



news CYF

Children, Youth, and Families Office



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SYSTEMS OF MENTAL HEALTH CARE FOR YOUTH IN FOSTER CARE



The current issue of CYF news is dedicated to providing a meaningful discussion of the myriad of issues related to the mental health of youth in foster care. It is not likely new information to find that youth in foster care are vulnerable to maladjustment given their exposure to both significant events that led to removal from their homes and the process itself of being in foster care. What is new perhaps is the fact that despite the clear and compelling evidence that youth in foster care demonstrate both short and long-term, clinically significant mental health problems, the process or systems created to meet the mental health need are rarely reviewed. The articles in the current newsletter are an attempt to encourage a dialog and synthesize what we know about the need for mental health care and how the current system of care addresses the mental health need of foster youth on both a direct care and policy level.

The article by Grayson provides an excellent review of the depth and breadth

of the mental health need in the foster youth population and the barriers and challenges faced by the system of care to provide effective intervention. Along with identifying the need, the article by Cuno addresses how mental health is assessed in youth who are in the process of reunifying with their families of origin. The article by Dorsey provides a specific example of how one treatment approach, Trauma-focused Cognitive-Behavioral Therapy can be effective to remediate mental health problems for youth in foster care and how foster parents can be engaged in the treatment process. Even when effective treatments exist, the evidence supporting psychological care is meaningless without access to treatment. The article by Risch et al. provides an important discussion of the access to treatment and quality of treatment received from the perspective of both caseworkers and foster parents.

For some youth in foster care, adoption into a new family is the goal. The need for mental health care, however, does not disappear once a youth is adopted.



Yo Jackson

About the editor:

Yo Jackson, PhD, ABPP (2012 CYF Co-Chair) Dr. Jackson received her PhD from the University of Alabama. Her research focuses on how children adapt to stress and trauma and development of the resilience in youth. Dr. Jackson is especially interested in identifying the role of protective factors in children exposed to child maltreatment.

SYSTEMS OF MENTAL HEALTH CARE FOR YOUTH IN FOSTER CARE

The article by Davies et al. illustrates some of the mental health concerns of previously foster- now adopted youth. In the same vein, given that exposure to traumatic events as a child and subsequent placement in foster care is likely meaningful for one's mental health over time, the article by Litrownik provides a big picture view of the course of services and mental health needs for foster youth in a longitudinal context.

Clearly youth in foster care are at-risk for mental health problems. Perhaps of equal importance is how our systems of care operate to address the risk. The information provided in these articles has great implication for how policies of local community and state social service and mental health agencies should be crafted and implemented. The field would benefit from a comprehensive review of not only the need, but also how the need is assessed, what treatments are supported to meet the mental health need, how those services are accessed, and how the system of care for foster youth fares over time.



MENTAL HEALTH NEEDS OF FOSTER CHILDREN AND CHILDREN AT RISK OF REMOVAL



Joann Grayson

About the author:

Dr. Joann Grayson has initiated more than 11 prevention programs in the Harrisonburg-Rockingham community, including a tutoring program that partners JMU students with at-risk children. She has advocated for children before the U.S. House of Representatives Select Subcommittee on Education and as past chair of the Governor's Advisory Board on Child

Abuse and Neglect in Virginia. She publishes the "Virginia Child Protection Newsletter" and has been recognized for outstanding teaching during her 30-year career in JMU's department of psychology.

Nationwide, approximately 510,000 children and youth are in the foster care system. Studies since the 1970's have found that children in foster care have greater need for mental health treatment than children in the general population. Typical findings are higher prevalence of developmental delays, conduct problems, language difficulty, attachment disorders, behavioral problems, and neurological impairments (Leslie et al., 2005; Marx, Benoit & Kamradt, 2003; McIntyre & Keesler, 1986; Pilowsky, 1995).

The National Institute of Mental Health funded a national survey of mental health needs and access to mental health services for youth involved in child welfare (Burns et al., 2004). Nearly half (47.9%) of youth in foster care were determined to have clinically significant emotional or behavioral problems. A literature review for the Casey Family Programs (Landsverk, Burns, Stambaugh & Rolls Reutz, 2006) concluded that between one-half and three-fourths of children entering foster care exhibited behavioral or social competency problems that warranted mental health services. In addition to the high rate of mental health problems, children under age seven who enter foster care show high rates of developmental problems (Landsverk et al., 2006).

The reasons for the high incidence of difficulty and increased need for services are understandable, according to a review by Austin (2004). Children in foster care struggle to cope with the events that brought them into the system such as caretaker abuse, neglect, or sexual abuse, homelessness, exposure to domestic violence, and/or parental substance abuse. The negative effects of these traumatic events are well-documented. At a time when reassurance, understanding, and stability are needed, children experience unpredictable contact with family, multiple placements, and an inability to direct their own lives. Unmet mental health needs for foster children can mean ongoing problems as youth in foster care enter adulthood. According to a study by the Casey Family

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Programs and the Harvard Medical School (Pecora et al., 2005), a disproportionate number of former foster children have mental disorders as adults. Over half of foster care alumni had diagnoses compared to 22% of the comparison group. For example, the rate of Post-traumatic Stress Disorder (30% for foster alumni) was nearly double the rate of PTSD found in U.S. combat veterans and was significantly higher than the 6.9% rate of PTSD in the comparison group. Likewise, differences were large and significant for diagnoses of Major Depression, Panic Disorder, Phobia, and Generalized Anxiety Disorder.

What is the Response?

While nearly half of the youth in the child welfare system need mental health intervention, only one-fourth of these youth received care during the NIMH study's one-year time period (Burns et al., 2004). According to an analysis of 1,291 children examined by Leslie, Hurlburt, Landsverk, Barth & Slymen (2004), older youth in foster care are more likely to be receiving mental health services. Children in foster care who had experienced sexual abuse were almost five times as likely to receive services when compared to children in care with no sexual abuse history. Still, almost a fourth of the children scoring above the 98th percentile on a clinical measure of symptoms did not receive services (Leslie et al., 2004).

What are the Challenges?

In addition to system challenges such as shortage of child and adolescent providers, there are some specific barriers to providing mental health services to foster children and children at risk for removal (Austin, 2005; Horwitz, Owens & Simms, 2000; Landsverk et al., 2006; Marshall, 2004; McMillen et al., 2004; Rosenkranz, 2006; Rubin et al., 2004; Zima, Bussing, Crecelius, Kaufman, & Belin, 1999):

- Training of providers, foster care workers, and foster parents.
- Lack of coordination between child welfare staff and mental health providers.
- Failure of the system to conduct screening assessments.
- Failure of community providers to identify mental health needs.
- Limited collaboration between providers and biological parents.
- Financial resources.
- Children with both medical and mental health needs.
- Instability in placements.
- Scarcity of providers and long waiting lists.



Best Practices for Assessment and Diagnosis

Various organizations and professional groups (e.g., Child Welfare League of America; American Academy of Child and Adolescent Psychiatry; American Academy of Pediatrics) have endorsed the concept that children entering foster care should be assessed for physical, developmental, and mental health problems so that appropriate interventions can begin early. Periodic assessment is also required as children adjust to new surroundings and relationships (Halfon, Zepeda, & Inkelas, 2002; Harden, 2004). Further, it is recommended that communities use a standardized procedure for screening and assessment so that information on each child is uniform and comprehensive (Landsverk et al., 2006).

The Importance of Family Participation in Treatment

Increasingly, there is recognition that family members should be involved and participate in children's mental health treatment, even if the child or youth is placed in foster care or placed through the juvenile justice system. To the extent possible, family members should be involved in the treatment planning, implementation, and evaluation of services. It is important that both parents and caregivers understand the results of any evaluation(s), the child's diagnoses, and the full range of treatment options (Virginia Commission on Youth, 2005). In general, participation of family results in improved treatment outcome. Without the involvement of families, it is extremely difficult for service providers to ensure that gains achieved by the child are maintained and solidified (Virginia Commission on Youth).

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Adequate mental health care for children in their biological homes can sometimes prevent placement in foster care. Families stressed by children with untreated serious mental health needs can be at increased risk for abuse and neglect. Offering services prior to removal can be cost-effective as well (Capriccioso, 2004).

What Agencies and Practitioners Can Do To Improve Outcomes

Historically, the child welfare system has not measured the experiences and functioning of foster children, but instead has focused on safety and permanency. Developmental outcomes or optimizing child functioning were not considered as measurable goals (Harden, 2004). Now, the developmental needs of foster children are a focus. As a result of the Adoption and Safe Families Act (ASFA), child well-being is now one of the performance measures that will be used to assess state and local child welfare systems.

The Northwest Foster Care Alumni Study (Pecora et al., 2005) examined the outcomes for 659 alumni of the foster care system who were in young adulthood. The youth had been in foster care between 1988 and 1998 and 479 of the 659 were also interviewed. Based upon the findings, the researchers made several recommendations about what agencies can do to improve outcomes for youth in foster care.

First, given the number and severity of mental health problems for foster youth, it is imperative to examine

barriers to mental health treatment and remove them. Medicaid and other insurance coverage must expand so that youth who require mental health treatment can be linked with available and affordable treatment providers. Health providers may require additional training concerning the foster care population and how to screen for mental health disorders in this population. Evidence-based treatments should be available to foster children and new interventions should be validated (Pecora et al., 2005).

Second, it appears vital to maintain placement stability. Placement stability (e.g., few placement changes, no reunification failures, and no runaway episodes) resulted in a 22% decrease in negative mental health outcomes in the Northwest study. Placement stability can be improved using several procedures. Workers can strengthen the initial placement decision so that children are placed in homes where the foster parents are equipped to meet their needs. Providers can train foster parents in social learning and behavioral interventions. Foster children can be taught skills for developing and maintaining positive relationships. Where appropriate, youth can be allowed and encouraged to maintain family connections.

Another set of recommendations concern educational success. A low number of school changes and the availability of tutoring and supplementary educational experiences resulted in a 13% decline in negative mental health outcomes (Pecora et al., 2005). Youth should be encouraged to complete a regular diploma rather than a GED credential. Foster care alumni in the Northwest study obtained a GED rather than a high school diploma 28.5% of the time, a rate nearly six times the 5% rate in the general population. While a GED is preferable to no high school completion, youth who earn a diploma have higher earnings than those with a GED, are 1.7 times more likely to complete an associate's degree, and are 3.9 times more likely to complete a bachelor's degree. School personnel who are educated about the challenges of individual foster children can better individualize the learning environment for the child. Also, mental health treatment can increase the likelihood of academic success.

For youth "aging out" of foster care, providing appropriate health and mental health care is a critical component of a successful transition into adulthood (English, Stinnett, & Dunn-Georgiou, 2006). Even if adequate services are available during growing years, some former foster children suffer from permanent chronic and disabling conditions due to maltreatment in their home of origin and these conditions require ongoing attention of health and mental health professionals.

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ASSESSING REUNIFICATION READINESS OF FOSTER CARE CHILDREN



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In over half of all foster care cases, the child welfare system works with parents, children, foster parents, and service providers to return children to safe and stable homes with the individual(s) from whom they were removed (Alpert & Britner, 2008). With the enactment of the Adoption of Same Families Act (AFSA, 1997), a time frame for reunification was explicitly specified for the first time in the history of child welfare legislation. AFSA provided financial incentives for states to move more children to permanency through adoption and placed an emphasis on preventing unsuccessful reunifications. Unfortunately, this mindset of foster care as a temporary service has consequently lead to the proportion of children with severe emotional and behavioral problems remaining in foster care increasing as other, less "challenging" children are reunified with the family of origin, other kin, or are adopted (Kerker & Doore, 2006).

Children with mental health issues are the least likely among their peers to be successfully reunified with their families of origin (Shaw, 2006). In the absence of detailed information about child, parent, and family characteristics and functioning, it is extremely difficult to determine what interventions are necessary in order for a reunification to be successful.

There are significantly negative and profound consequences of a reunification failure for children, including increased behavioral and mental health problems, impaired ability to form strong, effective relationships with caretakers, increased legal involvement, substance abuse, self-destructive behaviors, as well as clinically significant internalizing and externalizing symptoms as measured by standardized assessments (Barth et al., 2007). Children are often reunified without a resolution of the family issues and stressors that brought them into the child welfare system initially. With the stressors still present, it is unlikely a return to their former environment will be successful, as elevated levels of family stress put a child at risk for re-traumatization (Lau et al., 2003).

Many states have adopted assessment procedures to help ensure safe, timely reunification decisions and minimize both the risk of harm to children and re-entries to foster care. However, The Department of Health and Human Services (2009) has documented that at least 30 states were found to have had problems conducting adequate assessments, and that case plans often do not address the individual needs of families, and often lack clear objectives. Thus, there is a significant need for a renewed focus on assessment, prevention, and early intervention for this particularly vulnerable population of children and families, and further, for clinical psychologists to assist child welfare workers in assessing children entering the foster care system in order to link them with appropriate services that might aid in an effective and steadfast reunification.

Ensuring a positive outcome is dependent not only on services provided to the parents, as well as the nature and severity of their impairment, but also the functioning of the child. The goal is to implement assessment measures that address the broader needs of the child and family, a comprehensive assessment rather than gathering a set of symptoms, that focuses on presenting issues as well as underlying etiological factors for behaviors and conditions affecting abused children (Scene, 2005). Results ought to be integrated with risk and safety assessments, in order to help child welfare workers prioritize areas in need of intervention to increase the chances of a successful reunification.

An assessment of this nature ought to target family factors including access to social support; parenting practices; background and history of parents and caregivers; and the quality of the parent-child relationship. In addition, and of utmost importance, the assessment ought to focus on the individual needs of the child by assessing their intellectual ability and cognitive functioning, academic achievement, emotional and social functioning, both broadly speaking and specifically in relation to their abuse experiences (Crooks & Wolfe, 2007).

It is imperative to have a balance between child self-report (both interview and questionnaires), parent-report, and observation of child with their caregivers. Beginning with intellectual and academic functioning, the implementation of co-normed measures such as the Wechsler Intelligence Scale for Children – 4th Edition (WISC-IV; Wechsler, 2004) and the Wechsler Individual Achievement Test – 3rd Edition (WIAT-III; Wechsler, 2009) is recommended to gather a detailed picture of their strengths and weaknesses. It is further recommended to gain a broader understanding of the child's emotional, social, and behavioral func-

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tioning. For adolescents, this can be achieved via the Minnesota Multiphasic Personality Inventory for Adolescents (MMPI-A; Butcher et al., 1992), a self-report inventory of personality functioning for adolescents ages 14 – 18. For younger, broad-based self-report measures including the Child Behavior Checklist (CBCL; Achenbach, 1991), Parent and Teacher Report Form, and/or the Behavioral Assessment System for Children – 2nd Edition (BASC-2; Reynolds & Kamphaus, 2004) Parent and Teacher Report Form, can assist in understanding the child's general behavioral and emotional functioning across multiple settings. Regardless of age, symptom-specific self-reports such as the Child Depression Inventory (CDI; Kovacs, 2010) or the Multidimensional Anxiety System for Children (MASC; March, 1997), can assist with gaining more specific and detailed information regarding a particular symptom set that pertains to that individual child or adolescent.

It is of utmost importance to assess the child's functioning in relation to their abuse experiences. The Trauma Symptom Checklist for Children (TSCC; Briere, 1996), is a psychometrically sound instrument designed to measure the impact of child abuse (sexual, physical, and emotional) and neglect, other interpersonal violence, witnessing trauma to others etc., on a child's emotional, social and behavioral functioning. In addition, the Social Behavior Inventory (SBI; Gully, 2003) measures five dimensions of social behavior that are especially pertinent for children who have been maltreated, is quick to administer, and has exhibited enough sensitivity to be used to monitor progress in treatment.

For maltreated children, direct questioning can stimulate many emotions that result in difficulty or an inability to respond verbally (Veltman & Browne, 2002). Therefore, foster care children could benefit from age-appropriate ways to ventilate their fear, anger, aggression, and hostility and feelings surrounding their abuse experiences. Projective measures such as the House-Tree-Person or Kinetic Family Drawing (Burns, 1987), as well as the Draw-A-Person (Naglieri, 1988) are recommended to tap into how the child is processing their experiences in an indirect, non-confrontational, and supportive manner. These measures can also serve as a nice "ice breaker" when first assessing a child who has been a victim of substantiated abuse and has likely gone through a host of interviews, evaluations, and rounds of questioning that have left them weary of a formal assessment procedure. Lastly, the Children's Impact of Traumatic Events Scale – 2nd edition (CITES-II), Peritraumatic Reactions Scales, Attributional Scales, and Social Reactions Scales (Wolfe, Gentile, Micheienzi, Sas, & Wolfe, 1991) are recommended to gather information related to the impact of abuse on the child's cognitions and beliefs.

Increased knowledge of the effects of separation on the parent-child relationship and of the factors that contribute to changes in the parent-child relationship can improve the likelihood that the destructive emotional effects of the separation can be anticipated and minimized. The Parenting Interview (PI; Crittenden, 1980), assesses parental attachment strategies and elicits information from the parents' memories regarding their childhood and parenting experiences.

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The entire family is present for the interview, allowing you to observe the parent's attachment style in action. The interview is administered to both to parent and partner (if present), while the parents concurrently supervise the children; enacted aspects of parent-child, partner, and mother-interviewer behavior are coded and all of these contribute to classifying each adult's attachment strategy.

All children coming into foster care even those who are very young or who appear to be functioning well, should be routinely assessed for cognitive, developmental, emotional, and behavioral difficulties. We cannot continue to wait until problems develop in foster care to adequately address the mental health needs of any given child. While there are programs that attempt to do this, they often neglect the psychological and emotional outcomes of maltreatment and out-of-home placements (Kerker & Doore, 2006). Implementing the type of assessment system is fraught with challenges, including communication deficits between multiple systems, overlapping roles among child welfare workers and case managers, court systems involvement, budget crises, inflexible funding sources, and the need for cross-system training.

That being said, the goal is not for clinical psychologists to embark on the job of child protective services, rather to recommend services that are appropriate for a family given their current psychological functioning. There is no time like the present for psychologists to give a voice to this highly vulnerable population and help reduce the trend of children remaining in foster care longer and re-entering more often than necessary.

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TRAUMA-FOCUSED COGNITIVE BEHAVIORAL THERAPY WITH YOUTH IN FOSTER CARE: THE IMPACT OF CAREGIVER ENGAGEMENT

Youth in foster care have disproportionately high rates of trauma exposure and mental health problems compared to the general population. Untreated mental health problems have been linked to higher rates of placement disruption and lower rates of reunification and adoption in child welfare-involved youth (James, 2004; James, Landsverk, & Slymen, 2004). In a nationally representative study of children ages 3-18 involved in child welfare, and in a study of adult alumni of the foster care system, rates of Posttraumatic Stress Disorder (PTSD) were equivalent to those of war veterans (Kolko, et al., 2010; Pecora, et al., 2003). Given these high rates of mental health problems, trauma exposure and trauma sequelae, attention to mental health needs is critical. However, receipt of mental health care is not equivalent to need, and it is unclear whether children in foster care typically receive evidence-based treatments (Landsverk, Burns, Stambaugh, & Reutz, 2006).

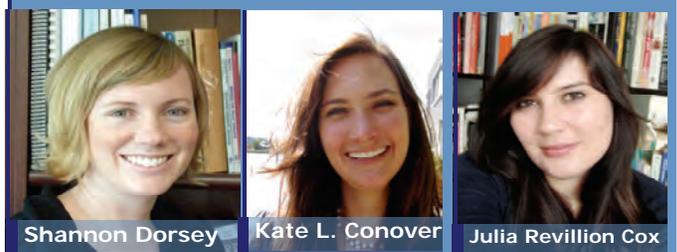
The child and adolescent PTSD treatment with the strongest empirical base, Trauma-focused Cognitive Behavioral Therapy (TF-CBT; Cohen, Mannarino, & Deblinger, 2006; Dorsey, Briggs-King, & Woods, 2011), offers considerable promise for addressing trauma-related sequelae as well as behavioral difficulties. In addition to trauma-specific components, TF-CBT focuses on parenting, to equip caregivers with necessary skills to handle trauma-related and general behavior problems. Until recently, TF-CBT had not been tested specifically with the foster care population. A recently published study examined the clinical impact of three evidence-based trauma treatments (including TF-CBT) provided to ethnically diverse children in foster care who were also system of care-involved (Weiner, Schneider, & Lyons, 2009). In this trial, for all children who received 11 or more sessions of TF-CBT (defined as active dose), PTSD symptoms were significantly reduced, as were other behavioral and emotional needs for a subset of the population.

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TRAUMA-FOCUSED COGNITIVE BEHAVIORAL THERAPY WITH YOUTH IN FOSTER CARE: THE IMPACT OF CAREGIVER ENGAGEMENT

A key consideration for therapy with children in foster care is the involvement of the foster parent(s). There are several reasons why caregiver participation may be even more important for foster children than for children in biological or adoptive family environments. As with all therapy, the goal is that children transfer skills learned in the office to the natural environment. Specific and active support from the foster caregiver is needed to prompt and reinforce use of anxiety coping skills for children who potentially are faced with a new environment (home, school), uncertainty about their future, court involvement, and visits with family (which can be both anxiety-producing and welcomed). The positive parenting TF-CBT components are even more likely to be necessary with foster children given the high rates of behavior problems. TF-CBT is a family-level intervention, with caregivers receiving approximately half the active treatment time. This level of involvement could be considered by foster parents to be an unusual expectation. Therefore, attention to engagement of the foster parent is especially important in achieving the maximum benefit from TF-CBT.

Several models for enhancing parent engagement in youth mental health treatment are available in the literature. One such model, developed by Mary McKay (McKay & Bannon, 2004), includes an engagement intervention conducted during the clinician's first telephone contact with the caregiver and during the first in-person visit. McKay's model has evidence for increasing both initial appointment attendance, and overall treatment retention in TF-CBT. A number of studies have tested the combination of an evidence-based treatment and specialized engagement strategies for a range of populations, including Latino families, child-welfare involved parents, and treatment-seeking parents of children with behavioral disorders, among others (e.g., Chaffin, Funderburk, Bard, Valle & Gurwitch, 2011; Coatsworth et al. 2001; Szapocznik and Kurtines 1989; Nock & Kazdin, 2005). These studies have found better caregiver engagement in treatment, and in some cases, better clinical outcomes when specific engagement strategies were included (i.e., Chaffin et al., 2011).

Our team conducted a NIH-funded randomized trial with foster youth ages 6-15. Youth and their foster parents were randomized to either TF-CBT plus McKay and colleagues' evidence-based engagement strategies or to standard delivery of TF-CBT. Children who participated in the study were referred by child welfare workers, with few exclusionary criteria. Consistent with the foster care population, the study sample was highly ethnically diverse (i.e., 53.1%



multiracial youth, 24.5% Caucasian, 18.4% African American, 2.0% Native American, 2.0% Asian). All clinicians who participated in the trial were employed in community mental health settings in a large metropolitan area. Clinicians received a two-day training in TF-CBT and weekly consultation and session tape review by TF-CBT experts. Clinicians in the TF-CBT plus engagement condition also received training (4-6 hours) in the engagement strategies and a brief training booster prior to provision of the engagement intervention with their client (15-20 minutes).

This trial is currently in the final stages, such that 29 of 49 enrolled youth completed treatment during the study period, three are in ongoing treatment, and three completed 11 or more sessions (defined as an active dose per Weiner et al., 2009). Across both conditions, for all children who either completed treatment or completed 11 or more sessions, PTSD symptoms were significantly reduced from the pre-treatment assessment to the end of treatment assessment by both foster parent and child report using the UCLA Posttraumatic Stress Disorder-Reaction Index (Steinberg, Brymer, Decker & Pynoos, 2004). Children and foster parents reported, on average,

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about a 50% and 30% reduction in symptoms, respectively.

Among youth who did not complete TF-CBT, five discontinued treatment due to placement disruption, and six dropped out of treatment before completing all TF-CBT components. Among treatment completers, 20 were in the TF-CBT engagement condition and nine were in the TF-CBT standard condition. All six youth who dropped out of treatment were in the standard condition; there were no treatment dropouts in the TF-CBT plus engagement condition. The five children whose treatment was discontinued subsequent to placement disruption were almost evenly split across the standard and engagement conditions, suggesting that the engagement procedures may not be enough of a protective factor to keep children in treatment when placements disrupt.

In summary, the addition of a few specific, easily administered engagement strategies significantly increased the likelihood that children would complete a sufficient number of sessions to benefit from TF-CBT. Given the few exclusionary criteria for this trial and the use of service provision by “real world” mental health providers in community-based settings, findings are generalizable to the broader foster care population. It should be noted, however, that obtaining referrals was challenging, despite the fact that the treatment was fully supported by Medicaid and readily available in the community. Even with multiple informal presentations at all child welfare offices in our region, referrals were slow and inconsistent until our team established monthly staffing meetings (with refreshments and coffee) at each office, during which social workers and supervisors could discuss cases with research staff in-person. Child welfare workers, who often serve as brokers to mental health services for children in foster care, have wide-ranging responsibilities, with identifying mental health need and appropriate treatment options being only one of many. The availability of an effective treatment is not by itself sufficient to insure that eligible foster children will be referred.

In our experience with this trial and another foster care study, the critical role of child welfare workers as brokers for mental health services—that is, their ability to recognize mental health needs and refer to appropriate EBTS targeting those needs—has been highlighted (Kerns, Dorsey, Trupin, & Berliner, 2010). A focus on engaging foster parents is one important component, as demonstrated by our trial, but building connections between mental health and child welfare is also critical, requiring attention by clinicians and agencies serving youth in foster care. As discussed above, five youth in this trial discontinued treatment

subsequent to placement changes. The child welfare worker’s involvement in evidence-based brokering and collaboration between the worker and clinician might decrease the likelihood of treatment interruption or discontinuation following a placement disruption.

Short-term, evidence-based treatments for children and adolescents in foster care can be effective, particularly when they include strategies for involving caregivers in treatment. However, too many youth in foster care receive non-specific, long-term therapy in which caregivers are not involved. Among the benefits of the type of engagement intervention used in this trial are the limited resources required for its implementation, paired with its potential to yield strong improvements in treatment and ultimately in youth PTSD outcomes and overall wellbeing. Our results suggest that with a time-limited training (4-6 hours) in McKay’s engagement procedures, and an additional 15 minutes dedicated to using them with each family, clinicians can substantially increase youth retention and influence outcomes for this high-needs population.

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ACCESSING MENTAL HEALTH SERVICES: PERSPECTIVES FROM CHILD WELFARE & FOSTER PARENTS

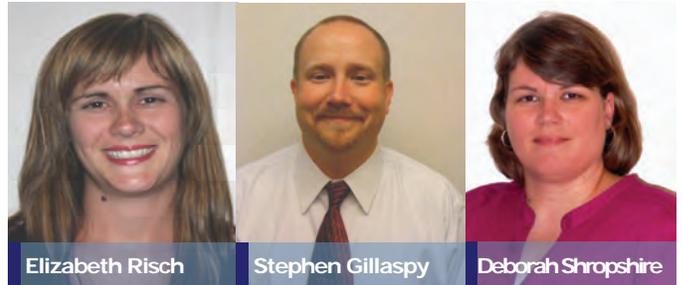
Access to mental health services is a significant concern for children in foster care. Research on a national sample of children in child welfare has shown that although 48% of children have mental health needs, only one-quarter of those children receive specialty mental health services (Burns et al., 2004). In a national survey of child welfare administrators, standard mental health services were felt to adequately address the needs of children in foster care only 25% of the time (Kolko et al., 2009). Proposed barriers to accessing mental health services for children in child welfare are complex and many (For a review, refer to Kerker & Dore, 2006; Simms, Dubowitz, & Szilagyi, 2000); however, minimal empirical research is available identifying barriers to mental health service provision.

Caseworkers and foster parents are most often responsible for accessing services for the children in their care. To date no study has examined their perceptions and experiences of accessing mental health services. This study sought to expand understanding of the accessibility and barriers to accessing mental health services by examining CW and FP perspectives.

Six hundred child welfare workers and 320 foster parents throughout Oklahoma completed online surveys, representing both rural and urban areas. The foster parents and caseworkers fulfilled diverse roles (e.g., emergency, kinship, traditional foster parents and supervisors, adoption workers, case managers in child welfare). Caseworker and foster parent surveys included items assessing ways in which respondents attempted to access mental health services, perceptions of availability of mental health services, and perceptions of the quality of available services. Access to mental health services was subdivided into three specialty areas: psychological testing, psychotropic medication management, and mental health therapy. Quality of available services was assessed through four yes/no items, specifically: "Quality of available services is good", "Services are easy to access", "Mental health treatment is appropriate and helpful", and "I am satisfied with available mental health services". Descriptive analyses of the survey data provided initial information on foster parent and child welfare worker experiences with mental health systems.

Regarding methods of access, foster parents most frequently accessed services through their family doctor (42%) and caseworkers reported accessing services through contact with other caseworkers (48%). Mental health services were most commonly rated the 'most difficult' to access among various

health service needs (e.g., vision, dental), with 20% of foster parents and 50% of caseworkers rating MH services as the most difficult service to access. Regarding specific types of MH services, while the majority of caseworkers and foster parents reported that mental health therapy is available (>90%); psychotropic medication management and psychological testing were reported as less available. Twenty percent of child welfare workers and 14% of foster parents reported psychological testing was not available in or near their county and 24% of child welfare workers and 21% of foster parents denied availability of psychotropic medication management. Not surpris-



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ingly, lack of available resources was significantly more a problem for child welfare workers and foster parents in rural areas.

Despite reporting that mental health services were generally available, approximately half of both child welfare worker and foster parents respondents reported that these services were difficult to access. Additionally, one-third of foster parents and half of caseworkers felt that mental health services were poor quality. Two-thirds of caseworkers and 45% of foster parents reported dissatisfaction with mental health services. Child welfare workers reported generally less satisfaction with services compared to resource parents.

This study provided new knowledge on access and quality to mental health services for children in foster care through the eyes of two key stakeholders, caseworkers and foster parents. Both CW and RP generally reported that mental health services were available, although to a lesser degree for specialty mental health services; however, the services were reported as difficult to access and to be of poor quality. These two points indicate that lack of mental health provision is not simply due to a lack of providers. This finding corresponds with research by Hurlburt et al. (2004) who found that number of providers in an area was not related to mental health service provision for children in the child welfare system, while increased interagency linkage did increase the likelihood of mental health service use for children in need.

The finding that foster parents most often access mental health services through their family doctor necessitates the integration of mental health services and providers into the primary care setting. The successful integration of behavioral health services into primary care has the potential to improve mental health screening to both clarify the need and specific focus of formal psychological testing, and appropriately refer children in foster care to evidence-based treatments. Additionally, the role of primary care providers as the primary source of referrals underscores the importance that they be sufficiently informed of common mental health service needs and resources for children in foster care.

Both child welfare workers and foster parents frequently perceived the quality of mental health services as poor, despite the fact that most child welfare workers and foster parents indicated that therapy services were generally available. One possible explanation for these findings may be that the majority of children are not receiving effective, evidence-based treatments, resulting in the frustration of child welfare workers and foster parents with lack of treat-

ment progress and continued functional impairment. These findings not only provide support for continued efforts focused on dissemination of evidence-based mental health practices for children in child welfare, but also continued efforts directed at educating stakeholders involved in this system (judges, medical professionals, foster parents) regarding the mental health needs and, associated effective treatments, for children in child welfare.

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MENTAL HEALTH SERVICES UTILIZED BY FAMILIES ADOPTING SPECIAL NEEDS CHILDREN

Special needs adoption (SNA) is an important permanency option for children in the child welfare system and foster care. The large majority of children adopted through special needs programs were previously placed in foster care, and many of them are adopted by their foster parents. States continue to invest substantial amounts of money in these children through monthly subsidies and provision of insurance to cover health and mental health services. Understanding the continuity of service needs across the developmental trajectory from child maltreatment to foster care to special needs adoption will inform policy discussions about meeting the needs of this very vulnerable population. Policy perspectives that view the permanency of SNA as resolving many of the mental health needs of this population are misguided and create particular stress for these families, who remain at heightened risk over developmental time.

Previous research on mental health needs and service utilization for SNA families is limited, however studies have shown that these children continue to present behavioral, emotional, and relationship challenges at rates far in excess of the general population (Palacios & Sanchez-Sandoval, 2005). Adoptive parents report high levels of stress, commonly attributed to their adoptive child's externalizing behavior problems, such as aggression, delinquent behaviors, hyperactivity, and inattention (McGlone, Santos, Kazama, Fong, & Mueller, 2002).

Research tracking rates of health and mental health service utilization following finalization of the adoption process has found that mental health services are the services most commonly sought out by SNA families. Estimates indicate that approximately 50% of SNA families seek individual and/or family therapy (McDonald, Propp, & Murphy, 2001). Another study investigating rates of mental health service use among SNA families indicated that 42% of the children were involved in individual therapy, while 31% were involved in family therapy (Reilly & Platz, 2004).

Methods

In cooperation with the State of Wisconsin, a state-wide stratified random sample of families adopting SNA children were contacted approximately two years following the finalization of the adoption. The sample was stratified by child age and region of the state. Primary caregivers in the adoptive families were asked to take part in a phone-based semi-structured interview regarding their experiences around the adoption. Children were between 6 and 17 at the time of the interview. The interview was completed with 430 parents. Interviews were coded independently by two coders on types of behavioral and emotional problems reported and types of services sought to help with these problems.



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MENTAL HEALTH SERVICES UTILIZED BY FAMILIES ADOPTING SPECIAL NEEDS CHILDREN

Results

Figure 1 displays the percentages of parents reporting the different types of behavioral and emotional challenges coded. Each family could have difficulties coded in multiple areas. This shows both the frequency and breadth of challenges faced by these families in an on-going way. Externalizing problems, separated here into non-aggressive and aggressive, were the most common challenges, but internalizing and relationship problems were also very common. Mental health services were accessed by 254 families (59% of the total sample).

Figure 1: Areas of Problems Reported by Parents Adopting Special Needs Children (N=430)

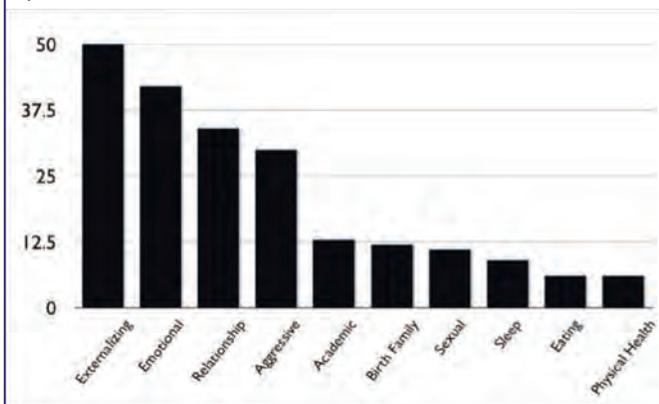
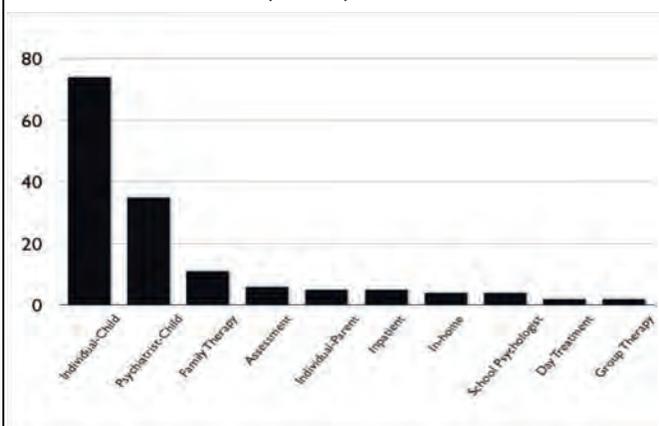


Figure 2 summarizes the types of services accessed by these families, with multiple services codes possible for each family. Most services were being provided to children individually by therapists and/or psychiatrists. Surprisingly few families were involved in family-based treatment, at least as far as we could determine through parents' descriptions. Despite high levels of parenting-related stress described by the parents, relatively few parents were actively receiving professional support.

Figure 2: Percentage of Parents Reporting Different Types of Mental Health Services (n=254)



Discussion and Implications

As high numbers of foster children move into the permanency of special needs adoption, it is important to understand constancy and change in the trajectory of behavioral, emotional, and relationship problems, and the treatment needs that these families continue to require. Our results indicate that the high level of service needs that are well-documented for children in foster care follows them into their adoptive families, with little evidence that there is a lessening of these challenges, even well after the finalization of the adoption.

SNA families continue to access services at a high rate, with the target of services typically being the individual child rather than the family. Anecdotally, the satisfaction with services varied widely, with many parents reporting that despite the relatively good coverage of mental health services through the child's insurance, they often had trouble finding mental health professionals who were familiar with the specific needs of SNA families.

It is imperative that we educate families considering special needs adoption about the on-going challenges that they will face. Many families reported the expectation that the permanency of the adoption would lead to a significant decrease in the child's behavioral and emotional problems, and these families reported frustration and disappointment in their adoptive experiences. We must also work diligently to educate service providers about the particular challenges faced by foster and SNA families, and disseminate the innovative interventions that are being shown to be effective.

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A LONGITUDINAL PERSPECTIVE ON MENTAL HEALTH SERVICES FOR FOSTER YOUTH: CONTINUED RISK AND THE CHALLENGE OF CHAOTIC CAREGIVING ENVIRONMENTS

An increasing number of descriptive studies in the 1980's and 1990's suggested that children and youth who were removed from their homes and placed in substitute care evidenced a number of problems that deserved attention (e.g., Clausen, Landsverk, Gangner, Chadwick, & Litrownik, 1998). Though subsequent research indicated that many of these foster children were provided mental health services, especially if they were older, had been sexually abused, and were in non-relative care, the majority were not (Raghavan, Inoue, Ettner, Hamilton, & Landsverk, 2010). As a result there has been an increasing focus on how to insure that these vulnerable children and youth not only receive needed mental health services, but also are provided with appropriate, evidence-based interventions (Horwitz, Chamberlain, Landsverk, & Mullican, 2010; Pecora, 2010). These efforts have involved evaluations of interventions that target youth (e.g., trauma-focused) and their caregivers (e.g., Parent Management Training, Multidimensional Therapeutic Foster Care, Project KEEP, Parent-Child Interaction Training), in addition to facilitating system responses (e.g., provision of services, implementation of best practices) (Aarons, Fettes, Flores, & Sommerfeld, 2009; Cohen, Deblinger, Mannarino, & Steer, 2004; Horowitz et al, 2010).

What I would like to do in this short piece is to take a step back and look at these efforts in a broader context that not only considers current policy, but also the population that these mental health services should be targeting. My intent is to then identify relevant barriers to the receipt of appropriate services and suggest where our future energies might be directed.

First, we need to recognize that the Child Welfare system has as its primary objective the protection of children who are at risk for abuse and neglect. Federal legislation (e.g., Adoption Assistance and Child Welfare Act of 1980, Adoption and Safe Families Act of 1997, and Foster Connections to Success and Increasing Adoptions Act of 2008) that has guided local jurisdictional efforts over the last 3 decades also emphasizes family maintenance, permanence, and more recently, child well-being. Informed in part by research findings, the current agenda of the Children's Bureau (i.e., Administration for Children and Families, US Department of Health and Human Services) is to reduce the number of children and youth in foster care by having them exit to permanent placements with biological parents, adoptive parents, or relative guardians within 3 years of entry into substitute care. Over the last 10 years there is some evidence of success in meeting these objectives, e.g., a 20% decline in the number of children and youth in foster care,

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increasing numbers of children and youth who exit the foster care system to reunification and adoption) (Child Welfare Information Gateway, 2011).

While these trends may be interpreted by some as a positive move, I would caution that these numbers do not tell the entire story. Specifically, most of the current research base is limited to snap shots of foster children, focusing on what happens to them (e.g., placements, moves, mental health service receipt) and how they are functioning when initially entering the Child Welfare system, or through a limited period of time (e.g., 18-months, 3-years). Based on my experience as the PI of the San Diego site of LONGSCAN (Longitudinal Studies of Child Abuse and Neglect: <http://www.iprc.unc.edu/longscan>), I would propose that a more complete longitudinal ecological perspective, such as one allowed by LONGSCAN is required to not only assess the outcomes of Child Welfare involvement, but also foster children's need for mental health services as well as barriers to their receipt.

The San Diego LONGSCAN study has followed 330 children who entered and remained in out of home care for at least 5 months due to substantiated maltreatment prior to 3.5 years of age. Subsequently, we have followed them through age 19. Though limited to a cohort who entered care between May 1990 and October 1991, the sample is representative of children from this jurisdiction (e.g., about a third Caucasian, a third African-American, a sixth Hispanic, and the remainder made up of multiracial and other groups). This sample is also of interest as it was young—current data indicate that one third of all reports are for children under 4 years of age; and the

A LONGITUDINAL PERSPECTIVE ON MENTAL HEALTH SERVICES FOR FOSTER YOUTH: CONTINUED RISK AND THE CHALLENGE OF CHAOTIC CAREGIVING ENVIRONMENTS



most frequent form of maltreatment reported was neglect—similar to current national reports (U.S. Department of Health and Human Services, 2010). In addition, approximately a third of the children were reunified, a third adopted, and the remainder permanently placed in foster or guardianship with relatives or non-relatives.

Consistent with prior studies, quantitative and qualitative data collected over the first 18 years of life for these youth suggest that they evidenced much dysfunction and delay based on early reports from caregivers on developmental (e.g., Vineland Adaptive) and problem behavior (e.g., Child Behavior Checklist) screeners. Reports from their caregivers indicated that they received lots of services (i.e., counseling, speech therapy, medications) in the early years (i.e., under 6), as well as in subsequent years (i.e., therapy, school counseling, medications, and involvement in residential treatment centers). Based on both caregiver and youth reports, it is apparent that the youth lived in chaotic environments during their first 18 years (e.g., multiple caregivers, moves, and schools; people moving in and out of their homes; people in their homes who were likely depressed, using substances, and engaging in violence; and more than two thirds were the subject of a re-report for suspected maltreatment after 4 years of age. This chaos or instability was more likely to be experienced by those individuals who were reunified with their biological parents compared to those who were adopted or re-

maintained with relative or non-relative caregivers (i.e., legal guardians or foster parents). Nevertheless, a chaotic dysfunctional caregiving environment was not unique to those youth who were reunified. That is, many of the youth who exited foster care through adoption or guardianship, as well as those who remained in the system with relatives and non-relatives continued to experience instability, including both formal and informal changes in caregivers.

Overall, this cohort of youth evidenced poor outcomes as they began the transition at 18 or 19 years of age from adolescence to early adulthood, with many more incarcerated than in college, fewer than a quarter with HS degrees, a number already having their own children, and a majority reporting social or emotional problems. Again, these poor outcomes were not unique to those who exited or remained in care, and it is unclear whether receipt of mental health services at any point in time had any positive impact or was simply a marker for (i.e., indicator of) who had more serious emotional and behavioral problems. At the same time there was some indication that those youth who exited care, especially those who were reunified, were less likely to receive mental health services.

These observations begin to put the delivery of mental health services to foster children and youth into a broader context. First, it is clear that children who enter foster care at an early age are at risk for poor

A LONGITUDINAL PERSPECTIVE ON MENTAL HEALTH SERVICES FOR FOSTER YOUTH: CONTINUED RISK AND THE CHALLENGE OF CHAOTIC CAREGIVING ENVIRONMENTS

physical, emotional, and behavioral health outcomes. Further, this risk does not appear to dissipate when foster children exit care (i.e., assumed permanence is not guaranteed) and risks for psychological problems due to unstable, chaotic environments continue throughout their lives. As a result I would urge that any discussion or consideration of appropriate mental health services for foster children and youth include not only those who enter or remain in the system, but also those who formally exit care. Second, a likely barrier to receipt of appropriate mental health services for those in need is the chaotic caregiving environment. Not only is there less likely to be follow-through on recommended services when changes in caregivers and/or moves occur, but it is also unlikely that caregivers who are trying to cope with multiple adaptive demands (i.e., financial, their own health problems, substance use, relationship disruptions) will devote the time and effort necessary to make sure their child or youth gets to a counselor or therapist in the first place, much less ensure their consistent involvement.

Efforts to involve caregivers may be critical in ensuring that foster youth receive appropriate and consistent mental health services. More importantly, caregivers will necessarily play a primary role as a change agent in evidence-based interventions that attempt to both empower caregivers as well as provide them with appropriate tools to manage child and youth problem behaviors (see Horwitz et al., 2010). Such interventions have the advantage of not only positively affecting both youth and their caregivers, but also there is evidence that the caregiving relationship is more likely to be maintained (Price, Chamberlain, Landsverk, Reid, Leve, & Laurent, 2008).

There is also some evidence to suggest that involvement of caregivers beyond just transporting children and youth to therapy can facilitate positive outcomes in cases where trauma focused interventions are appropriate (Cohen et al., 2004). Thus, the first challenge for therapists who are providing mental health services to foster youth (both current and former) is to prepare the caregiver. While having some common components (e.g., providing appropriate expectations for involvement, anticipated outcomes, and need for consistency), such preparation will likely need to be tailored so it is appropriate for the specific caregiver (e.g., biological or adoptive mother, relative or non-relative guardian) as well as the characteristics of the caregiving environment (i.e., economic resources, other family issues).

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25 YEARS WITH APA'S CHILDREN, YOUTH, AND FAMILIES OFFICE



Mary Campbell

About the author:

Mary staffed the Committee on Children, Youth, and Families (CYF) and headed CYFO since its inception in 1986. In these roles she implemented and managed programs and policies that applied psychological knowledge to the challenges that children, youth, and families face. Her work included reports on child and adolescent mental health, advertising and children, posttraumatic stress disorder and trauma, psychoactive medications, and resilience and strength in African American children and adolescents.

Mary received several awards including two awards for her 25 years of achievement and excellence from Division 43 and CYF, a Lifetime Advocacy Award from Division 37 (2011), Interdivisional Exemplary Service Award (2009), an award to recognize Mary's 30 years plus of outstanding service in advocacy for children, youth, and families, the Raymond D. Fowler Award (2008), and an APA Presidential Citation for her years of service to the Association and CYF (2007).

The Committee on Children, Youth, and Families (CYF) was established in 1986 to assure that child, youth and family issues receive the Association's full attention. CYF gives a voice to children, youth, and families and added the American Psychological Association's voice to those who so eloquently spoke to and for those populations.

I joined the American Psychological Association (APA) in 1986 as the first staff liaison to CYF. It was my honor, privilege and pleasure to serve in that capacity for the following 25 years. Prior to coming to APA, I served as a legislative assistant for a member of the U. S. House of Representatives working with the congressman to craft, introduce, and implement legislation benefiting children and families.

Throughout my career I have maintained a desire to use my knowledge and experience to improve the lives of children, youth, and families and this desire grew during my years at APA. I knew first-hand the constant need for sound, science based information for educating the public and for policy development. The APA membership was and remains a rich source of the evidence-based knowledge so necessary for crafting sound policy and for creating the public will for its implementation. Hopefully, the Children, Youth, and Families Office (CYFO) was and will remain a critical part of the team that brought psychological science to the policy arena.

Over time and using many sources, I developed goals for myself as APA's primary staff responsible for child, youth, and families issues. It was necessary to be flexible with regard to process and product from time-to-time as circumstances changed, but the core remained solid. The goals were: to provide staff support to CYF; to assure that child, youth, and family issues were ever present and recognized in and across the various APA systems; to develop and disseminate educative materials for broad and diverse audiences; and to build effective working networks for child and family issues across the APA membership.

CYFO staff provided support to CYF and many time limited, topic specific working groups. The Committee and working groups produced a variety of products that included newsletters, APA public policy statements, reports, and public education materials. APA policy statements or resolutions adopted by the Council of Representatives numbered 25 and reports received by Council numbered in the teens.

These resources were designed to raise awareness about child, youth, and family issues, to educate psychologists and the public, to articulate research gaps, and to add psychology's science based voice to policy development. A non-exhaustive topic list includes child abuse and neglect, child and adolescent mental health, adolescent development, disasters and their impact on children, youth, and families, psychoactive medications, child day care, bullying, dropout prevention, homelessness, promoting healthy behaviors to prevent obesity, evidence based practice with children and adolescents, advertising and children, sexuality education, violence prevention, children and the media, children and advertising, lesbian, gay and bisexual children in schools, African American children and adolescents, refugee children and families, and immigrant children, youth, and families.

The CYFO became very adept at repurposing resolutions, policy statements and reports developed by various APA groups to educate a wide range of consumers. These consumers included psychologists and other health care providers, policy makers, and the public. Here are some examples that illustrate how psychology's science can inform psychologists, educate the public, articulate research needs, and inform the public policy debate using the same information for different purposes. The Report of the Working Group on Advertising and Children is used by a range of health care providers working to improve children's exposure to advertising. The Report of the Working Group on Psychotropic Medications for Children and Adolescents was used to provide data at a panel con-

25 YEARS WITH APA'S CHILDREN, YOUTH, AND FAMILIES OFFICE

vened by the Food and Drug Administration investigating the "off label" use of psychoactive medications with children. The report of the Working Group on Black Children and Adolescents, through the Public Interest Government Relations Office (PI-GRO), went directly to the Congressional Black Caucus (CBC) to inform their discussions as they planned their legislative year. The CBC used the report to craft a congressional resolution on Black children and families that was introduced during Black History Month. APA's work on children's mental health yielded many products and initiatives. APA collaborated with the Society for Research in Child Development to convene a Summit on Early Childhood Mental Health. This led to a congressional briefing with a standing room only audience composed of Members of Congress, their staff, and representatives of many federal agencies and associations. All of these reports include sections with research recommendations disseminated broadly to public and private funding sources. A quick review of the Children, Youth, and Families web page (www.apa.org/pi/families) displays many topics and final products available on line and in hard copy.

Another essential CYFO function was the creation and nurturing of strong working relationships with APA divisions including the Division of Developmental Psychology (7), Division of School Psychology (16), Society for Child and Family Policy and Practice (37), Section on Child Maltreatment (Section 1 of 37), Division of Clinical Neuropsychology (40), Society for Family Psychology (43), the Society for the Study of Ethnic Minority Issues (45), Society of Child and Adolescent Clinical Psychology (53), and Society of Pediatric Psychology (54). These relationships enabled the CYFO to move forward on many controversial issues adding richness to the discussions and yielding products that reflect the depth and breadth of psychology's science based knowledge. This network also played a key role in maintaining the visibility of child, youth, and families issues across the Association and in product dissemination.

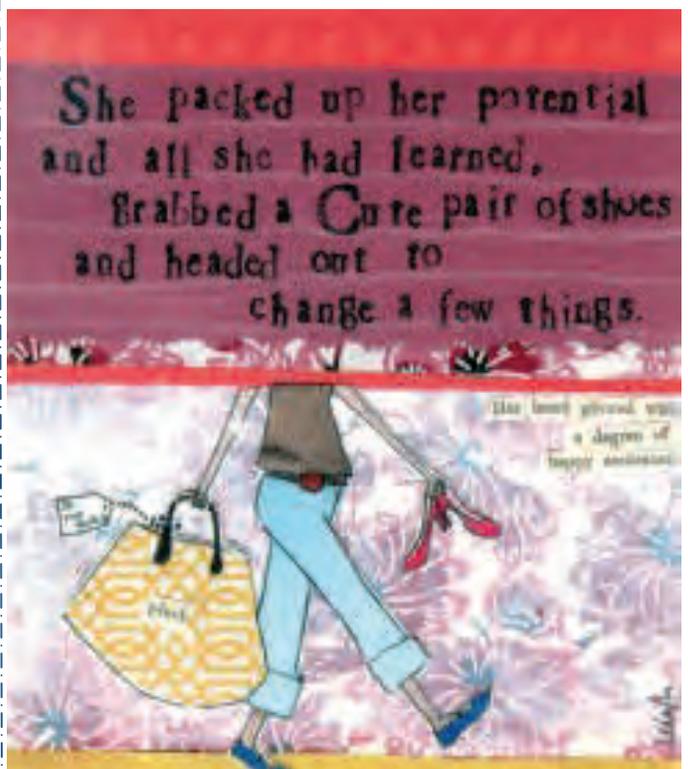
I consider myself very fortunate to have worked with such dedicated and knowledgeable APA staff and members over the years. I have been honored with numerous awards from the Association (APA Core Values Award for Employee Recognition and the APA Raymond D. Fowler Award) and from Divisions (43 -- Distinguished Service to the Division of Family Psychology Award 2001 and Certificate of Appreciation 2005; the Interdivisional Award for Exemplary Service from Divisions 7, 16, 37, 43, 53 & 54, 2009). In 2006, on CYF's behalf I accepted a Presidential Citation from then President Gerald P. Koocher, PhD. CYF honored me with an award for my commitment and

dedication to research, policy and practice to benefit children, youth, and families.

As I ended my APA career and said farewell to friends, members and co-workers at the 2011 APA Convention, I was again honored by my colleagues. I was the privileged recipient of a Certificate of Commendation from the Society of Family Psychology and I thank you most sincerely for this recognition. The Committee on Children, Youth, and Families presented me with the 2011 Award of Outstanding Achievement – a truly beautiful award received with heartfelt thanks and much appreciation. The Society for Child and Family Policy and Practice, during an award symposium, presented me with their Lifetime Achievement in Child Advocacy Award – I am deeply honored to receive this award.

I know that the hundreds of people I worked with over the years will continue to give a strong voice to children, youth, and families and that they will continue to work tirelessly to assure that the best science, research and practice form the basis for sound child, youth and family policy.

I thank you most sincerely for taking this journey with me and I wish you much success as you continue on your way.



2011 APA CONVENTION HIGHLIGHTS

Committee on Children, Youth, and Families Celebrates 25th Anniversary

The APA Convention was particularly momentous for the Committee on Children, Youth, and Families (CYF) in 2011. The Committee celebrated its 25th anniversary at the annual social hour cosponsored with the Society for Child and Family Policy and Practice (Division 37) and Society for Family Psychology (Division 43). The social hour was well attended by members of several child-focused divisions and former CYF chairs Drs. John Hagen, Anita Thomas, Karen Budd, and Barbara Fiese. Current CYF co-chairs Drs. Manny Casas and Monica Mitchell honored the occasion with heartfelt words recapping the accomplishments and critical mission of the Committee. A commemorative 25th anniversary booklet looking back at the history of CYF's achievements is available online at: <http://www.apa.org/pi/families/committee/anniversary.pdf>



Mary Campbell (Retired CYFO Director) Receives Division and CYF Awards

Mary Campbell, long-time outgoing director of the Children, Youth, and Families Office, received awards for her 25 years of achievement and excellence from both Division 43 and CYF at the social hour men-

tioned above. In addition, she received a lifetime advocacy award from Division 37. Ms. Campbell joins the esteemed company of the following previous awardees: former U.S. representative Christopher Dodd (D-CT) and groundbreaking psychologists Drs. Kenneth and Mamie Clarke and Ada Maurer. Drs. Sandra Bishop-Josef, Daniel Dodgen, Gerry Koocher, and Anita Thomas presided over the award ceremony. Each presenter recounted instances of past collaborations with Ms. Campbell that culminated in the advancement of public policy aimed at children, youth, and families. Ms. Campbell concluded the ceremony with a speech reflecting on her long career at APA and on Capitol Hill and thanking the many APA members and staff with whom she had partnered in the past.

Presidential Task Force on Immigration Presents on Upcoming Report

APA President Melba Vasquez's Task Force on Immigration was tasked with the mission of developing an evidence-based report addressing the psychological factors related to the experience of immigration, with particular attention to the mental and behavioral health needs and strengths of immigrants across the lifespan and the effects of acculturation, prejudice/discrimination, and immigration stressors on individuals, families, and society. At standing-room only capacity, the task force presented a symposium titled *Humanizing the Dehumanized: Psychological Implications of the Immigration Experience* that offered a preview of certain subsections of the upcoming report. 2011 CYF Co-Chair, Dr. Manny Casas is a member of the Presidential Task Force and presented briefly on issues surrounding intervention and best practices with immigrant populations. The Task Force was honored to have Drs. Lillian Comas-Diaz, Jose Cervantes, and Hiro Yoshikawa serve as chair, discussant, and presenter on public policy implications. Release of the report is anticipated in early 2012.

Symposium on the Mental Health of Youth in Foster Care

Dr. Yo Jackson (2011 CYF Co-Chair-elect) chaired a symposium titled *Mental Health and Youth in Foster Care: Systems of Care in Need of Review*. The symposium panelists included Dr. Heather Ringeisen, Sonya Leathers, and John Lyons. Dr. Ringeisen presented recent data from the National Survey of Child and Adolescent Well-Being II relevant to kids in the child welfare system. Dr. Leathers presented on recommended ways to integrate evidence-based interventions into child welfare services. Dr. Lyons concluded the symposium with an innovative look at how systems can improve services for youth in foster care by focusing on producing positive outcomes.

PUBLIC INTEREST GOVERNMENT RELATIONS UPDATE



The Public Interest Government Relations Office (PI-GRO; www.apa.org/about/gr/pi) engages in federal advocacy on behalf of APA Public Interest Directorate priorities. This year, PI-GRO has worked at the federal level to address CYF issues in areas including child and adolescent health, education, child and family development, child and family safety and violence prevention, and juvenile justice and delinquency prevention. This update highlights three areas in which PI-GRO has been particularly active during 2011: reauthorization of the Elementary and Secondary Education Act, bullying prevention, and child trauma.

APA Recommends Improvements in the Elementary and Secondary Education Act

As Congress considers legislation to reauthorize the Elementary and Secondary Education Act (ESEA), PI-GRO is advocating for policies that support students' learning and achievement. Throughout 2011, PI-GRO has collaborated closely with APA's Education and Science Government Relations Offices to advise Congress on improving ESEA. APA's recommendations include support for evidence-based programs in the areas of social and emotional learning, positive behavior supports and interventions, student threat assessment, and bullying prevention and intervention. Consistent with the APA Zero Tolerance Task Force Report (2006), these policy recommendations offer effective alternatives to counterproductive "zero-tolerance" policies and exclusionary discipline practices. Timing of the ESEA reauthorization is currently uncertain, in part because the House and Senate have taken very different approaches to the reauthorization. PI-GRO staff are following the progress of this legislation closely and advocating for inclusion of APA's recommendations in the reauthorization.

APA Advocates for Bullying Prevention

During 2011, PI-GRO has advised both Congress and federal agencies on applying psychological science to prevent bullying. As noted above, PI-GRO is advocating for support of evidence-based bullying prevention and intervention programs in the reauthorization of ESEA. Consistent with psychological research, APA's policy recommendations reflect the importance of addressing social norms that support bullying. For example, federal law currently does not protect students from bullying and harassment based on sexual orientation or gender identity. In May 2011, PI-GRO sent a letter of support to the U.S. Commission on Civil Rights that outlined research on effective methods for promoting a safe and positive school environment. As part of APA's bullying prevention advocacy, PI-GRO is working to support passage of the Student Non-Discrimination Act (H.R. 998 and S. 555), legislation that would establish a comprehensive federal prohibition against discrimination in public schools based on sexual orientation or gender identity.

APA Continues Advocacy for Child Trauma Initiative

During 2011, PI-GRO spearheaded an advocacy campaign aimed at stopping proposed cuts to the National Child Traumatic Stress Network (NCTSN). President Obama's Fiscal Year 2012 budget proposed a 72% cut to the NCTSN, which is administered by the Substance Abuse and Mental Health Services Administration and supports over 130 centers and affiliates focused on increasing access and raising the standard of care for children and families exposed to trauma. Advocacy efforts have included coordinating coalition letters, action alerts encouraging grassroots advocacy, congressional briefings, a policy webinar for NCTSN centers and affiliates, and a Capitol Hill Day for interdisciplinary teams of child trauma professionals. APA is now working with congressional appropriators in support of the strong collaborative mission and full funding for the NCTSN in Fiscal Year 2012.

Get Involved

Would you like to receive updates on federal policy issues and participate in coordinated outreach to your federal legislators? If so, please sign up for the APA Public Policy Advocacy Network (<http://www.apa.org/about/gr/advocacy/network.aspx>). If you have questions or would like more information about APA's federal policy activities related to children, youth, and families, please contact Kerry Bolger, PhD, Senior Legislative & Federal Affairs Office in APA's Public Interest Government Relations Office, at kbolger@apa.org.