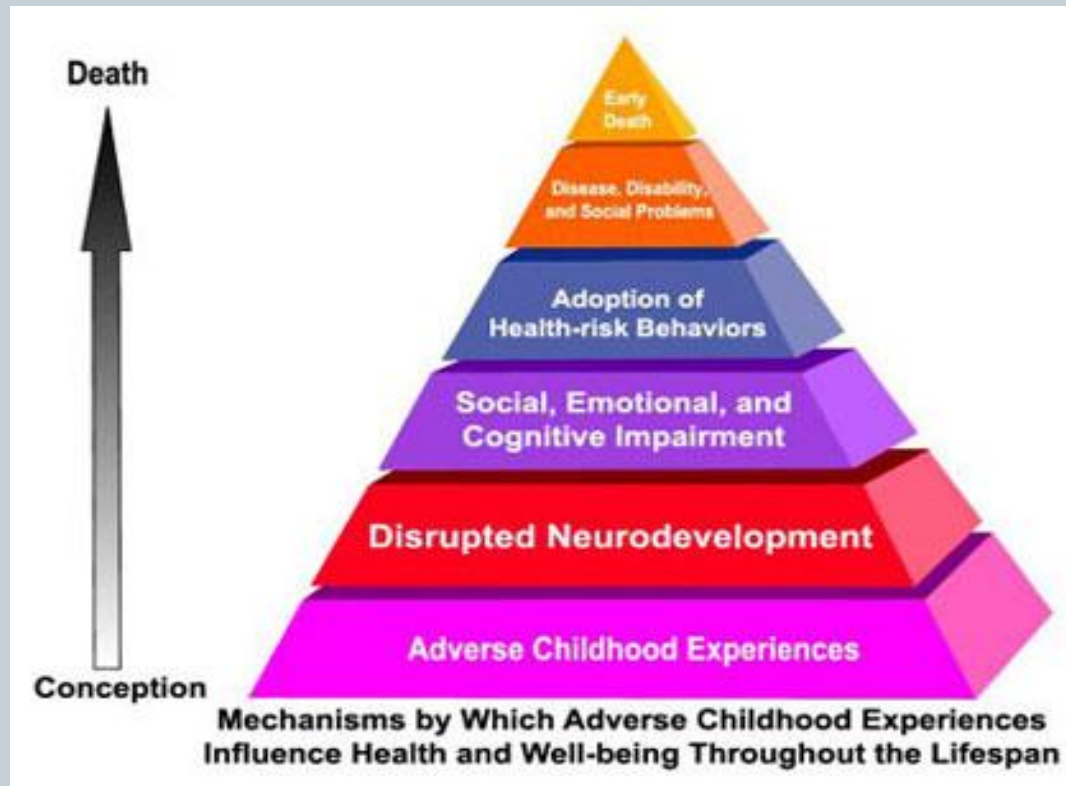
- Understand the characteristics of children and youth in child welfare custody

Relevance? Child Welfare/ Child Protective Services System (CWS)



- **America's Children: A Snapshot**
 - U.S. child welfare population under 18 in 2010: 408,425
 - White children under 18 in 2010: 41%
- **Children in Child Welfare**
 - U.S. referrals possible child abuse/neglect in 2009: 702,000 children
 - 78% suffered neglect
 - 18% were physically abused
 - 10% were sexually abused
 - 8% were emotionally or psychologically maltreated
 - 2% were medically neglected
 - Estimated 10% experienced other types of maltreatment (e.g., abandonment, treats of harm, congenital drug addiction, etc)

The Adverse Childhood Experiences (ACE) Study



<http://www.cestudy.org/aboutcestudy.php>

Children in CW: “The Known”



- Children in foster care in 2010:
 - Racial Breakdown
 - ✦ Alaska Native/American Indian: 2%
 - ✦ Asian: 1%
 - ✦ Black: 29%
 - ✦ Hawaiian/Other Pacific Islander: 0%
 - ✦ Hispanic: 21%
 - ✦ White: 41%
 - ✦ Unknown: 2%
 - ✦ Two or more races: 5%
 - Male gender: 52%
 - Average age: 9.4 years
 - ✦ 36% 0-5 years, 20% 6-10 years, 23% 11-15 years, 21% 16 or greater

CW's Revolving Door



- Children entering foster care in 2010: approximately 250,000 per year
- Children exiting foster care
 - In care for 1+ years: 41%
 - In care for 3+ years: 6%
- Average length of stay in foster care: 13.7 months
- Average number of placement changes: 1-2/year
- Children who re-enter foster care within 1 year following reunification: 33% (*Chapin Hall*); 10% (*Child Welfare Outcomes 2002: Annual Report*)

See ACF, CWLA, Chapin Hall websites for more information

Children in CWS: “The Unknown”



- Children not placed in out-of-home care
 - Termed “in-home”
 - May be undergoing investigation or be post-investigation
 - ✦ Some receive no services
 - ✦ Some receive family maintenance/preservation services
 - Very little research done on this subpopulation of children in CW

What is Background Rate of MH Need?



- 10-22% of all youths will have some symptoms of a mental health disorder before age 21
- 5-8% of all youths will meet criteria for emotional disturbance (ED)* at some time before age 21

***ED is synonymous with severely emotionally disturbed (SED) and defined in P.L. 94-142 (Education for All Handicapped Children Act) although states show considerable variability; requires a mental health diagnosis & evidence of moderate to severe impairment*

Data on Impairment: NSCAW Findings 1



- 2823 CW children ages ≥ 2 yrs (includes in home & out-of-home) : 42% at or above the clinical cutpoint on the CBCL 5 months following initial contact date (*Hurlburt et al., 2004*)
- Separate sample of 462 children ages ≥ 2 yrs in foster care for over 12 months: 47% at or above the clinical cutpoint (*Leslie et al., 2004*)

**Note. Clinical cutpoint is 97th percentile; mental health needs are on a continuum*

Data on Impairment: NSCAW Findings 2



- Targeting service use to those with needs
- Higher rates of need associated with
 - Older age
 - Placement in non-relative foster care or group home compared with kinship care or in-home with or without services
 - Neglect versus maltreatment
 - Higher caseworker reports of impaired parenting skills (*Burns et al., 2004*)

Mental Health/ Developmental Overlap in Young Children

	0 Areas of Risk	1 Area of Risk	2 Areas of Risk
0-2 years	61%	29%	10%
3-5 years	49%	32%	20%

- **Next steps**

- Define specific subgroups of need
- Examine how need changes over time
- Examine if service use has any impact on need

(Stahmer et al., 2005; percentages indicate scores < 2 SD from the mean)

NSCAW: Other Problems in Latency Age/Adolescence

(Lambros, Leslie, et al., in review)



- **50% with borderline or lower cognitive skills**
 - 17% >2 SD from the mean (average) on cognitive measures
 - 33% 1-2 SD from the mean on cognitive measures
- **20% of children > 4 years in special education**
 - 27% ED
 - 41% Specific learning disability
 - 20% Speech/language delay

Foster Care Alumni

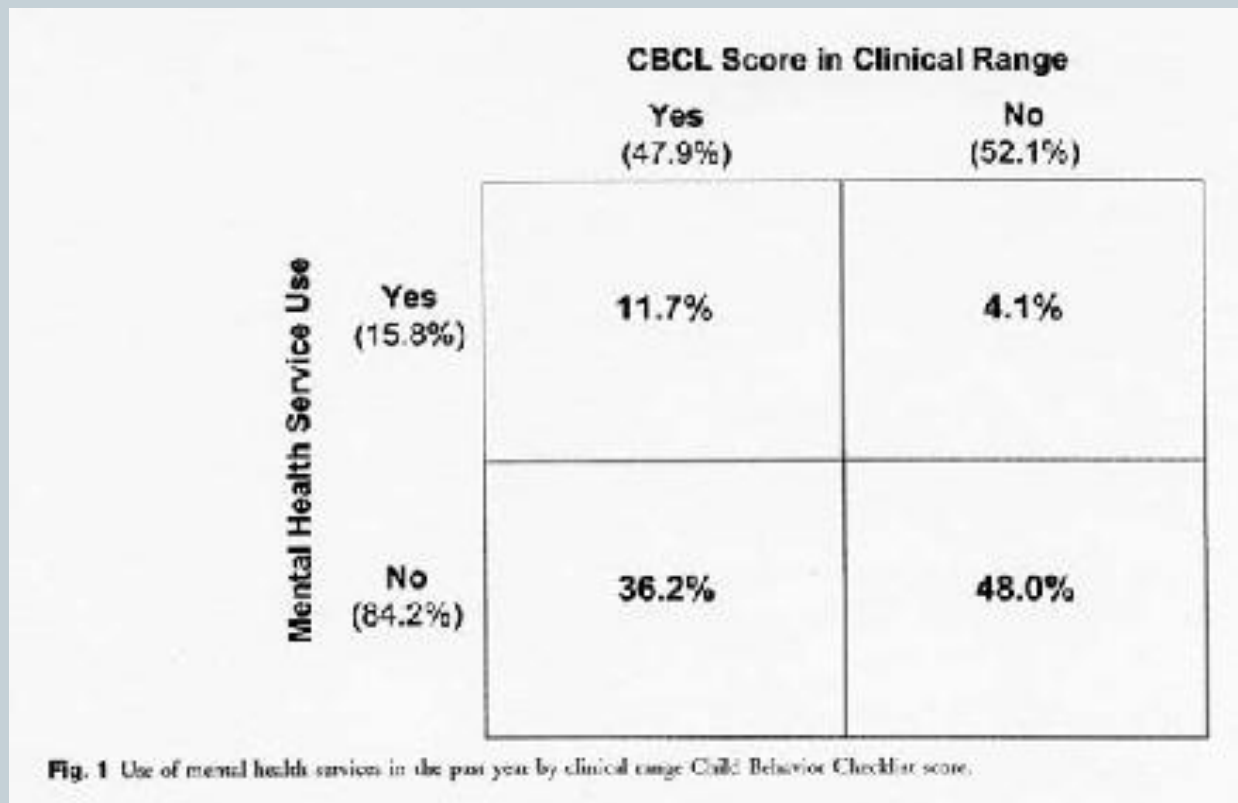


- Lifetime prevalence of mental health disorders among adults who experienced stays in foster care exceeds the incidence rate of the general population (Northwest Alumni Study, Pecora et.al. 2005):
 - PTSD 30% Alumni vs. 7.6% Gen Pop
 - Major Depression 41.1% vs. 21% Gen Pop
 - Panic disorder 21.1% vs. 4.8% Gen Pop
 - GAD 19.1% vs. 7% Gen Pop
 - Drug dependence 21% vs. 4.5% Gen Pop



NSCAW Results

(Burns et al., 2004)



Note. In-home & out-of-home combined; 12 months preceding the first out-of-home interview at approximately 5 months post-contact date with CW)

Race/Ethnicity & Need

(Leslie et al., 2004)



L.K. Leslie et al. / Child Abuse & Neglect 28 (2004) 697-712

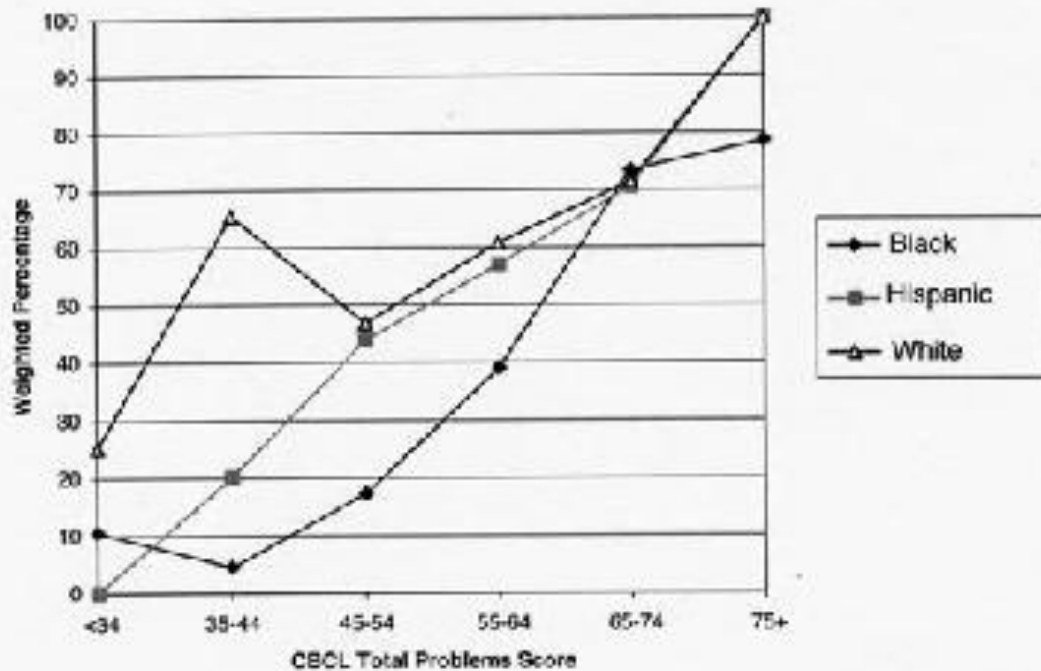


Figure 1. Proportion of children receiving specialty outpatient mental health services by race/ethnicity.

De Facto Mental Health System?



- Historical focus of Child Welfare has been safety and permanence.
- Well-being goals were not added until 1997 (Safe Families Act). Vast majority of states fail on mental health well-being goals as measured by the Child and Family Services Reviews (CFSRs).
- Given the high prevalence of emotional and behavioral disorders in the CW population, should CW systems have mental health services as a core component?

Screening & Assessment

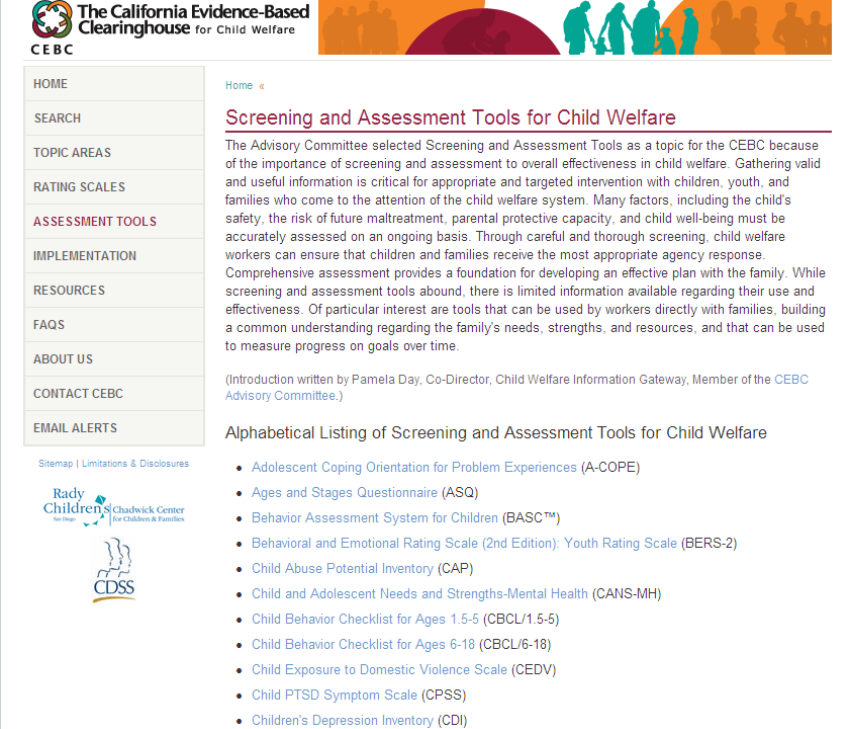


- AACAP/CWLA joint policy statement calls for immediate mental health and alcohol and other drugs (AOD) screening followed by a comprehensive mental health and AOD assessment for positive screens as well as periodic reassessment.
- Generally, comprehensive assessments are recommended within 60 days of placement for those youth with positive screens.
- Given the high prevalence of SED and inherent stressors associated with removal, universal interventions would appear warranted.

Screening & Assessment Con't

- A number of standardized instruments are in use to screen youth entering the CW system including:
 - Behavior Assessment System for Children (BASC-2)
 - Child and Adolescent Needs and Strengths-MH (CANS-MH)
 - Child Behavior Checklist (CBCL)
 - Pediatric Symptom Checklist (PSC-17)
 - Strengths and Difficulties Questionnaire (SDQ)

**Note. For a comprehensive list of screening and assessment instrument see the CEBC website (<http://www.cebc4cw.org/assessment-tools/>)*



The screenshot shows the website for The California Evidence-Based Clearinghouse for Child Welfare (CEBC). The page is titled "Screening and Assessment Tools for Child Welfare". It features a navigation menu on the left with links to HOME, SEARCH, TOPIC AREAS, RATING SCALES, ASSESSMENT TOOLS (highlighted), IMPLEMENTATION, RESOURCES, FAQs, ABOUT US, CONTACT CEBC, and EMAIL ALERTS. The main content area includes an introduction by Pamela Day, Co-Director of the Child Welfare Information Gateway, and an alphabetical listing of screening and assessment tools for child welfare. The tools listed are:

- Adolescent Coping Orientation for Problem Experiences (A-COPE)
- Ages and Stages Questionnaire (ASQ)
- Behavior Assessment System for Children (BASC™)
- Behavioral and Emotional Rating Scale (2nd Edition): Youth Rating Scale (BERS-2)
- Child Abuse Potential Inventory (CAP)
- Child and Adolescent Needs and Strengths-Mental Health (CANS-MH)
- Child Behavior Checklist for Ages 1.5-5 (CBCL/1.5-5)
- Child Behavior Checklist for Ages 6-18 (CBCL/6-18)
- Child Exposure to Domestic Violence Scale (CEDV)
- Child PTSD Symptom Scale (CPSS)
- Children's Depression Inventory (CDI)



**LEARNING
OBJECTIVE 2**

- Learn the about evidence-based interventions for children and parents who are child welfare-involved.

What are Evidence-Based Interventions?



- Evidence-based interventions (EBIs) are treatments that have been found to be effective (at least to some degree) through outcome evaluation research.
- EBIs are treatments that are likely to be effective in changing a target behavior if implemented with integrity and with the appropriate population or individual.

More on EBIs



- EBIs have been developed for numerous parties involved with child welfare, including:
 - Children
 - Youth
 - Biological Parents
 - Foster Parents
 - Kinship Providers
- EBIs include:
 - Behavioral interventions
 - Psychopharmacological interventions
 - Parent training
 - Home and community-based interventions





EBIs on the California Evidence-Based Clearing House (CEBC)



- The CEBC provides child welfare professionals with easy access to EBIs.
- A scientific rating is attached to all interventions provided on the website:
 - 1 = Well-supported by research evidence
 - 2 = Supported by research evidence
 - 3 = Promising research evidence
 - 4 = Evidence fails to demonstrate effect
 - 5 = Concerning Practice
 - NR = Not able to be Rated

EBIs on the California Evidence-Based Clearing House (CEBC) Con't



HOME
SEARCH
TOPIC AREAS
RATING SCALES
ASSESSMENT TOOLS
IMPLEMENTATION
RESOURCES
FAQS
ABOUT US
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EMAIL ALERTS

Search for a Program:

Welcome to the CEBC:
California Evidence-Based Clearinghouse for Child Welfare
Information and Resources for Child Welfare Professionals

The California Evidence-Based Clearinghouse for Child Welfare (CEBC) provides child welfare professionals with easy access to vital information about selected child welfare related programs. The primary task of the CEBC is to inform the child welfare community about the research evidence for programs being used or marketed in California.* The CEBC also lists programs that may be less well-known in California, but were recommended by the Topic Expert for that Topic Area.

How do You Use the CEBC?	What's New on the CEBC?
What is Evidence-Based Practice?	How are Programs on the CEBC Reviewed?
How is Culture Related to Evidence-Based Practice?	Sign-up to get Email Alerts!

* Please note that the CEBC was created for informational and educational purposes and as such does not endorse any of the programs listed on the website.

Information presented on the CEBC website is considered public information and may be distributed or copied. When using information obtained from the CEBC, we ask that you please use the following acknowledgment: Material/Information obtained from the California Evidence-Based Clearinghouse for Child Welfare (CEBC) at www.cebc4cw.org.



Home [Search](#)

Search by Topic Area
 Select a topic area to view the programs that have been reviewed and rated

- Anger Management (Adult)
- Anxiety Treatment (Child & Adolescent)
- Behavioral Management for Adolescents in Child Welfare
- Bipolar Disorder Treatment (Child & Adolescent)
- Casework Practice
- Child Welfare Initiatives
- Depression Treatment (Adult)
- Depression Treatment (Child & Adolescent)
- Disruptive Behavior Treatment (Child & Adolescent)
- Domestic/Intimate Partner Violence: Batterer Intervention Programs
- Domestic/Intimate Partner Violence: Services for Women and their Children
- Father Involvement Interventions
- Higher Level of Placement
- Home Visiting for Child Well-Being
- Home Visiting for Prevention of Child Abuse and Neglect
- Infant and Toddler Mental Health (0-3)
- Interventions for Neglect
- Motivation and Engagement
- Parent Partner Programs for Families Involved in the Child Welfare System
- Parent Training

Sitemap | Limitations & Disclosures





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Sitemap | Limitations & Disclosures

Behavioral EBIs for Children & Youth in CW

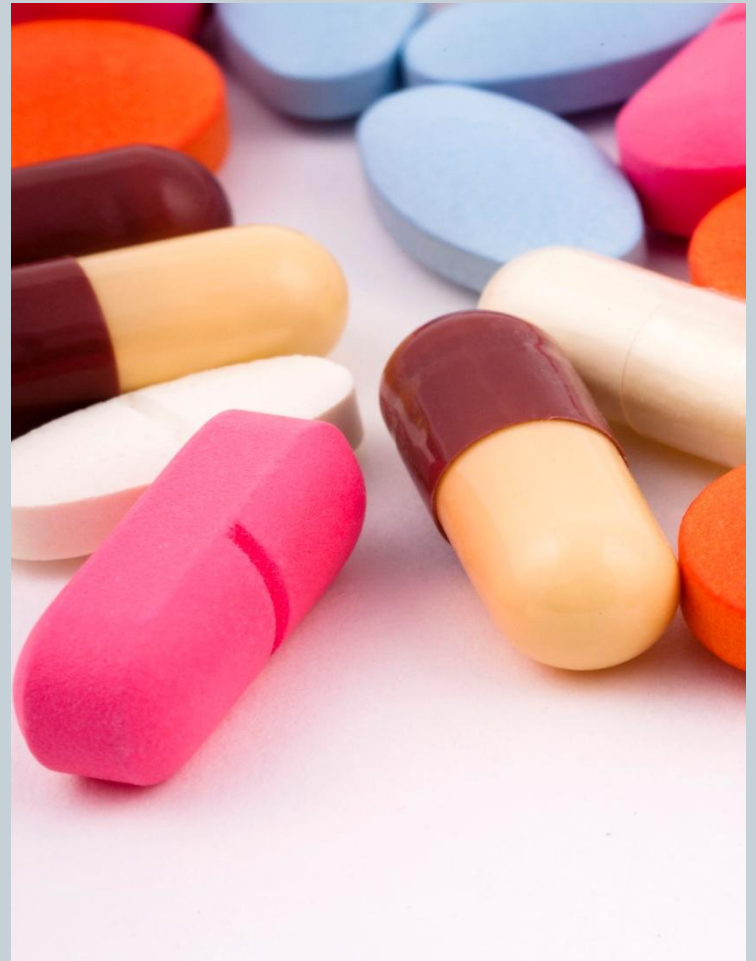


- There is a strong evidence base for behavioral and cognitive-behavioral interventions such as:
 - Young Children
 - ✦ Coping Cat (CBT for Anxiety in children and youth)
 - ✦ Building Confidence (Anxiety treatment)
 - Adolescents/Youth
 - ✦ Trauma-focused CBT (TF-CBT)
 - ✦ Cognitive Behavioral Therapy for Depression
 - ✦ Prolonged Exposure Therapy for Adolescents (PE-A)
- Caregiver involvement increases the efficacy of these interventions.

Psychopharmacological Interventions for Children & Youth in CW



- **SSRIs**
 - PTSD and depression
- **Stimulants**
 - ADHD
 - ADHD + behavioral disturbance
- **Atypical antipsychotics**
 - Disruptive behavior disorders
- **Mood stabilizers**
 - Aggression.



Use with Caution



- SSRIs can cause behavioral disinhibition.
- Atypicals associated with significant weight gain and risk for metabolic syndrome, obesity, diabetes and heart disease.
- Evidence supports meds in combination with evidence-based psychosocial interventions.

A Growing Concern



- States are reporting rates of psychotropic medication use ranging from 13-52% for youth in child welfare.
- Growing concern that children are being prescribed psychotropic medication in lieu of other therapies.
 - States driven to investigate by litigation, emerging research, high-profile media reports.
- Disparities in medication use are linked to:
 - Race/ethnicity, gender, age, history of physical abuse, demonstrated clinical need, placement type, and receipt of public insurance
- Parents are rarely involved in the decision-making regarding medication trials once the child is in care.

EIBs for Parents



All have some aspect of the following four components:

1. Parenting problems are assessed.
2. Parents are taught new skills.
3. They apply the skills with their children.
4. They receive feedback about the application of the skills.

EBIs for Parents: “Triple P” –Positive Parenting Program



- **The Triple P (Sanders, 1999):**
 - Varies in intensity based on assessment and may include prevention, intervention and treatment.
 - Is applicable to varying developmental levels.
 - Offers consistent parenting principles and age-appropriate parenting strategies.
 - Is well validated with over 40 RCTs.

Note. CEBC rating = 1



EBIs for Parents: Parent-Child Interaction Therapy (PCIT)



- Target population: physically abusive parents and their children ages 4-12
- Level of evidence: RCTs (Chaffin et. al. 2004)
- Main findings:
 - Decreased parent physical abuse
 - Reduced negative parent-child interactions
 - Maintenance of effects 3-6 years after treatment

Note. CEBC rating = 1



EBIs for Parents: Parent Management Training (PMT)



- PMT was developed in the 1960s by Gerald Patterson at the Oregon Social Learning Center for 3-18 years olds with conduct problems.
- Based on operant conditioning principles (i.e. rewarding positive behaviors and ignoring or punishing deviant behaviors).
- 9 weekly two-hour sessions, no direct child involvement.
- Numerous RCTs show that compared to psychodynamic therapy and no-treatment controls, PMT has superior outcomes for children with conduct disorder.

Note. CEBC rating = 1

EBIs for Parents: Incredible Years (IY)



- IY is an intervention developed by Webster-Stratton, teaches behavior management skills to parents of 3-10 year olds at risk of exhibiting conduct disorders. Promotes effective parental discipline and praise, and reduce spanking, critical statements, and other negative discipline practices.
- Videos of parent-child vignettes are shown to parents in group settings with discussion by a therapist over 12 two-hour sessions.
- Evidence base: at least 7 RCTs with improved parenting skills being noted and effects maintained for at least 1 year.

Note. CEBC rating = 1

EBIs for Parents: Functional Family Therapy (FFT)



- FFT is a family-based treatment focusing on decreasing maladaptive behaviors in youth ages 11-18 at risk of or presenting with disruptive behavior disorders and/or substance abuse. < 26 hours of direct service.
- Intervention sites: home, clinic, juvenile facility.
- Controlled trials comparing FFT to residential treatment shows FFT better at reducing re-offending behavior and reducing onset on behavioral problems in siblings.

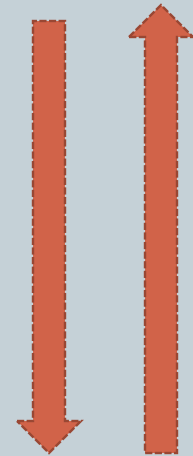
Note. CEBC rating = 2

EBIs for Parents: Brief Strategic Family Therapy (BSFT)



- BSFT is designed for youth ages 6-17 with emotional and behavioral problems and families with anger, blaming and other negative interactions.
- RCTs have shown positive outcomes:
 - Decreased behavioral problems
 - Decreased association with antisocial peers
 - Increased family involvement in therapy
 - Increased family communication and warmth

Note. CEBC rating = 2



EBIs for Parents: Project 12-Ways/Safe Care for Child Neglect



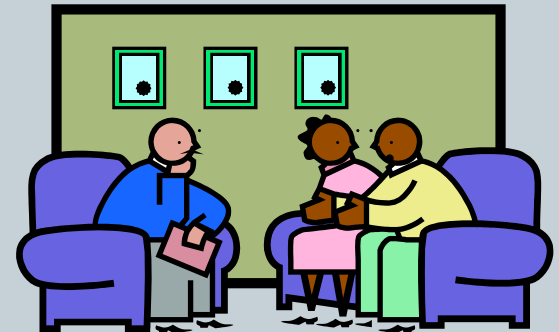
- Intervention targets the ecology in which the child and family live and is based on behavioral principles (Lutzker et al., 1998).
- Parents are taught skills in safety, bonding and health care and incorporates video modeling.
- Evidence base: Quasi-experimental studies (Chaffin & Friedrich, 2004).
- Outcomes: improvement in interpersonal (social interactions, assertion skills) and functional (job training, home management skills) domains for parents.

Note. CEBC rating = NR

Home & Community-Based Interventions



- There is a strong evidence base for multisystemic therapy and treatment foster care.
- Additional services that support foster and kinship families include:
 - Intensive case management
 - Mobile crisis service
 - Respite care
 - Home-based therapy
 - Therapeutic mentoring
 - SPED services
 - Recreational/work opportunities



EBIs for Parents: Multisystemic Therapy (MST)



- MST is ecologically oriented, family-based treatment for behavior and substance abusing adolescents at risk of out-of-home placement.
- Brief (3-6 months) and uses community resources. Aim is family preservation. Therapist available 24/7.
- Evidence base: 9 RCTs
- Outcomes:
 - Decreased aggression
 - Fewer arrests
 - Fewer placements
 - Improvements in family functioning

Note. CEBC rating = 1

EBIs for Parents: Multidimensional Treatment Foster Care (MTFC)



- MTFC originated from the Oregon Social Learning Center and uses social learning theory. Foster parents receive training and supervision and only one child is placed at a time.
- Evidence base: 4 RTCs
- Outcomes:
 - More rapid improvement
 - Decreased aggression
 - Better post-discharge outcomes

Note. CEBC Rating for adolescents = 1, for preschoolers = 2



**LEARNING
OBJECTIVE 3**

- Understand the need for parent engagement and support and develop strategies to achieve goals.

Need for Parental Involvement



- The majority of children in CW custody remain with their biological parents.
- Despite the conditions that lead to the removal of the child (neglect and abuse), there remain compelling reasons to involve parents:
 - Families are primary social context in which children function.
 - Shape attitudes about service which can influence compliance and outcomes.
 - Need families to provide history.
 - Most children will be reunified.

Need For Parental Involvement Con't

- Upon reunification, parents need:
 - To understand their child's developmental and mental health strengths and needs.
 - How to implement therapeutic strategies for their child in the home.
 - Basis for the child's diagnosis and treatment including medications that may have been initiated while the child was in care.
 - Continuity of care with treatment providers including a means to pay for that care.



Need for Parental Involvement Con't



- Children's emotional and behavioral problems escalate upon return from foster care (Bellamy, 2008).
- Parents are also vulnerable to relapse (substance abuse, reabuse) secondary to stress of re-establishing parental role.
- Often results in children moving in and out of care, further compromising basic sense of safety, well-being and attachment.

Challenges to Effective Parent Engagement



- System is inherently adversarial (State has taken your child and labeled you as unfit).
- Parental mental health and substance abuse disorders often go untreated (CW rarely provides treatment for parents even though goal may be reunification).
- Unstable housing, employment, transportation, poverty, lack of insurance, interpersonal and community violence.
- Families of color receive and use fewer services than white families (Barth et al., 2006).

Challenges to Effective Parent Engagement Con't



- Butler et al (1994): found that parents who did not attend court-ordered services were more likely to have histories of alcohol and other drug abuse, spousal violence and criminal behavior.
- Sheppard (2002): depression negatively impacted mother's participation in planning and decision-making and invoked a cycle where the response by CW further impaired their depression and ability to engage in services.
- Fewer than half of caregivers receive mental health treatment (Libby et al., 2009).

Challenges to Effective Parent Engagement Con't



- **Parent's emotions may include:**
 - Guilt and blame
 - Fear
 - Anger or outrage
 - Trauma from separation with their child
 - Profound stigma
- **Often parents have had long, contentious histories with service systems impacting treatment alliance and trust.**

Systemic Barriers to Effective Parent Engagement



- CW systems often prioritize work with systems, courts and record keeping over work with parents (Smith and Donovan, 2003).
- CW system functions under a “ticking clock” to determine whether reunification is likely or whether to move towards long-term substituted care or adoption which may be at odds with the time it takes for parents to attend to their mental health and substance abuse disorders.

Systemic Barriers to Effective Parent Engagement Con't



- We are asking some of the most-challenged parents to get a job, visit with their child, engage in their own and their child's treatment, maintain sobriety, end violent relationships, and see a future that they may never have experienced themselves AND to manage this with little or no support from the system making these demands.



Systemic Barriers to Effective Parent Engagement Con't



- Smith and Donovan (2003) found CW workers were unconvinced that change was feasible given the extensive problems typical of families given limitations of time and resources.
- Workers may avoid parents when they see little likelihood of reunification to avoid difficult interactions with parents including real threats of safety.
- Worker burnout and turnover in CW is exceedingly high as is turnover of CW administrators making reform and alliance development a challenge.

Building Treatment Alliance



- Must be able to understand, validate and engage parent's negative or ambivalent feelings about treatment and sense of powerlessness.
- Find sources of motivation and hope.
- Appeal to parent's love of and for their child.
- Remain focused on the successful reunification of their family.
- Clarify role as agent to help facilitate positive change and family's successful functioning.

Building Treatment Alliance



- Think “out of the box” for solutions to challenges (eg. Access flexible funds).
- Build trust-start with goals that will have clear, practical, and positive impact on the family.
- Build on family’s strengths.
- Relinquish control but expect accountability.
- Respect different parenting styles and cultural variation.

Cultural Factors



- Children of color are over-represented in CW compared to their rates in the population (58% vs 44%).
- Racial disparity particularly acute for African-American youth (38% vs 15%).
- Racial disparities lead to mistrust of system.
- Generational experiences with CW furthers mistrust (many parents may themselves have been in the CW system).
- Linguistic and cultural competency remain a challenge within the CW and treatment workforce.

Parent Engagement



- Kemp et. al. (2009) identify six overlapping engagement strategies:
 1. Early outreach and responsiveness to parents' identified needs and priorities.
 2. Practical help.
 3. Knowledge, skills and efficacy in engaging, understanding and navigating complex issues and systems.
 4. Supportive, respectful, culturally relevant and available relationships with birthparent peers, foster parents, and CW workers.
 5. Consultation and inclusion in planning, decision-making and service provision.
 6. Policy, organizational and administrative practice that supports inclusive, family-centered and culturally-responsive practice.

Parent-Engagement Con't



- **2007 Best Practices for Mental Health in Child Welfare Consensus Guidelines recommend:**
 1. Use adult peer family mentors with experience working with different populations to advocate *with* and assist families seeking care.
 2. Provide training, education and consultation for peer family mentors on child and family mental health issues to assist them in their professional roles.
 3. Provide families experiencing removal of a child an immediate orientation to their rights and responsibilities.

Parent-Engagement Con't



4. Complete comprehensive family assessments in collaboration with the family to identify strengths, service needs, and necessary support services.
5. Child welfare staff should receive family engagement training.
6. Refer family members for substance abuse and mental health treatment as part of a comprehensive service plan.

Parent-Engagement Con't



7. Utilize early assistance and differential response strategies to support families and possibly divert them from entering the foster care system whenever possible (may be playing a role in the lower numbers of youth in care since 2002).
8. Encourage parents to be involved in their child's mental and physical health promotion, assessment, treatment, education, medical care, and other services the child may receive while placed away from their biological family.

Counter-Transference



- How do you make a meaningful alliance with a parent who may have harmed their child?
- Who is your patient and how do you manage situations when there is a conflict between what is best for the child and what is best for the parent?
- On-going role as a mandated reporter can place a barrier to honest, open dialogue about parenting practices, substance abuse and treatment compliance.

Key Components of Success in Working with Families



- Role and job clarity
- Adequate, regular supervision
- Working within a team
- Good self-care skills
- Belief that a positive outcome is not only possible but achievable
- Ability to break down tasks into small, short-term goals to create cycle of success



**LEARNING
OBJECTIVE 4**

- Understand implications for youth serving systems.

Workforce & Access Challenges



- Access to evidence-based interventions for youth remains a critical dilemma.
- There is a dearth of trained practitioners.
- Concern that standard out-patient treatment is ineffective for CW youth compounded by the challenges of keeping youth engaged in their treatment (frequent moves, in and out of care, lack of parental involvement).

Where Do You House Mental Health Services?



- **Emerging models include:**
 - Embedding MH services in Child Welfare (Illinois, Naylor) and in the courts (Florida, Lederman)
 - Using specific interventions adapted for the CW population (statewide implementation of PCIT in Oklahoma; Modular Approach to Therapy for Children (MATCH) in Maine (Weisz & Chorpita)
 - Trying to make foster care itself a therapeutic intervention (Treatment foster care)

Requires CW to Have Partners



- No CW system can meet all the needs of the youth in their care. Best practice calls for partnerships with:
 - Mental health
 - Developmental disabilities
 - Special Education/Schools
 - Juvenile Justice
 - Medicaid
 - Primary Care
 - Community



References



- Barth, R.P., et.al. (2005). Parent-Training Programs in Child Welfare Services: Planning for a More Evidence-Based Approach to Serving Biological Parents. *Research on Social Work Practice*, 15 (5), 353-371.
- California Evidence-Based Clearinghouse for Child Welfare (CEBC; 2011). <http://www.cebc4cw.org/>.
- Chaffin, M., Friedrich, B. (2004). Evidence-based treatments in child abuse and neglect. *Children and Youth Services Review*, 26, 1097-1113.
- Hunter Romanelli, L., et.al. (2009). Best Practices for Mental Health in Child Welfare: Parent Engagement and Youth Empowerment Guidelines. *Child Welfare*, 88(1), 189-212.
- Landsverk, J.A., et.al. (2009). Psychosocial Interventions for Children and Adolescents in Foster Care: Review of Research Literature. *Child Welfare*, 88(1), 49-69.
- Linares, L.O., Montalbo, D., Li, M., and Oza, V.S. (2006). A Promising Parenting Intervention in Foster Care. *Journal of Consulting and Clinical Psychology*, 74(1), 32-41.
- Mackie TI, Hyde J, * Rodday AM, Dawson EH, Lakshmikanthan R, Bellonci C, Schoonover D, Leslie L. K. (2011). Psychotropic medication oversight for youth in foster care: A national perspective on state child welfare policy and practice guidelines. *Children and Youth Services Review*, 33, 2213-2220.