

**We want your comments! Please review the parameter and come to the Member Forum on Friday, October 30 during the AACAP Annual Meeting in Honolulu at 10:45 AM or complete the comment form at the end of the parameter and fax to 202.966.9518.**

**PRACTICE PARAMETER FOR THE ASSESSMENT AND TREATMENT OF YOUTH  
IN FOSTER CARE SETTINGS**

**October 2009 Draft**

Word Count: 10,734

**ABSTRACT**

This practice parameter presents principles for the mental health assessment and treatment of youth in foster care. It outlines important definitions, background and history. Practical guidance, including advice on potential modifications to evaluation and treatment, is provided for psychiatrists and other physicians and mental health professionals who work with children and adolescents in foster care settings. Relevant legal issues are described. The epidemiology of psychiatric disorders in this population is described and evidence based treatments that have been shown to be useful are outlined. **Key Words:** practice parameters, practice guidelines, child and adolescent psychiatry, foster care, placement, child welfare worker, adoption.

**ATTRIBUTION**

This parameter was developed by Rachel Brown, MBBS, principal author and the Work Group on Quality Issues (WGQI): Oscar Bukstein, M.D. and Heather Walter, M.D., Co-Chairs, and Chris Bellonci, M.D., Scott Benson, M.D., Allan Chrisman, M.D., Tiffany R. Farchione, M.D., John Hamilton, M.D., Helene Keable, M.D., Joan Kinlan, M.D., Ulrich Schoettle, M.D., Matthew Siegel, M.D., and Sandra Stock, M.D. AACAP Staff: Kristin Kroeger Ptakowski and Jennifer Medicus.

AACAP practice parameters are developed by the AACAP Work Group on Quality Issues in accordance with American Medical Association policy. Parameter development is an iterative process between the primary author(s), the WGQI, topic experts, and representatives

**AACAP MEMBERSHIP REVIEW ONLY – NOT FOR DISTRIBUTION**

October 2009 Draft

1 from multiple constituent groups, including the AACAP membership, relevant AACAP  
2 components, the AACAP Assembly of Regional Organizations, and the AACAP Council.  
3 Responsibility for parameter content and review rests with the author(s), the WGQI, the WGQI  
4 Consensus Group, and the AACAP Council.

5         The AACAP develops both patient-oriented and clinician-oriented practice parameters.  
6 Patient-oriented parameters provide recommendations to guide clinicians towards best treatment  
7 practices. Recommendations are based on empirical evidence (when available) and clinical  
8 consensus (when not), and are graded according to the strength of the empirical and clinical  
9 support. Clinician-oriented parameters provide clinicians with the information (stated as  
10 principles) needed to develop practice-based skills. Although empirical evidence may be  
11 available to support certain principles, principles are primarily based on expert opinion derived  
12 from clinical experience. This parameter is a clinician-oriented parameter.

13         The primary intended audience for the AACAP practice parameters is child and  
14 adolescent psychiatrists: however, the information contained therein may also be useful for other  
15 mental health clinicians. The authors wish to acknowledge the following experts for their  
16 contributions to this parameter: Chris Bellonci M.D., Marilyn Benoit M.D., Christine V.  
17 Davidson Ph.D., Ronald H Davidson Ph.D., April Fields M.D., George Fouras M.D., Terry Lee  
18 M.D., Michael Naylor M.D., J Matthew Orr Ph.D., Guy Palmes M.D., Alvin Rosenfeld M.D.,  
19 Alan Rushton Ph.D., Enrico Suardi M.D., Moira Szilagyi M.D. and Jill Welte LCSW.

20         This parameter was reviewed at the Member Forum at the AACAP Annual Meeting in  
21 [month, year].

22         From [month, year] to [month, year], this parameter was reviewed by a Consensus Group  
23 convened by the Work Group on Quality Issues. Consensus Group members and their  
24 constituent groups were as follows: Work Group on Quality Issues [co-chair's name, shepherd's  
25 name, members' names]; Topic Experts [names]; AACAP Components [names and component  
26 affiliations]; AACAP Assembly of Regional Organizations [names]; AACAP Council [names].

27         Disclosures of potential conflicts of interest for authors and Work Group chairs are  
28 provided at the end of the parameter. Disclosures of potential conflicts of interest for all other  
29 individuals named above are provided on the AACAP web site on the Practice Information page.

30         This practice parameter was approved by the AACAP Council on [date].

## AACAP MEMBERSHIP REVIEW ONLY – NOT FOR DISTRIBUTION

October 2009 Draft

1 This practice parameter is available on the Internet ([www.aacap.org](http://www.aacap.org)). Reprint requests to  
2 the AACAP Communications Department, 3615 Wisconsin Ave., NW, Washington, D.C. 20016.

3 © [year] by the American Academy of Child and Adolescent Psychiatry.  
4

### 5 **INTRODUCTION**

6 This parameter provides an introduction to the knowledge and skills that are important to  
7 successful psychiatric evaluation and intervention with children and adolescents who live in  
8 foster care settings. Child and adolescent psychiatrists, and other skilled, knowledgeable  
9 clinicians and professionals, play an important role in the identification, diagnosis and treatment  
10 of developmental, emotional and behavioral problems in this challenging, but ultimately very  
11 rewarding, patient group. Work with this population requires that the psychiatrist utilizes their  
12 full range of professional knowledge, training and expertise in normal child development,  
13 psychopathology and treatment. He or she must understand family and system as well as  
14 individual dynamics and be able to effectively interact with patients, families of origin, foster  
15 parents, child welfare, the education system and the courts. This parameter focuses on those  
16 aspects of evaluation and treatment that are particularly useful in this area of practice.  
17

### 18 **METHODOLOGY**

19 The list of references for this parameter was developed by searches of the MedLine and  
20 Psychological Abstracts, by reviewing the bibliographies of book chapters and review articles,  
21 and by asking colleagues for suggested source materials. The MedLine search conducted in  
22 December 2008 used the following text words: “foster care,” “child welfare,” and “mental  
23 health.” The search covered the period 1996 to 2008 and yielded about 250 articles. Each of  
24 these references was reviewed and only the most relevant were included in this document.  
25

### 26 **DEFINITIONS**

27 Psychiatrists who are evaluating or treating foster children should be familiar with  
28 commonly used terms. These terms are defined broadly as laws and procedures will vary widely  
29 from state to state.

**AACAP MEMBERSHIP REVIEW ONLY – NOT FOR DISTRIBUTION**

October 2009 Draft

- 1       1) **Child Protective Services:** This is an umbrella term used to refer to any state or county  
2       social service agency that accepts/investigates reports of possible child abuse and makes  
3       a disposition based on the findings.
- 4       2) **Foster Care:** A system that is managed by the state or county social service agency. For  
5       the purposes of this parameter, the children and adolescents in foster care refer to youth  
6       who have been made dependents of the juvenile court, and are in out-of-home placement.  
7       In other circumstances the term is also used more generally to refer to any young person,  
8       who is a client of a social services department, particularly those individuals referred to  
9       Child Protective Services.
- 10      3) **Child Welfare Worker (CWW):** This is the person who is ultimately responsible for the  
11      case management of the youth in question. The child welfare worker prepares  
12      documentation for the courts, and represents social services in any juvenile court  
13      proceedings. The worker is also responsible for the coordination of services to the child  
14      and family, including making referrals to appropriate agencies/services, working with the  
15      parents or other stakeholders, and monitoring the youth’s placement.
- 16      4) **Child Care Worker:** Generally used to refer to workers in residential care settings  
17      responsible for day-to-day care of residents, including support for personal needs, 24  
18      hour supervision, transportation to school and other appointments etc.
- 19      5) **Units:** There is considerable variation in the structure of social services departments. In  
20      some states, children and adolescents are assigned to the same CWW throughout their  
21      time in contact with the department. Many departments, however, consist of CWWs  
22      working in various units, with each unit responsible for shepherding the youth and family  
23      through one or several components of the court process. Both Child Protective Services  
24      and Foster Care are examples of such units. Other examples could include: Emergency  
25      Response, Court Dependency, Family Preservation, Adoption, or Long Term Placement.  
26      Unit responsibilities are described below.
- 27              o **Emergency Response Unit:** Investigation of alleged abuse and the filing of a  
28              detention petition (Facts of the Petition), if indicated. Staff from this unit may  
29              visit the youth in the school, at home, or wherever the youth may be located.

## AACAP MEMBERSHIP REVIEW ONLY – NOT FOR DISTRIBUTION

October 2009 Draft

1           Several people may be interviewed before a final decision as to the outcome of  
2           the investigation is made.

- 3           ○ **Court Dependency Unit:** Shepherding of the family through the initial court  
4           process until a disposition is generated. A court plan will be generated indicating  
5           when the child may be re-unified if the youth was placed, and under what  
6           circumstances the case may be dismissed from the dependency court.
- 7           ○ **Foster/Adopt Unit:** Receipt of referrals for placement, often while the parents  
8           are working on reunification requirements. Services provided or contracted  
9           typically involve therapy or counseling or the youth and family. Should the  
10          parental rights be terminated, the youth will have already been prepared for the  
11          possibility of being adopted. Staff from this unit also actively recruit for adoptive  
12          homes or work with outside (private) adoption agencies to finalize placement.
- 13          ○ **Family Preservation Unit:** Maintenance and monitoring of youth who are not  
14          court dependent, and continue to live at home, provision and coordination of  
15          voluntary services to the family.
- 16          ○ **Family Maintenance Unit:** Maintenance and monitoring of youth who are court  
17          dependent but continue to live at home. Assessment of criteria stipulated by court  
18          order prior to a case being dismissed.
- 19          ○ **Family Reunification Unit:** Work with the family of origin of youth in out-of-  
20          home placements to ensure that the family meets criteria stipulated by court order  
21          prior to the youth's return to family of origin and, eventually, the case being  
22          dismissed. Criteria for the family may include parenting classes, adequate  
23          housing, employment, and substance abuse and/or mental health treatment. Youth  
24          may also be involved in therapy and other programs.
- 25          ○ **Long Term Placement Unit:** Work with youth who are no longer eligible for  
26          reunification with the parents/legal guardians and who may not be appropriate for  
27          adoption, generally because of significant behavioral problems, such as sexual  
28          offending, that might place others at risk. Youth may be placed in residential  
29          treatment programs, Independent Living Programs, and, in some cases, adoption  
30          may continue to be pursued.

**AACAP MEMBERSHIP REVIEW ONLY – NOT FOR DISTRIBUTION**

October 2009 Draft

- 1       6) **Levels of Care:** Each state will have developed some form of a “level” system for  
2       providing appropriate care to youth in foster care. The rate of reimbursement received by  
3       the foster parent or agency is tied to the intensity of services provided at each level, with  
4       more intense services being reimbursed at higher daily rates. In general, foster family  
5       care will be reimbursed at a lower rate than group home care because the latter involves a  
6       greater intensity of support. In most cases, the highest level of care will be some form of  
7       secure residential treatment.
- 8       7) **Foster Family Agency (FFA):** This is a non-profit agency that licenses and maintains a  
9       group of foster families for purposes of placement. A youth may be placed by the  
10      county/state CWW with an FFA. An FFA worker will then be designated, who will place  
11      the youth in a foster family, coordinate transportation and appointments between  
12      providers of services, and serve as liaison between the foster family and the county  
13      CWW.
- 14      8) **Kinship Care:** The philosophy that care and placement should preferentially occur with  
15      members of the biological family. As a result, care for children who need to be removed  
16      from their biological parents’ care will go to related extended family members.
- 17      9) **Subsidized Guardianship:** Provides financial support for licensed relative caregivers of  
18      a child who cannot return to their biological parent’s care in the foreseeable future.
- 19      10) **Permanency:** The philosophy that children will thrive in an environment that provides a  
20      sense of permanency and stability, and that policies and practices throughout the court  
21      and foster care system should support that philosophy. Permanent placements include  
22      return to the biological family, adoption and legal guardianship.
- 23      11) **Concurrent Planning:** Simultaneous planning for reunification with biological family  
24      and alternative permanent placement, most often adoption.
- 25      12) **Placement:** This refers to the physical location where a youth is living with a caregiver.  
26      It may be a relative or non-relative foster home, short-term shelter home, group home,  
27      residential treatment facility, or secure residential facility. Placement is occasionally a  
28      hospital setting.
- 29      13) **Treatment (Therapeutic) Foster Care:** Family foster care designed for children with  
30      severe emotional and behavioral problems. Typically, only one child is placed in each

**AACAP MEMBERSHIP REVIEW ONLY – NOT FOR DISTRIBUTION**

October 2009 Draft

1 therapeutic foster family. Additional support, including financial, supervision, and  
2 training is provided.

3 **14) Independent Living Program:** Federally supported programs providing skills training  
4 (education, employment and life skills) to young people over the age of 14 who are in  
5 foster care.

6 **15) Transitional Living Program:** Federally supported programs providing  
7 accommodation, skills training, and other services to homeless youth aged 16-21 years.

8 **16) Interstate Compact for the Placement of Children (ICPC):** A statutory agreement  
9 among all 50 states pertaining to the placement of court dependent children in states other  
10 than the original state of dependency. There is an ICPC coordinator in each jurisdiction  
11 to coordinate care and provide courtesy supervision for the youth. The state or county of  
12 original dependency maintains overall fiscal responsibility for the youth, and is  
13 ultimately responsible for the care of the youth while in out-of-state care.

14 **17) CASA (Court Appointed Special Advocate) Worker:** Volunteer who has received  
15 special training in order to advocate for abused and neglected children so that they can  
16 thrive in safe, permanent homes. They are given certain powers and can speak on the  
17 youth's behalf in front of the court. They cannot sign consent for treatment, but can  
18 function as an educational surrogate if specifically given that function.

19 **18) Guardian ad Litem:** A person appointed by the court to handle the affairs of, act or  
20 speak on behalf of someone involved with the court. Some Guardians are attorneys. Not  
21 all cases will have a Guardian appointed and it is up to the individual bench officer to  
22 decide.

23 **19) Stakeholder:** Any person or entity that has an interest in a youth or a family. This may  
24 include, but is not limited to: social service agencies, a CWW, a CASA worker, lawyers,  
25 teachers, family members, friends of the family, foster parents, medical providers,  
26 therapists, or anyone else involved in the care of the youth.

27  
28 **BACKGROUND AND HISTORY**

29 Foster care is defined, for the purposes of this parameter, as a living situation away from  
30 either biological parent after intervention by child welfare services and the courts, usually

## AACAP MEMBERSHIP REVIEW ONLY – NOT FOR DISTRIBUTION

October 2009 Draft

1 because of abuse or neglect in their families of origin. Approximately half a million American  
2 children and adolescents are living in foster care at any one time and around 800,000 spend time  
3 in foster care each year.<sup>1</sup> Foster care is provided in a wide range of circumstances, from the very  
4 short term care of infants or in an emergency, to long-term placement in a family or in a  
5 residential home with no plan for return home or adoption. It includes treatment foster care for  
6 seriously behaviorally and emotionally disturbed youth, and placements for young people  
7 seeking asylum because of parental abuse, absence, or neglect. Children may exit the foster care  
8 system in a variety of ways. In some cases, this may occur through re-unification with the  
9 parents or legal guardian. Other cases may involve placement with an extended family member,  
10 or perhaps adoption. It is rare that a youth would be emancipated through legal means prior to  
11 reaching the age of majority. Occasionally, a youth may be maintained as a court dependent after  
12 reaching the age of majority up to the age of 21. This most often occurs when the court feels that  
13 maintaining dependency is in the “best interest of the child,” for example, they would graduate  
14 from high school after the age of 18.

15 Local placements and provision for individuals in foster care are also quite variable.  
16 Federal data compiled from state reporting statistics<sup>1</sup> show that, in most places, most youth in  
17 foster care are likely to be living with a family, most commonly an unrelated foster family  
18 (46%). Growing numbers live with relatives in ‘kinship care’ (24%). A minority live in pre-  
19 adoptive families (4%), short-term shelter homes, group homes (9%), hospitals or other  
20 residential group settings. The route to foster care will also vary. Though most (70%) are there as  
21 a result of a referral to child protective services, some are admitted to foster care from the  
22 juvenile justice system.

23 Some children and adolescents survive the turmoil of life in foster care extraordinarily  
24 well, and demonstrate considerable resilience in the face of their adverse experiences. However,  
25 many of these young people experience a combination of genetic risk, adverse prenatal and early  
26 childhood experiences, neglect, abuse and multiple separations, both before and after their  
27 placement in foster care.<sup>2</sup> Exposure to domestic violence, and chaotic, unpredictable care-giving  
28 by parents with mental illness and/or substance abuse are also major stressors.<sup>2</sup> Not surprisingly,  
29 this is a population with particularly high rates of mental health disorders,<sup>3</sup> at risk for adverse  
30 long-term outcomes,<sup>4</sup> including substance abuse, delinquency,<sup>5</sup> teenage pregnancy and

**AACAP MEMBERSHIP REVIEW ONLY – NOT FOR DISTRIBUTION**

October 2009 Draft

1 educational underachievement in adolescence,<sup>6</sup> and homelessness and mental health disorders in  
2 adult life. Given their high prevalence of mental health, developmental, and physical needs, it is  
3 not surprising that children and adolescents in foster care use psychiatric and psychological  
4 services extensively. Indeed, for some children their entry into care actually brings with it the  
5 opportunity for treatment. Some states have found that youth in foster care use mental health  
6 services up to 15 times more frequently than other children in the Medicaid system.<sup>7-9</sup> Up to a  
7 third of youth receive psychotropic medications, including stimulants, antidepressants,  
8 anticonvulsants and antipsychotics.<sup>10</sup>

9         The idea that the state should have some say in the welfare of children is an old one.  
10 Prior to the beginning of the twentieth century, in the U.S., children who could not be cared for  
11 by their biological families lived mostly in orphanages, or were sent in the “orphan trains” from  
12 the crowded cities of the northeast to distant homes in the Midwest where farming families  
13 needed labor. In 1909, the first White House Conference on the Care of Dependent Children  
14 recommended that children be placed instead with selected local foster families.<sup>11</sup> At that time,  
15 there was a shift away from the needs of the families offering foster placements towards an  
16 increasing recognition of the primacy of the needs of the child. This shift has continued, and with  
17 it has come a focus on the threat to child development posed by foster care placement itself, as  
18 well as its potential role in safeguarding and enhancing child development. The child welfare  
19 system has always been a dynamic process, constantly modified by oversight from state  
20 agencies, federal agencies, and by legislation that is drafted at state and federal levels. For that  
21 reason, no uniform national system exists: each state/county will have slightly different systems  
22 of care or child welfare, governed by federal and state law and informed by locally developed  
23 policy and practice. Some of the historically-based tensions that remain, often unrecognized, but  
24 embedded in current policy and practice, are discussed below.

25         Firstly, tensions have always been present between the rights of the state, parents and  
26 caretakers and the protection of children. Historically, children were considered chattel, the  
27 property of their parents (particularly their fathers) and could be rejected or even killed if they  
28 were thought to be out of control. Although parental rights are no longer considered quite so  
29 extensive, the rights that biological parents of foster children ought to have continue to be

**AACAP MEMBERSHIP REVIEW ONLY – NOT FOR DISTRIBUTION**

October 2009 Draft

1 important considerations, both ethically and legally, in working with and making decisions about  
2 foster children’s futures.

3 Debate also continues over whether, and to what extent, the rights of biological parents  
4 should take precedence over the developmental needs of their children. Fifty or more years ago,  
5 the courts essentially did not recognize that a child in the custody of the state had any rights at  
6 all. Over the years there has been a shift, first to the “tender years” concept -- which  
7 acknowledged the developmental needs of young children, and more recently, to considering the  
8 concept of “the best interests of the child.”<sup>12</sup> In practice, considerable variability remains in the  
9 way in which this concept is applied. Parental rights remain centrally important to the ways in  
10 which laws are framed and decisions made around child custody. The United States is one of  
11 only two member countries that have not ratified the United Nations Convention on the Rights of  
12 the Child, which set the “best interest of the child” as a requirement of the state.<sup>13</sup>

13 Cultural competence and sensitivity are essential to clinical practice in this, as in other  
14 arenas. The history of foster care in the U.S. and elsewhere includes examples where the rights  
15 of parents in certain ethnic and racial groups have been inappropriately overridden: such  
16 examples include the treatment of Native American children in the U.S. and the placement of  
17 Australian aboriginal children. Current legislation, the Indian Child Welfare Act (ICWA),  
18 mandates that if possible, all child welfare cases involving Native American children must be  
19 heard by a tribal court.<sup>14</sup> The Act also sets specific guidelines for the placement of Native  
20 American children into foster care in order to preserve the child’s cultural identity.

21 Tensions also exist between federal and state legislation. National standards for services  
22 in the U.S. date back only to the 1930s when federal grants to states for child welfare services  
23 were first authorized under the Social Security act of 1935.<sup>15</sup> More than forty years later, the  
24 Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272) created the Title IV-E  
25 program that established court review of the status of a foster child at least every six months,  
26 stipulated that the child be placed in the least restrictive setting, that “reasonable efforts” be  
27 made to reunify the youth with their parent(s) or legal guardian, and that a plan for permanent  
28 placement be established within 18 months of entry into foster care.<sup>16</sup> The act also provided  
29 financial assistance for adoptive parents. In 1997 the Adoption and Safe Families Act (PL 105-

## AACAP MEMBERSHIP REVIEW ONLY – NOT FOR DISTRIBUTION

October 2009 Draft

1 89) modified the Title IV-E program to include financial incentives to states for completed  
2 adoptions.<sup>17</sup> It specified that the case plan include “concurrent planning.”

3 While funding for foster care comes from national and local sources, each system is  
4 managed locally by the state or county social service agency charged with providing care and  
5 custody of the youth. Potential foster parents are assessed and, if accepted, trained either directly  
6 by their local social services department or by a non-profit Foster Family Agency, which  
7 maintains and licenses a group of foster families for placement. Foster parents are expected to  
8 continue training on an annual basis. Reimbursement rates are set locally for foster families and  
9 for other placing agencies using a “levels of care” system, whereby the rate is tied to the  
10 intensity of services provided. Despite the fact that reimbursement generally covers expenses  
11 only, the perception that foster parents are ‘in it for the money’ persists and may carry over from  
12 the early years of foster care when most foster families lived on farms, and foster children,  
13 especially older children, did indeed generate income.<sup>18</sup> In fact, most foster parents are motivated  
14 largely by altruism and the wish to help needy children.<sup>19</sup>

15

### 16 **PRINCIPLES**

17 **Principle 1. *Psychiatrists should be aware of a referred child’s current legal status, including***  
18 ***who has the authority to give consent for evaluation and treatment.***

19 Every child and adolescent in foster care has some representative of the state’s Child  
20 Protective Services (generally called a Child Welfare Worker [CWW]) responsible for managing  
21 their case. Each specific legal status (e.g. detained but not a court dependent, court dependent,  
22 ward of the court, legal guardianship, shared social services/juvenile justice custody, etc.) has  
23 different implications for consent, release of information and treatment. Psychiatrists should be  
24 aware that the individual with the physical custody of the child may not be in a position to  
25 provide consent, because the child’s legal custody may rest with the Department of Social  
26 Services, or the biological parent. Questions about a child’s legal status, as well as requests for  
27 informed consent, release of information and coordination of treatment should be directed to the  
28 CWW. Psychiatrists should be aware that the child’s biological parents may retain certain rights  
29 and that, in some circumstances, their consent to evaluation and/or treatment may be required.

**AACAP MEMBERSHIP REVIEW ONLY – NOT FOR DISTRIBUTION**

October 2009 Draft

1           Laws about consent to psychiatric treatment are state specific and vary between  
2 jurisdictions. Issues that may arise around consent should be addressed prior to the first  
3 appointment. The child and adolescent psychiatrist should find out which individual or what  
4 component of the system has legal authority to give permission to evaluate, treat, or perform any  
5 procedures on this particular child. In some jurisdictions, prescribed medications can only be  
6 administered with court authorization. Courts are also likely to be involved when psychiatric  
7 treatment recommendations include more restrictive environments, such as residential  
8 placement. The legal situation is even more complicated when the child has been placed in an  
9 out-of-state foster home as part of the Interstate Compact for the Placement of Children (ICPC.)  
10 Those children are subject to the jurisdiction and legal requirements of the state in which they  
11 resided when Child Protective Services became involved and in which the original petition was  
12 drawn up. The ICPC coordinator in each jurisdiction is responsible for coordination of care and  
13 courtesy supervision. When legal decision making is in the hands of an official in another state,  
14 the psychiatrist may have to comply with out of state policy with which he or she is unfamiliar.

15

16 ***Principle 2. Psychiatrists who expect to be reimbursed for their services should investigate the***  
17 ***funding stream for a foster child’s psychiatric and medical care prior to accepting the referral.***

18           This is an area in which local practice is likely to be quite variable. In some jurisdictions,  
19 all medical care for young people in foster care is billed to Medicaid. Local legislation and  
20 policy may establish carve-outs, procedures for billing and specific fees. Other sources of  
21 payment may sometimes be available, including grant funding and special payment mechanisms.  
22 In many states, only face-to-face contact is reimbursable. Because treating children in foster care  
23 is likely to be very time-consuming necessitating numerous collateral contacts, attendance at  
24 meetings and court appearances, psychiatrists in private practice should be aware of local  
25 legislation and custom concerning how such services are reimbursed. Some psychiatrists  
26 establish their own policies and determine the structure of fees for attending the collateral care  
27 and legal meetings. Others choose to consider this work, which is often not readily reimbursable,  
28 as either pro-bono or simply part of the services they provide for working with this population.

29

**AACAP MEMBERSHIP REVIEW ONLY – NOT FOR DISTRIBUTION**

October 2009 Draft

1 **Principle 3. *Prior to accepting a referral, the psychiatrist should establish the circumstances***  
2 ***and goals of the referral.***

3 Referrals for youth in foster care may come from any of the multiple individuals involved  
4 in that child's life. A psychiatrist accepting a referral needs to be clear about the relationship of  
5 the referrer to the referred individual, and whether the referrer has the legal right to make the  
6 referral. If the psychiatrist is in doubt, he or she should make contact made with the CWW  
7 responsible for the case to clarify the situation. It is also often helpful to spend some time  
8 clarifying the reason for a referral to psychiatry and why it is being made at this particular time.  
9 Psychiatrists should be aware that the goals of the foster care system are not necessarily identical  
10 to the goals of mental health treatment, though the two sets of goals are likely to be  
11 complementary. The goals of the foster care system for a particular child are likely to be around  
12 issues such as placement stability, permanency planning and the development of functional skills  
13 necessary for independent living in the community. Some referrals are crisis-based and require  
14 only short-term involvement. Some ask specific questions, such as advice on placement or the  
15 possibility of a child's reunification with their biological parents. In other situations, evaluations  
16 may be complex and time-consuming, and subsequent psychiatric treatment may last for a long  
17 time.

18 Besides helping focus the issues to be addressed during the initial evaluation, a  
19 conversation prior to the initial patient evaluation may also be an opportunity to help the  
20 referring individual(s) clarify their own thinking. Time spent gaining clarity about the nature of  
21 the request and the goals of the referrer in obtaining psychiatric input will help to focus the  
22 evaluation. At times, it may become apparent that the referral is being made because the referrer  
23 is seeking support for a decision they already have sufficient information to make by themselves,  
24 but for which they may be seeking additional professional support. A conversation at the point of  
25 referral may also assist the psychiatrist in deciding whether they can be helpful to the referrer in  
26 relation to the specific issues that arise around a particular case. It is also a good opportunity for  
27 the physician to educate the referrer on the role of a psychiatrist and to clarify boundaries and  
28 expectations. It may even be an opportunity for the psychiatrist to provide education around  
29 normal child development and expected reactions to trauma and separation.

30

**AACAP MEMBERSHIP REVIEW ONLY – NOT FOR DISTRIBUTION**

October 2009 Draft

1 **Principle 4. *Psychiatrists should request, and attempt to obtain, relevant documents and***  
2 ***historical information, and consider thoughtfully how best to proceed with evaluation and***  
3 ***treatment when limited information is available.***

4         Psychiatrists should attempt to obtain, when available, copies of relevant documentation.  
5 Besides the facts of the petition, the psychiatrist should request copies of psychological  
6 evaluations, psycho-social assessments, Individual Education Plans (IEPs), and recent court  
7 reports. The American Academy of Pediatrics guidelines for assessing children and adolescents  
8 in foster care state that in most cases, foster children will have a pediatric appointment before or  
9 shortly after placement to identify issues that may be of immediate concern.<sup>20</sup> It should include a  
10 comprehensive pediatric assessment, addressing physical, behavioral, emotional and cognitive  
11 function, and should be completed within 30 days of the child's placement. Some children and  
12 adolescents may also have been taken for emergency room visits at the time of placement; copies  
13 of these pediatric assessments should also be obtained. For many children and adolescents in  
14 foster care, however, appropriate documentation is simply not available and large gaps in history  
15 may be evident.

16         It is common for interviews with informants to provide limited historical information as  
17 well as limited information about present functioning. Young people sometimes arrive for  
18 evaluation accompanied only by patient transportation staff. In order to avoid such a situation in  
19 the clinic setting, the psychiatrist is well advised to ask specifically that someone familiar with  
20 the case accompany the youth to the evaluation. In emergency room assessments, essential  
21 information may need to be obtained through telephone calls to on-call administrators and  
22 supervisors. Occasionally, foster families, especially when a child has recently been moved to  
23 their home, may not have been notified of an appointment arranged and facilitated by the CWW.  
24 Group homes are notorious for high staff turnover rates. Even when they are able and willing to  
25 attend appointments, the child or adolescent's current caregivers (foster parents, group home  
26 workers, or CWWs) may know surprisingly little about the youth or about the reason for the  
27 mental health referral.

28         The assessment of youth in foster care often entails spending time making collateral  
29 contacts to get necessary information not available from the CWW at the time of initial referral.  
30 Psychiatrists should be prepared to obtain releases of information and to actively contact schools

1 and other professionals and families involved in a child’s life to gather information and  
2 coordinate care.

3

4 **Principle 5. *Psychiatrists should obtain the history of the child or adolescent’s involvement in***  
5 ***the foster care system.***

6 An important and unique component in the evaluation of children and adolescents in  
7 foster care is the history of their involvement with the foster care system. The history obtained  
8 from informants should include the specific circumstances surrounding their entry into care, the  
9 nature of each placement and the reasons for their transition from one placement to another.  
10 These facts are usually obtained from the CWW with input from other informants, including  
11 biological and foster parents when available. In addition, the psychiatrist should clarify the long  
12 term plan for the child’s future (reunification, adoption, or long-term placement in foster care)  
13 and be aware that the plan may change as the child’s circumstances change. In addition to the  
14 facts of their history, the psychiatrist should also obtain the child’s personal recollection and  
15 perception of their involvement with foster care. Psychiatrists should be prepared to hear an  
16 account from a child that may differ significantly from the account provided by their CWW or  
17 their documentation, as well as plans for the future embellished by fantasy or magical thinking.  
18 Children may also mention many deep disappointments and losses.

19

20 **Principle 6. *Psychiatrists should consider how biological and foster family members should be***  
21 ***involved in assessment and treatment.***

22 The sometimes delicate task of when, whether and how to involve family members, both  
23 biological and foster, in assessment and treatment, needs to be given careful thought. In general,  
24 as in work with children and adolescents in other living situations, engaging both the biological  
25 family and the people with whom a child resides is crucial to both evaluation and treatment  
26 planning. Past events, including safety issues, present circumstances, such as incarceration or  
27 physical or mental health issues, and plans for the future, such as reunification or termination of  
28 parental rights, may dictate the extent to which biological parents and other birth family  
29 members are involved. Although it is generally advisable to involve the current foster family in  
30 an evaluation, few jurisdictions will provide alternative care for other children in the foster

1 family home in order to allow a foster parent to attend psychiatric appointments and proactive  
2 arrangements may need to be made. The circumstances of a child’s placement and the particular  
3 plan for permanence may also play a part in the decision about the extent to which a foster  
4 family should be engaged. A short-term, crisis family may be unwilling or feel unable to  
5 contribute even to an initial evaluation, whilst a long-term foster or pre-adoptive family may  
6 want to be closely involved and participate throughout long-term treatment. Involvement of the  
7 foster family even at initial emergency placement may have some benefit for the child, in that it  
8 may highlight for the foster family their responsibility for the care and protection of the child and  
9 encourage them to remain vigilant. It may also be an opportunity to provide education for them  
10 around normal development, mental health issues and the kinds of information that psychiatrists  
11 might be interested in obtaining.

12

13 ***Principle 7. Psychiatrists should be aware of common issues affecting the evaluation and***  
14 ***treatment of youth in foster care.***

15 Psychiatrists should be aware that the transition from home to foster care and between  
16 foster care placements may be quite traumatic for some children. The child’s immediate reaction  
17 may make it difficult to tell – in the initial assessment – whether symptoms are reactive or signs  
18 of a long-standing psychiatric disorder. Any individual child’s or adolescent’s reactions to  
19 placement will depend on numerous factors, including the circumstances of the removal, the age  
20 and development of the child and pre-existing psychiatric disorders. Evaluators should keep in  
21 mind the typical manifestations of grief in children and adolescents, as well as normal  
22 developmental reactions to separation from attachment figures. Frequently, opportunities exist  
23 for the professional to provide education for carers around the normal and/or expected reactions  
24 of children to trauma and separation. It is not uncommon for children in placement to express a  
25 strong desire to return to their previous placement, including the home from which they were  
26 originally removed because of abuse or neglect allegations. Some children and adolescents may  
27 run from their placement and attempt to return to their family of origin, even when that family  
28 continues in chaos.

29 Psychiatrists should also be aware that unpredictability in placement and high worker  
30 turnover is the rule, not the exception, and be prepared to work with a series of foster families

## AACAP MEMBERSHIP REVIEW ONLY – NOT FOR DISTRIBUTION

October 2009 Draft

1 and CWWs if treatment for a particular child is prolonged. For some individuals, placements  
2 may fail rapidly and often. Normal developmental changes, such as the tendency for older  
3 infants (i.e. 12 to 24 months) to behave in avoidant or resistant ways when distressed may  
4 challenge foster parent commitment.<sup>21</sup> Children with behavioral problems are particularly at risk  
5 for placement breakdown; placement disruption itself increases the risk of problem behaviors,  
6 including for those children whose behavior was initially within normal limits.<sup>22</sup>

7 Most foster care placements are defined as short-term. Depending on the jurisdiction, a  
8 particular placement in a family or residential setting can be terminated at very short notice  
9 (days). Even when strong, longstanding attachments exist between youth in foster care and those  
10 with whom they reside, the care of a child in foster care reverts to social services should a crisis  
11 arise in a particular foster family. As a result, a child with long established relationships in one  
12 family may be moved with little notice or preparation to a completely strange setting, family,  
13 school and neighborhood. The focus of treatment may need to shift towards more practical issues  
14 and support for a child. It may sometimes be important to increase the intensity of treatment to  
15 help a child through a difficult transition. The relationship with a familiar therapist may be very  
16 reassuring for a child or adolescent struggling to cope with profound uncertainty in a totally new  
17 environment.

18 The psychiatrist's role will vary considerably from case to case and through the course of  
19 treatment if involved long-term with a particular child. Tasks may include diagnostic  
20 clarification and treatment advice for the referrer or other professionals involved, clarification  
21 for the child about their real life situation, education for a CWW on the child's developmental  
22 level, negotiation between the child and caretakers/agency workers, the provision of medical or  
23 psychiatric intervention or referral for such intervention, recommendations to those with custody  
24 of the child, and/or advocacy for a child's point of view. In many cases, referrals will need to be  
25 made for collaborative care. Psychiatrists should be knowledgeable about the approaches likely  
26 to be taken by colleagues before they make referrals.

27 In some circumstances, work on relationships between the families and professionals  
28 involved in the child's life, as well as on problem-solving using behavioral and cognitive frames  
29 of reference will be important. When uncertainty about the permanency plan exists, or there is  
30 conflict and dissension between foster and birth parents, work on relationships may be very

**AACAP MEMBERSHIP REVIEW ONLY – NOT FOR DISTRIBUTION**

October 2009 Draft

1 challenging or even impossible and the mental health setting may instead provide a place for the  
2 child to work on self-concept and self-efficacy. Many children and adolescents in foster care  
3 need a forum to explore their early trauma experiences, and their families and other carers need  
4 an environment where they can learn how to understand behavior in terms of those traumas. A  
5 psychodynamically informed formulation may directly translate into treatment. However, even if  
6 it does not, the identification of issues surrounding attachment and loss (for example),  
7 identification with the aggressor, reaction formation, and compulsive repetition of traumatic  
8 experiences, may be very helpful in understanding a child's presentation and guide decision-  
9 making and the provision of support services.<sup>23</sup> The circumstances surrounding a case (abuse,  
10 neglect, disrupted attachments) give rise to strong emotions and differences of opinion, and  
11 professionals should be conscious of their own transference and countertransference issues.

12 Children and adolescents in foster care interact with more than one family system and  
13 with a wide range of professionals. As a result, physicians working with children and adolescents  
14 in foster care should expect to engage over time with more than one nuclear family and with a  
15 system of care. Time may need to be spent within or between appointments identifying changes  
16 in caretakers, placements and case workers, and establishing contact and, where necessary,  
17 working relationships with a range of different professionals and family members. Additional  
18 phone contact, face-to-face meetings and attendance at case conferences may be required for  
19 optimal treatment to take place. Because children in foster care have so many individuals  
20 professionally and personally involved in making decisions about them, physicians involved in  
21 their care are likely to have to need to explain treatment to multiple individuals before reaching  
22 consensus about a course of action. Questions about, or challenges to, a physician's  
23 recommendations may arise from unexpected quarters. Adequate treatment may also be delayed  
24 as the deliberative process occurs, and until a final decision is reached.

25 Working with the foster care system can be particularly frustrating because a serious  
26 discrepancy often exists between the child's perception of time and need for certainty about their  
27 future and the court system's measured pace. Moreover, professionals may move towards  
28 permanence planning (termination of parental rights and adoption) whilst birth family members  
29 remain benign, alive and active in a child's mind, despite the fact that in reality their  
30 involvement faded away long ago. It is important for mental health practitioners to understand

## AACAP MEMBERSHIP REVIEW ONLY – NOT FOR DISTRIBUTION

October 2009 Draft

1 what the permanency plan is at any particular point in time, and to be aware that the plan may  
2 change because of circumstances beyond the control of anyone involved, least of all the child. It  
3 is not unusual for treating physicians working with children and adolescents in foster care to  
4 become frustrated by unpredictable placement changes and delays in decision-making, including  
5 the provision of treatment. Psychiatrists who elect to work with youth in foster care must be  
6 willing to accept that many decisions that may affect an individual patient's mental health are  
7 out of their control. On the other hand, this area of practice does provide opportunities for child  
8 and adolescent psychiatrists to advocate for a child's best interests, as well as to work as part of a  
9 team with social services personnel, planning both for individual children and, at times, for  
10 programs. The assistance of child and adolescent psychiatrists can help in the development of  
11 protocols around, for example, initial placement or transition from residential care to a foster  
12 family that can be transformative for individual children and even for entire systems of care.

13 The content of feedback and written reports to CWWs should be thoughtfully considered  
14 if it is to add value to the understanding of the child's situation and inform the work and  
15 decision-making of other professionals involved. It may be particularly helpful to give specific  
16 advice and recommendations that can be implemented in the child's foster home or by child care  
17 workers in a residential setting. Child psychiatrists who work in residential settings have the  
18 opportunity to improve care by participating as a regular and active member of the unit treatment  
19 team and by mentoring the child care workers by, for example, creating opportunities to talk  
20 with them about each child's problems, helping them implement practical strategies for working  
21 with their cases, and explaining the reasons for using medication and the potential side effects.

22 Professionals involved in treatment relationships with children and adolescents in foster  
23 care may also be asked to provide reports or opinions for legal proceedings or to act as expert  
24 witnesses. Psychiatrists should be aware of the professional conflicts between therapeutic and  
25 forensic roles that may arise around such requests and follow AACAP Practice Parameter  
26 guidelines in their relationships to the courts.<sup>24,25</sup>

27 It is particularly important that clinicians working with children and adolescents in foster  
28 care take a long-term, continuous, developmental approach to assessment and treatment, taking  
29 into account the child's past and thinking beyond their childhood and adolescence to adult  
30 adjustment. Most children reared for extensive periods in foster care are able to overcome their

## AACAP MEMBERSHIP REVIEW ONLY – NOT FOR DISTRIBUTION

October 2009 Draft

1 childhood adversities and function well as adults, particularly where support is available.<sup>26</sup>  
2 However, foster care and the adverse experiences that often accompany it, do bring increased  
3 risk for problems in a number of areas in adult life, including homelessness,<sup>27</sup> problems in social  
4 integration<sup>26</sup> and lawbreaking,<sup>5</sup> alcoholism and substance abuse,<sup>28</sup> and depression and suicidal  
5 ideation.<sup>29</sup> Foster care also increases the risk of poorer outcomes for adult individuals with  
6 schizophrenia.<sup>30</sup> If at all possible, psychiatrists accepting referrals should be prepared to engage  
7 in or facilitate ongoing treatment for their patients. This may entail contacting inpatient  
8 physicians if a youth is hospitalized, providing an emergency prescription for a youth whose  
9 placement has changed and medications lost, or providing history and treatment plans to a  
10 supervising CWW or a new physician who takes over the psychiatric care if a youth moves. The  
11 primary care physician, often a pediatrician, may be the only resource available to a young  
12 person in transition between placements, and may take over the management of their care,  
13 including the prescription of psychotropic medications, for at least brief periods of time. Most  
14 pediatricians do not have the level of training needed to evaluate and treat complex psychiatric  
15 disorders, nor much experience in prescribing many of the medications commonly used in  
16 psychiatric practice. The psychiatrist can be very helpful in letting a child's primary care  
17 provider know the mental health diagnoses, and plan of treatment, including medications, their  
18 expected effects and side effects. It is also important for psychiatrists to contact the primary care  
19 physician after a psychiatric emergency room visit or an inpatient hospitalization. Psychiatrists  
20 working in hospitals that admit children and adolescents who are in foster care should consider  
21 ways in which they can communicate with the physician and ensure continuity of care into the  
22 outpatient setting. Finally, child psychiatrists may be called upon to coordinate care of the youth  
23 into adult psychiatric services and work with adult systems of care should the youth reach the  
24 age of majority and dependency is dismissed.

25

26 **Principle 8. *High standards of record keeping should be maintained with due attention to***  
27 ***confidentiality.***

28 Psychiatrists should pay particular attention to record keeping and be aware of the  
29 dilemma that may arise between the need for detailed records and the sometimes compromised  
30 confidentiality issues that may arise for youth in foster care. On the one hand, foster placements

**AACAP MEMBERSHIP REVIEW ONLY – NOT FOR DISTRIBUTION**

October 2009 Draft

1 change so frequently that the continuity of a child’s treatment may rely heavily on the accuracy  
2 of records passed from one psychiatrist to another. On the other hand, psychiatrists should be  
3 aware that copies of medical records provided to CWWs, group home staff, foster parents and  
4 others are the property of social services departments and may be accessed by many different  
5 individuals. In most states, when active investigations of abuse and neglect are underway, all  
6 records may be subject to disclosure. Psychiatrists should be aware that records may become part  
7 of court proceedings, including the prosecution of an abusing or neglectful parent, without the  
8 knowledge or consent of either patient or physician. For that reason, in some situations,  
9 psychiatrists may choose to record only minimal essential medical information.

10         Suspicions of abuse and neglect concerning biological or foster family members or other  
11 individuals may arise in the course of evaluation or treatment. Professionals who work with  
12 youth in foster care must remember that, even though a child may already be in foster care, any  
13 new suspicion of abuse or neglect must still be reported following local reporting guidelines.  
14 Ethical dilemmas around confidentiality may also arise when a child or adolescent reports being  
15 involved in delinquent and/or criminal behavior, including sexual activity and substance use.

16

17 **Principle 9. *Psychiatrists should be familiar with common clinical presentations in children***  
18 ***and youth in foster care.***

19         Studies using a variety of methods of population ascertainment and assessment have  
20 repeatedly demonstrated that children and adolescents in foster care have significantly higher  
21 rates of mental health disorders than the general population.<sup>10,31,32</sup> Comparably high rates of  
22 disorders are only found in children living in homes who are well known to child welfare.<sup>33</sup> By  
23 the time children in foster care reach school age, easily one half of them have manifest emotional  
24 and/or behavioral problems, particularly disruptive behavioral disorders, other anxiety disorders,  
25 including acute and post traumatic stress disorders, and depression.<sup>10</sup> Furthermore, as many as  
26 one third are diagnosed with three or more mental health problems.<sup>10</sup> Many also have school  
27 related problems, including learning disabilities and reading delay. Policies that have reduced the  
28 number of children in foster care and emphasized placement in the least restrictive environments  
29 have resulted in a concentration of youth (mostly adolescents) with serious psychiatric disorders  
30 in residential placements.

## AACAP MEMBERSHIP REVIEW ONLY – NOT FOR DISTRIBUTION

October 2009 Draft

1           Very young children in foster care are of particular concern. Those five and under make  
2 up one third of children in contact with child welfare.<sup>1</sup> In some studies, as many as one third of  
3 this group experience developmental delays<sup>33,34</sup> and up to 40% significant behavioral  
4 problems.<sup>35-37</sup> Given that they need to be removed from their biological parents' homes, it is not  
5 surprising that the consequences of significant disturbance in the parent-child relationship are of  
6 particular concern.<sup>38</sup> The longer term outcomes of these disturbances in attachment may manifest  
7 in the high rates of reactive attachment disorder seen in school age children in foster care.<sup>39</sup> Low  
8 self esteem and sexualized behaviors are also seen in this age group.

9           The most common problems of grade school aged children in foster care are externalizing  
10 disorders, including aggression and self destructive behavior.<sup>40</sup> Common diagnoses are attention-  
11 deficit/hyperactivity, oppositional defiant, conduct and bipolar disorders. Pre-adolescent children  
12 in foster care are also at risk for unipolar depression and anxiety disorders, including  
13 posttraumatic stress disorders. Adolescence poses a particular challenge for at least a significant  
14 minority of those in foster care. High rates of depression, suicidality, anxiety, mood disorders,  
15 conduct problems and substance abuse disorders have been repeatedly identified.<sup>32</sup> The path to  
16 independence may be particularly problematic, and adults with a history of having been in foster  
17 care have high rates of homelessness and mental health problems, including suicide attempts,  
18 depression and psychoses.<sup>41</sup>

19           Predictably, foster children with behavioral problems are more likely to be seen in  
20 psychiatric settings than those without.<sup>42,43</sup> However, data also show that other factors, such as  
21 age, male gender, non relative placement,<sup>43</sup> and type of abuse<sup>42,43</sup> independently affect whether  
22 children are likely to receive services.<sup>42</sup> Some evidence suggests that African-American and  
23 Hispanic children – even those displaying more pathology - are less likely to receive services,  
24 including medication management.<sup>44</sup> In contrast, concern has been raised by some about the  
25 possibility of psychotropic medications being over-utilized in this group of patients.<sup>45</sup>

### 26 27 **Principle 10. Psychiatrists should be knowledgeable about evidence based treatment** 28 ***interventions that have been shown to be successful in this population***

29           Psychiatrists should follow professional practice and guidelines for the assessment and  
30 treatment of identified psychiatric disorders in children and adolescents in foster care, as well as

**AACAP MEMBERSHIP REVIEW ONLY – NOT FOR DISTRIBUTION**

October 2009 Draft

1 in working with their families and the agencies that care for them. They should be aware of state  
2 guidelines, especially for the use of medications, because a growing number of states (for  
3 example, Texas and Illinois) have developed parameters for the use of psychotropic medications  
4 in children and adolescents in state custody. The American Academy of Child and Adolescent  
5 Psychiatry has a position statement on the use of psychotropic medications in children and  
6 adolescents in foster care, which includes recommendations on consent to treatment and the  
7 availability of educational materials, as well as oversight and consultation for professionals.<sup>46</sup>

8         Studies have examined the efficacy of some treatment approaches for this group of  
9 patients, as well as the effects of enhanced foster care as a whole on child development and child  
10 outcomes. Psychiatrists may be asked to participate in comprehensive treatment programs  
11 targeting youth in foster care. The literature includes descriptions of such programs and evidence  
12 of their benefit. Multidimensional treatment foster care (MTFC) for adolescents includes highly  
13 supervised, individualized foster placements, individual and family therapy and educational and  
14 psychiatric interventions.<sup>47</sup> It has been shown to reduce delinquency, reduce teen pregnancy  
15 rates, and enhance educational outcomes among female juvenile offenders.<sup>48</sup> Early Intervention  
16 Foster Care (EIFC) utilizes similar principles to MTFC in work with younger children. EIFC  
17 increases the likelihood of stable placement for preschool children in foster care, even when  
18 previous placements have been unsuccessful.<sup>49,50</sup> The parallel planning intervention described by  
19 Zeanah et al.<sup>38</sup> has also been shown to reduce foster placement disruption. All of these programs  
20 included psychiatric evaluation, treatment and medication management alongside a variety of  
21 other interventions, including family and individual therapy, support and supervision for foster  
22 parents, and school and emergency interventions where appropriate. A recent Cochrane  
23 DataBase Review examining the outcomes of Treatment Foster Care found it to be a useful  
24 intervention.<sup>51</sup> Outcomes included decreased time in secure settings, fewer runaways, more time  
25 in treatment and better educational and employment outcomes. Similar reviews of the effects of  
26 cognitive behavioral therapy and parent child intervention are less definitive in their outcomes,  
27 but these remain promising interventions. Programs targeting foster parent behavior with the  
28 secondary goal of enhancing child development have been less successful, but show some  
29 benefit for parents and children.<sup>52</sup> Recent work utilizing a parent child relational intervention

**AACAP MEMBERSHIP REVIEW ONLY – NOT FOR DISTRIBUTION**

October 2009 Draft

1 shows impact on the modulation of stress hormones in young children and toddlers in foster  
2 care.<sup>53</sup>

3  
4 **Principle 11. *Physicians working regularly with youth in foster care should thoughtfully***  
5 ***consider their potential role as advocates either for their individual patients or for this group***  
6 ***of patients as a whole.***

7         Psychiatrists working with youth in foster care will develop relationships with case  
8 workers, as well as birth families and foster parents in the course of treatment. Good working  
9 relationships with individual CWWs, supervisory staff from group homes and foster and birth  
10 families are likely to be of considerable benefit to the patient, and facilitate decision-making and  
11 treatment planning. Some agencies and families develop particular expertise and comfort in  
12 working with children and adolescents with psychiatric disorders; with them the relationships  
13 may transcend the treatment of an individual child. Agencies may wish to hire psychiatrists and  
14 other mental health professionals to provide direct services or develop consultative relationships  
15 to assist the agency in policy development, training or practice. New legislation passed,  
16 Fostering Connections to Success and Increasing Adoptions Act, includes a provision requiring  
17 states to develop health systems to coordinate care for children in foster care and improve their  
18 health outcomes.<sup>54</sup> It will take a while for this to find its way into state legislation and regulation  
19 and into practice, but this law gives a unique opportunity to work with child welfare to ensure  
20 that health standards are incorporated into policy along with health care management.

21         Those psychiatrists who choose to work extensively in this area of practice may find it  
22 helpful to spend time understanding the organizational structure of the local Department of  
23 Social Services and getting to know personnel involved in policy and decision making. Local  
24 organizations are quite variable and often quite complicated. Departments of Social Services are  
25 organized by county within most states. Most counties, except for those with very small  
26 populations, will have a separate Child Division, with a Director or the equivalent, which  
27 includes those individuals and units responsible for foster care. A few agencies utilize one CWW  
28 to follow a youth through the entire system. Most agencies are, however, organized by units,  
29 with each unit taking responsibility for a different phase of a child/family's contact with agency.  
30 Psychiatrists may also wish to develop professional relationships with the local Director as well  
31 with other key individuals with supervisory and policy making authority, including guardians ad

1 litem and juvenile court judges.

2       Some child psychiatrists choose to develop their relationships with other organizations  
3 beyond the treatment of an individual child and move into advisory or advocacy roles alongside  
4 or even within foster care agencies. University-based child psychiatrists, in particular, may have  
5 the opportunity to contribute at the program development, training and service delivery policy  
6 level. Recent research provides convincing support for increased investment in higher quality  
7 foster care.<sup>4</sup> Child psychiatrists interested in advocacy roles for this group of children can point  
8 to the importance of simple enhancements in care, such as lower caseloads, high levels of  
9 education and salary for caseworkers, and summer camps, mental health counseling and tutoring  
10 for youth, in the prevention of mental disorders. In addition, there is the small, but growing,  
11 body of research evidence for particular forms of interventions described above, which can help  
12 in the establishment of programs that may benefit large numbers of children and adolescents in  
13 foster care.

14

15 **PARAMETER LIMITATIONS**

16       AACAP practice parameters are developed to assist clinicians in psychiatric decision-  
17 making. These parameters are not intended to define the standard of care; nor should they be  
18 deemed inclusive of all proper methods of care or exclusive of other methods of care directed at  
19 obtaining the desired results. The ultimate judgment regarding the care of a particular patient  
20 must be made by the clinician in light of all the circumstances presented by the patient and  
21 his/her family, the diagnostic and treatment options available, and available resources.

---

22

## AACAP MEMBERSHIP REVIEW ONLY – NOT FOR DISTRIBUTION

October 2009 Draft

### 1 REFERENCES

- 2
- 3 1. AFCARS (US Dept of Health and Human Services June 2006)  
4 [http://www.acf.hhs.gov/programs/cb/stats\\_research/afcars/tar/report14.htm](http://www.acf.hhs.gov/programs/cb/stats_research/afcars/tar/report14.htm) (accessed  
5 August 5, 2008)
- 6 2. Chernoff R, Combs-Orme T, Risley-Curtiss C, Heisler A (1994), Assessing the health  
7 status of children entering foster care. *Pediatrics* 93:594-601.
- 8 3. Burns BJ, Phillips SD, Wagner HR, Barth RP, Kolko DJ, Campbell Y, Landsverk J  
9 (2004), Mental health need and access to mental health services by youths involved with  
10 child welfare: a national survey. *J Am Acad Child Adolesc Psychiatr* 43:960-70.
- 11 4. Kessler RC, Pecora PJ, Williams J, Hiripi E, O'Brien K, English D, White J, Zerbe R,  
12 Downs AC, Plotnick R, Hwang I, Sampson NA (2008), Effects of enhanced foster care  
13 on the long term physical and mental health of foster care alumni. *Arch Gen Psych*.  
14 65:625-633.
- 15 5. Stewart A, Livingston M, Dennison S (2008), Transitions and turning points: examining  
16 the links between child maltreatment and juvenile offending. *Child Abuse Negl* ;32:51-  
17 66
- 18 6. Lee MY, Jonson-Reid M (2009), Needs and outcomes for low income youth in special  
19 education: Variations by emotional disturbance diagnosis and child welfare contact.  
20 *Child Youth Serv Rev*. 1:31:722-731
- 21 7. Halfon N, Berkowitz G, Klee L (1992), Mental health service utilization by children in  
22 foster care in California. *Pediatrics* 89(Pt2):1238-1244.
- 23 8. Takayama JI, Bergman AB, Connell FA (1994), Children in foster care in the state of  
24 Washington. Health care utilization and expenditures. *JAMA* 271:1850-5
- 25 9. Report of the Surgeon General's Conference on Children's Mental Health: A National  
26 Action Agenda. U.S. Public Health Service, Washington, DC: Department of Health and  
27 Human Services, 2000.
- 28 10. dosReis S, Zito JM, Safer DJ, Soeken KL (2001), Mental health services for youths in  
29 foster care and disabled youths. *Am J Public Health* 91:1094-1099.
- 30 11. First White House Conference on the Care of Dependent Children.  
31 <http://www.libertynet.org/edcivic/whoukids.html>. Accessed September 24, 2009.
- 32 12. Goldstein, J. The Best Interests of the Child: the Least Detrimental Alternative. 1996:The  
33 Free Press, Simon and Schuster, New York.
- 34 13. United Nations Convention on the Rights of the Child. Adopted by the UN General  
35 Assembly resolution 44/25 of 20 November 1989  
36 <http://www.unhchr.ch/html/menu3/b/k2crc.htm> Accessed August 5, 2008
- 37 14. Indian Child Welfare Act  
38 [http://www.mass.gov/?pageID=eohhs2terminal&L=4&L0=Home&L1=Consumer&L2=Family+Services&L3=Foster+Care&sid=Eeohhs2&b=terminalcontent&f=dss\\_c\\_icwa&csid=Eeohhs2](http://www.mass.gov/?pageID=eohhs2terminal&L=4&L0=Home&L1=Consumer&L2=Family+Services&L3=Foster+Care&sid=Eeohhs2&b=terminalcontent&f=dss_c_icwa&csid=Eeohhs2) accessed August 5, 2008
- 39 15. Social Security Act 1935 <http://www.socialsecurity.gov/history/tally.html> (Accessed  
40 August 5, 2008).
- 41 16. Social Security Administration. Adoption assistance and child welfare act of 1980. Pub L  
42 No. 96-272. [http://www.ssa.gov/OP\\_Home/comp2/F096-272.html](http://www.ssa.gov/OP_Home/comp2/F096-272.html). Published 1980.  
43  
44 Accessed November 15, 2007.  
45

## AACAP MEMBERSHIP REVIEW ONLY – NOT FOR DISTRIBUTION

October 2009 Draft

- 1 17. US Department of Health and Human Services. Adoption and safe families act of 1997.  
2 Pub L No. 105-89.  
3 [http://www.acf.hhs.gov/programs/cb/laws\\_policies/policy/pi/pi9802.htm](http://www.acf.hhs.gov/programs/cb/laws_policies/policy/pi/pi9802.htm). Published  
4 1997. Accessed November 15, 2007.
- 5 18. Child Welfare League of America: Foster Parent Recruitment and Retention.  
6 1995:CWLA Washington DC\
- 7 19. Rodger S, Cummings A, Leschied AW (2006), Who is caring for our most vulnerable  
8 children? The motivation to foster in child welfare. *Child Abuse Negl.* 30:1129-42
- 9 20. American Academy of Pediatrics. Health Care of Young Children in Foster Care.  
10 *Pediatrics.* 2002;109:536-541.
- 11 21. Stovall-McClough, KC and Dozier M (2004). Forming attachments in foster care: Infant  
12 attachment behaviors in the first 2 months of placement. *Development and*  
13 *Psychopathology*, 16, 255-271
- 14 22. Newton RR, Litrownick AJ and Landsverk JA (2000), Children and youth in foster care:  
15 disentangling the relationship between problem behaviors and number of placements.  
16 *Child Abuse Negl.* 24:1361-74
- 17 23. Stein JM, Derdeyn AP (1980), The child in group foster care. *J Am Acad Child*  
18 *Psychiatry* 19:90-100
- 19 24. American Academy of Child and Adolescent Psychiatry. Practice Parameters for Child  
20 Custody Evaluation. <http://aacap.org/galleries/PracticeParameters/Custody.pdf>
- 21 25. American Academy of Child and Adolescent Psychiatry. Practice parameter for child and  
22 adolescent forensic evaluations. In press.
- 23 26. Dumaret AC, Coppel-Batsch M, Couraud S (1997), Adult outcome of children reared for  
24 long-term periods in foster families. *Child Abuse Negl* ;21:911-27.
- 25 27. Fowler PJ, Toro PA, Miles BW. (2009) Pathways to and from homelessness and  
26 associated psychosocial outcomes among adolescents leaving the foster care system. *Am*  
27 *J Public Health* 99:1453-8.
- 28 28. Dube SR, Felitti VJ, Dong M, Chapman DP, Giles WH, Anda RF (2003), Childhood  
29 abuse, neglect, and household dysfunction and the risk of illicit drug use: the adverse  
30 childhood experiences study. *Pediatrics* 111:564-72.
- 31 29. Dube SR, Anda, RF, Felitti VJ, Chapman DP, Williamson DF, Giles WH (2001),  
32 Childhood abuse, household dysfunction, and the risk of attempted suicide throughout  
33 the life span: findings from the Adverse Childhood Experiences study. *JAMA* 286:3089-  
34 96.
- 35 30. Rosenberg S.D, Lu, W, Mueser KT, Jankowski MK, Cournos F (2007), Correlates of  
36 adverse childhood events among adults with schizophrenia spectrum disorders.  
37 *Psychiatr Serv* 58:245-53.
- 38 31. Taussig HN (2002), Risk behaviors in maltreated youth placed in foster care: a  
39 longitudinal study of protective and vulnerability factors. *Child Abuse Negl* 26:1179-99
- 40 32. Pilowsky DJ, Wu L (2006), Psychiatric symptoms and substance use disorders in a  
41 nationally representative sample of American adolescents involved with foster care. *J*  
42 *Adolesc Health* 38:351-358.
- 43 33. Stahmer AC, Leslie LK, Hurlburt M, Barth RP, Webb MB, Landsverk J, Zhang J (2005),  
44 Developmental and behavioral needs and service use for young children in child welfare.  
45 *Pediatrics* 116:891-900.

**AACAP MEMBERSHIP REVIEW ONLY – NOT FOR DISTRIBUTION**

October 2009 Draft

- 1 34. Leslie K, Gordon J, Meneken L, Premji K, Michelmore KL, Ganger W (2005), The  
2 physical, developmental, and mental health needs of young children in child welfare by  
3 initial placement type. *J Dev Behav Pediatr* 26:177-185
- 4 35. Hochstadt NJ, Jaudes PK, Zimo DA, Schachter J (1987), The medical and psychosocial  
5 needs of children entering foster care. *Child Abuse Negl* 11:53-62
- 6 36. Reams R (1999),. Children birth to three entering the state's custody. *Infant Ment Health*  
7 *J.* 20:166-174
- 8 37. Urquiza AJ, Wirtz SJ, Peterson MS, Singer VA (1994),Screening and evaluating abused  
9 and neglected children entering protective custody. *Child Welfare* 73:155-71
- 10 38. Zeanah CH, Larrieu JA, Heller SS, Valliere J, Hinshaw-Fusselier S, Aoki Y, Drilling M  
11 (2001), Evaluation of a preventive intervention for maltreated infants and toddlers in  
12 foster care. *J Amer Acad Child Adolesc Psychiatry* 40; 214-221
- 13 39. Minnis H, Everett K, Pelosi AJ, Dunn J, Knapp M (2006), Children in foster care: mental  
14 health, service use and costs. *Eur Child Adol Psychiatry* 15:63-70.
- 15 40. Kerker BD, Dore MM. Mental health needs and treatment of foster youth: barriers and  
16 opportunities. *Am J Orthopsychiatry.* 2006;76(1):138-47
- 17 41. Vinnerljung et al. 2005
- 18 42. Garland AF, Landsverk JL, Hough RL, Ellis-MacLead E (1996) Type of maltreatment as  
19 a predictor of mental health service use for children in foster care. *Child Abuse*  
20 *Negl*;20:675-88.
- 21 43. Leslie, LK, Landsverk J, Esset-Lofstrom R, Tschann JM, Slymen DJ, Garland AF (2000).  
22 Child in foster care: factors influencing outpatient mental health service use. *Child*  
23 *Abuse Negl*; 24:465-76.
- 24 44. Zito, JM, Safer, D, dosReis, S, Et Al. Trends in the prescribing of psychotropic  
25 medications to preschoolers. *JAMA* 283:1025-30. 2000.
- 26 45. Zito JM, Safer DJ, Sai D, et al. Psychotropic medication patterns among youth in foster  
27 care. *Pediatrics.* 2008 Jan;121(1):e157-63 2008.
- 28 46. American Academy of Child and Adolescent Psychiatry. AACAP Position Statement on  
29 Oversight of Psychotropic Medication Use for Children in State Custody: a Best  
30 Practices Guideline.  
31 [www.aacap.org/galleries/PracticeInformation/FosterCare/BestPrinciples\\_FINAL.pdf](http://www.aacap.org/galleries/PracticeInformation/FosterCare/BestPrinciples_FINAL.pdf)
- 32 47. Chamberlain, P. Treating juvenile offenders: Advances made through the Oregon  
33 Multidimensional Treatment Foster Care Model. 2003: Washington, DC: American  
34 Psychological Association.
- 35 48. Chamberlain, P., Leve, L.D. and DeGarmo DS. Multidimensional treatment foster care  
36 for girls in the juvenile justice system. *J Consulting and Clin Psychol* 2007;75:187-193.
- 37 49. Fisher PA, Gunnar MR, Chamberlain P, Reid JB (2000), Preventive intervention for  
38 maltreated preschool children: impact on children's behavior, neuroendocrine activity  
39 and foster parent functioning. *J Am Acad Child Adolesc Psychiatr* 39:1356-64.
- 40 50. Fisher PA, Burraston B and Pears K (2005), The early intervention foster care program:  
41 permanent placement outcomes from a randomized trial. *Child Maltreat.* 10:61-71
- 42 51. Macdonald GM, Turner W (2008), Treatment foster care for improving outcomes in  
43 children and young people. *Cochrane Database Syst Rev* 23:CD005649

**AACAP MEMBERSHIP REVIEW ONLY – NOT FOR DISTRIBUTION**

October 2009 Draft

- 1 52. Turner W, Macdonald GM, Dennis JA (2005), Cognitive-behavioural training  
2 interventions for assisting foster carers in the management of difficult behaviour.  
3 *Cochrane Database Syst Rev* CD003760  
4 53. Dozier M., Peloso E, Lewis E, Laurenceau JP, Levine S (2008). Effects of an attachment-  
5 based intervention on the cortisol production of infants and toddlers in foster care. *Dev*  
6 *Psychopathol* 20:845-59  
7 54. Fostering Connections to Success and Increasing Adoptions Act  
8  
9 Puddy RW, Jackson Y (2003), The development of parenting skills in foster parent training.  
10 *Child and Youth Services Review* 25:987-1013  
11

**Practice Parameter Member Comment Form**

**PRACTICE PARAMETER FOR THE ASSESSMENT AND TREATMENT OF  
CHILDREN AND ADOLESCENTS WITH SCHIZOPHRENIA**

*Please write your comments below, noting a specific page and line if appropriate. Please focus your feedback on content rather than editorial issues; the parameter will be professionally edited prior to approval. All comments are reviewed and discussed by the authors and the Work Group on Quality Issues. Please fax your comments to 202.966.9518 or email [jmedicus@aacap.org](mailto:jmedicus@aacap.org) **by January 22, 2010**.*

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Email: \_\_\_\_\_