Application of Evidence-Based Therapies to Children in Foster Care: A Survey of Program Developers

Amy J. L. Baker, PhD, Elissa J. Brown, PhD, Mel Schneiderman, PhD,
Komal Sharma-Patel, PhD, and Lauren M. Berrill, BA

Introduction

It is well established that children in foster care have elevated rates of mental health problems (e.g., dos Reis, Zito, Safer, & Soeken, 2001; Marsenich, 2002; Polihronakis, 2008). According to a literature review by Casey Family Programs, anywhere from 50% to 75% of children entering foster care have behavioral difficulties that rise to the level of requiring mental health services (Fanshel, Finch, & Grundy, 1989). Pilowsky (1995) found rates of psychopathology among children in family foster care that were higher than expected when compared with children from similar backgrounds. More recent data reveal that compared to youth in the general population, youth in foster care are significantly more likely to have at least one lifetime diagnosis of a mental illness (Pecora, Jensen, Romanelli, Jackson, & Ortiz, 2009). The kinds of emotional and behavioral disorders that have been documented among foster care youth include depression, anxiety, and aggression (Clausen, Landsverk, Ganger, Chadwick, & Litrownik, 1998; Handwerk, Frimen, Mott, & Stairs, 1998).

In New York City specifically, Lyons (2001) conducted a survey of the health and mental health needs of foster care children to address concerns about the adequacy of mental health interventions for children in this population. Lyons found that nearly one third of a sample drawn from New York City Administration for Children's Services (New York City's child protection services) was classified as having serious emotional disorders compared with 15% in the general population. Lyons also found that 74% of children living in kinship foster care, 73% of children living in regular foster family homes, and 88% of children living in congregate care had diagnosable emotional-behavioral problems. There is no doubt that foster care children in general and in New York City specifically are at high risk for current and long-term mental health problems.

These high rates of mental health problems are understood in the context of the multiple risk factors associated with foster care placement. The vast majority of youth served in the United States foster care system have been removed from their homes due to abuse or neglect, a significant risk factor for poor outcomes (Barlow, Smailagic, Ferriter, Bennett, & Jones, 2010; Goldman, Lloyd, Murphy, et al., 2007; Perry, 2002, 2006). Not only have children in foster care been abused and neglected but they also have been separated from their primary caregivers, resulting in emotional problems that can interfere with the parent-child attachment bond and placing them at high risk for establishing insecure and dysfunctional relationships (e.g., Bernard, Dozier, Bick, et al., 2012). Other risk factors that contribute to the development of serious emotional and behavioral problems for this population include environmental, social, biological and psychological influences (Kolko & Swenson, 2002).

Despite the overwhelming need, mental health services are not routinely available to children in foster care (Halfon, Mendonca, & Berkowitz, 1995; Halfon, Zepeda, & Inkelas, 2002; Landsverk, Burns, Stambaugh, & Rolls Reutz, 2006). For example, in a national survey only one fourth of children were found to have received what was defined as "adequate" mental health services within a year of entering foster care (Stahmer, Leslie, Hurlburt, et al., 2005). According to a Federal Child and Family Service Review (CFSR), most states failed to meet the psychological and behavioral treatment needs of child abuse and neglect victims (Huber & Grimm, 2004). More recent data are consistent, showing that only a handful of states met the goal of 95% compliance with well-being outcome number 3, defined as children receiving services that met their physical and mental health needs (JBS International, 2011).

Left out of the CFSR is whether the services that were offered were evidence based. This is a notable omission in light of the fact that the field of mental health treatment of emotional and behavioral problems of children (as well as adults) has moved toward evidence-based practice (EBP) (Chambless & Hollon, 1998; Cochrane, 1999). EBP is generally defined as the preferential use of interventions for which systematic empirical research has provided evidence of statistically significant effectiveness as treatments for specific problems (Cochrane, 1999). EBP

promotes the use of valid evidence for the purpose of helping service delivery organizations select programs and services that will allow them to use their limited resources in the most effective way. Evidence-based practice is distinguished from other types of knowledge such as "evidence-informed" or "evidence-suggested" by Chaffin and Friedrich (2004), who argue that the difficulty with these standards is that the bar is set so low that "inert or harmful practices can qualify, especially given reasonably articulate proponents and a rationale that resonates with current social values" (p. 1099).

According to Barth (2008), the move toward EBP in child welfare practice is now well established, beyond a passing fad or phase, as evidenced by funding sources and government agencies increasingly emphasizing EBP and rewarding agencies for using EBP in their service delivery systems. Several developments, such as a special issue of *Child Welfare* devoted to the topic and the creation of databases cataloguing evidence-based child welfare practices, indicate that the time for evidence-based child welfare programs and policies has come. Nonetheless, research demonstrates that the majority of youth in foster care may not be receiving evidence-based treatments (Cosgrove, Frost, Chown, & Anam, 2013).

Moreover, it remains unknown whether existing evidence-based mental health treatments would in fact be a good fit for children in foster care in light of their specific and sometimes unique needs. Children in foster care typically deal with a set of emotional and behavioral issues some of which are specific to their circumstances that ideally need to be addressed in treatment. However, not all evidence-based treatments—in their current manualized forms—may be able to address these issues.

Based on the combined clinical and research experience of the authors, the following ten issues have been identified as essential for treatment of children in foster care. Most children in foster care have been abused or neglected, or both. Hence, the first essential component of treatment of children in foster care is trauma work to help children process and recover from their traumatic experiences (Issue 1). This should include training in affect regulation (Issue 2), social-interpersonal skills (Issue 3), and promoting secure attachments (Issue 4) as these areas are typically compromised for abused and neglected children (e.g., van der Kolk, Pelcovitz, Roth, et al., 2006). Children in foster care have not only been abused or neglected but they also have been removed from their home and are navigating new and multiple care-giving relationships. The majority of children in the foster care system have a permanency goal of reunification (Goldhaber-Fiebert, Babiarz, Garfield, et al., 2013), and for those whose goal is not reunification, there is still the possibility of ongoing contact with the family of origin. Thus, any mental health treatment a child in foster care receives should include attention to these multiple relationships the child is affected by and involved with (Issue 5). Treatment should, therefore, involve family work on a number of levels, including improving attachment relationships that have been compromised from abusive or inadequate care-giving (Issue 6), facilitating and helping the family prepare for reunification (Issue 7), reducing family conflict while increasing family bonding and cohesion (Issue 8), and working directly with the biological and foster parents on parenting skills and sensitivity to infant and child developmental needs (Issue 9). A final essential issue relates to the fact that children in the foster care system straddle multiple agencies and social environments (educational, mental health, child welfare, and medical) and that mental health treatment may require coordination and integration across these settings to maximize its effectiveness (Issue 10).

The Current Study

The current study was designed to survey the developers of empirically-supported mental health therapies for children to determine the extent to which they are applicable to the needs of youth in foster care system. We identified three possible categories of treatments: (1) treatments designed and developed specifically for children in foster care, (2) treatments not developed or designed specifically for children in foster care but have been evaluated in a randomized controlled trial (RCT) that included foster care children in the sample, and (3) treatments neither designed nor tested for children in foster care but developed to address at least one of the ten essential foster care treatment issues.

For the Category 1 treatments, we wanted to know (1) how many have been evaluated with children in foster care using a RCT design, (2) how many analyzed the data specifically for children in foster care, (3) how many found positive results for the foster-care specific analyses, (4) how many published and/or presented the results of the foster care-specific analyses, and (5) how many and which of the essential foster care treatment issues could the treatment address without modification.

For the Category 2 treatments—all of which had been evaluated with a RCT that included foster care children in the sample—we wanted to know (1) how many analyzed the RCT data specifically for children in foster care, (2) how many found positive results specifically for the foster care sample, (3) how many published and/or presented the findings of the foster care-specific analyses, and (4) how many and which of the essential foster care treatment issues could the treatment address without modification.

For the Category 3 treatments—none of which had been tested with children in foster care—we wanted to know how many and which of the essential foster care treatment issues could the treatment address without modification.

Identification of Treatments

A comprehensive Internet and academic literature search was conducted to identify therapies for inclusion in our guidebook. We sought manualized (in English) mental health treatments

currently in operation in the United States that could be applicable for children in foster care—that is, the exclusion criteria did not preclude children in foster care.

To identify potential therapies, several evidence-based program registries were reviewed, noting that each uses slightly different procedures and standards for deeming a treatment evidence-based. A second source of identification of therapies came through an extensive literature search using the following search terms: *treatment for foster care, therapy for foster care, evidence-based treatments for maltreatment, and treatment for children who have experienced trauma*. Through this process, 81 treatments were identified. Table 1 provides an overview of the sources consulted. Where the source is a report, a date is provided.

Table 1. Program Registries Searched

Source	Search Criteria
Web site: Substance Abuse and Mental Health Services National Registry of Evidence-Based Programs and Practices (NREPP). http://www.nrepp.samhsa.gov	Searchable listing. Keywords used: mental health treatment for children 0–17 years of age.
Report: Kauffman Best Practices Project to Help Children Heal From Child Abuse. (2004). http://www.chadwickcenter.org/Documents/Kaufman%20Report/ChildHosp-NCTAbrochure.pdf.	Non-searchable listing of 3 treatments.
Report: Child Physical and Sexual Abuse: Guidelines for Treatment. http://www.musc.edu/ncvc/resources_prof/OVC_guidelines04-26-04.pdf	Non-searchable listing of 22 treatments.
Web site: California Evidence-Based Clearinghouse for Child Welfare/ http://www.cebc4cw.org/	Searchable database. Nine topics related to mental health treatment were searched: anxiety in children, behavioral management of adolescents, bipolar disorder treatment for children and adolescents, depression treatment for children, discipline behavior treatment for children and adolescents, infant and toddler mental health, sexual behavior problems in children, sexual behavior problems in adolescents, and trauma treatment in children.
Web site: National Child Traumatic Stress Network Empirically Supported Treatments and Promising Practices. http://www.nctsnet.org/nccts/nav.do?pid=ctr_top_trmnt_prom	Non-searchable listing of 38 treatments.
Report: Implementing Evidence-Based Practice in Treatment Foster Care: A Resource Guide Prepared by Foster Family-Based Treatment Association. (2008).	Non-searchable listing of 21 treatments.
Report: Regional Research Institute for Human Services.	Non-searchable listing of 7 treatments.

Study Procedures

An introductory letter was sent via e-mail to the 81 treatment developers or contact persons (obtained from various Web sites) inviting them to review information we had compiled about their treatment and inviting them to complete a brief survey via Qualtrics. We explained that their responses would be compiled in a compendium of treatments (currently available at https://www.nyfoundling.org). Over a four-month period, 75 (92.6%) of the surveys were completed.

Survey

The 27-item survey was neither confidential nor anonymous and asked the respondents to report on the types of evaluations conducted on the therapy, with special attention to the sampling and effects specific to children in foster care. The survey asked (1) whether the treatment was designed specifically for children in foster care, (2) whether the treatment was deemed effective with children in foster care (the type of research conducted on the treatment, the proportion of foster care children in the various studies, whether the data for children in foster care were analyzed and reported separately), and (3) whether the treatment could—without modification—address the ten essential concerns for children in foster care: promoting secure attachments with caregivers; training in affect regulation; social-interpersonal skills training; parenting skills of caregivers of child clients; working with multiple caregivers; integrating and coordinating with social service agencies and a child's social environment; conducting trauma work around physical, sexual, and emotional abuse and neglect; engaging in family work to improve attachment relationships; facilitating family reunifica-

tion for children in out-of-home care; and reducing family conflict and promoting family cohesion. The following information was collected from Internet write-ups and confirmed with the program developer or contact person: targeted age of child clients, role of parents in treatment, modality (individual, dyadic, family, or group), core components, and inclusion-exclusion criteria.

Results

Category 1 treatments. Four treatments were reported to have been designed specifically for children in foster care. Information about these treatments is presented in Table 2. As can be seen, of these four treatments, two were tested with children in foster care with a RCT design. Both of these reported to have analyzed the foster care data separately, found positive results, and published and/or presented the findings. These two treatments are attachment and bio-behavioral catch-up and MTFC-P (formerly EIFC). Next we asked how many of these four Category 1 treatments were reported to be able to address the ten essential issues. All but one of the four treatments were rated as being able to address each of the ten issues.

Category 2 treatments. Twenty-two treatments were reported to have been—although not designed specifically for children in foster care—evaluated in a RCT design with foster care children in the sample. These treatments are presented in Table 3. Of these 22 treatments, only one (incredible years) met the criteria of having the foster care data analyzed separately, with positive results, and published and/or presented. Next we asked how many of these 22 treatments were reported to be able to address the ten essential issues. Six of the treatments were rated as addressing all ten issues, ten were rated as addressing nine of the issues, two were rated as addressing eight and seven each, and one treatment each was rated as being able to address six and two issues.

Category 3 treatments. Of the remaining 49 evidence-based mental health treatments for children, we aimed to identify which ones—although neither designed for nor evaluated with children in foster care—would be applicable because of their ability to address the ten issues. Table 4 presents these data. As can be seen, between 38% and 90% of the treatments were rated as being able to address each of the essential issues. A summary score was created that represented the number (out of ten) of the essential issues each treatment was rated as being able to address. The frequency distribution of these variables is presented in Table 5. We found that slightly fewer than one fourth of the treatments were rated as being able to address all ten issues, 13% were rated as being able to address nine issues, and fewer than 10% each were rated as being able to address between two and eight issues.

Discussion

This study was conducted to ascertain whether the current landscape of mental health treatment for children would be appropriate for children in the foster care system. Only four treatments were reported to be specifically designed for foster care youth. Additionally, only two of those four were evaluated using a RCT design that included foster children in the sample, with these data analyzed separately, and with positive results published and/or presented. Furthermore, two treatments developed and tested for the foster care population focus on young children: the ABC program (birth–5 years of age) and MTFC/formerly EIFC, a group-based treatment (3–6-year-olds). No mental health treatment was designed and tested specifically for children in foster care over the age of 6. Moreover, both ABC and MTFC/formerly EIFC require the active participation of parents, which is ideal but not always possible. Thus, of all the evidence-based treatments for providing mental health services to children currently in operation, only four were created with foster children in mind. This represents

Table 2. Category 1 Treatments

Treatment	RCT	% foster care youth	Foster care data analyzed	Foster care data positive	Published foster care data	**Essential Issues**	Promoting secure attachment	Training affect regulation skills	Social skills training	Parenting skills	Multiple caregivers	Integrating across systems	Trauma work	Family work to improve attachment	Facilitating reunification	Reducing family conflict
ABC	✓	30%	✓	✓	✓		✓			✓	✓	✓		✓	✓	✓
MTFC-P/EIFC	✓	100%	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Path-ways		n/a	n/a	n/a	n/a		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Real Life Heroes		n/a	n/a	n/a	n/a		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

n/a = not applicable

Table 3. Category 2 Treatments

Treatment	RCT	% foster care youth	Foster care data analyzed	Foster care data positive	Published foster care data	**Essential Issues**	Promoting secure attachment	Training in affect regulation skills	Social skills training	Parenting skills	Multiple caregivers	Integrating across systems	Trauma work	Family work to improve attachment	Facilitating reunification	Reducing family conflict
ACTION	✓	65	no	n/a	n/a			✓	✓	✓	✓	✓	✓	✓	✓	✓
Adolescent Coping with Depression Course	✓	10	no	n/a	n/a			✓	✓	✓	✓	✓		✓		
AF-CBT	✓	10	no	n/a	n/a			✓	✓	✓	✓	✓	✓			✓
Challenging Horizons	✓	Don't know	no	n/a	n/a			✓	✓	✓	✓	✓	✓			✓
Child-Parent Psychotherapy	✓	Don't know	no	n/a	n/a		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Collaborative Problem Solving	✓	Don't know	no	n/a	n/a			✓	✓	✓	✓	✓	✓	✓	✓	✓
Combined Parent-Child Psychotherapy	✓	25	no	n/a	n/a			✓	✓	✓	✓	✓	✓	✓	✓	✓
Coping Cat	✓	05	no	n/a	n/a		✓	✓	✓	✓	✓	✓	✓	✓		✓
Coping Power and Anger Coping	✓	10	no	n/a	n/a		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Family Behavior Therapy	✓	05	no	n/a	n/a		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Incredible Years	✓	100	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Integrative Developmental Therapy	✓	Don't know	no	n/a	n/a		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Multidimensional Treatment Foster Care for Specialized Populations	✓	25	✓	✓	no		✓	✓	✓	✓		✓	✓		✓	✓
Multidimensional Family Therapy	✓	20	no	no	n/a		✓	✓	✓	✓	✓	✓	✓		✓	✓
MST for Child Abuse and Neglect	✓	05	no	n/a	n/a		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Parent-Child Interaction Therapy	✓	65	no	n/a	n/a		✓	✓	✓	✓	✓	✓		✓	✓	✓
Problematic Sexualized Behaviors CBT	✓	13	no	n/a	n/a		✓	✓	✓	✓	✓	✓		✓	✓	✓
Prolonged Exposure for Adolescents	✓	??	no	n/a	n/a			✓						✓		
Risk Reduction Through Family Therapy	✓	25	no	n/a	n/a			✓	✓	✓	✓	✓	✓	✓	✓	✓
Seeking Safety	✓	Don't know	no	n/a	n/a		✓	✓	✓	✓		✓	✓			✓
TF-CBT	✓	40	✓	✓	No		✓	✓	✓	✓	✓	✓	✓	✓		✓
TARGET	✓	33	no	n/a	n/a		✓	✓	✓	✓	✓	✓	✓	✓		✓

n/a = not applicable

an obvious gap in the service delivery landscape for some of the nation's most vulnerable children. On a positive note, we found that three of the four Category 1 treatments designed specifically for children in foster care were reported to be able to address all ten essential issues. However, it is important to note that while we consider the ten issues essential for foster care youth, it is unknown at this time whether all ten are essential for effective treatment. This represents an obvious area for future research.

In light of how few treatments have been designed specifically for children in the foster care system, we also aimed to identify treatments that—while not designed specifically for foster care children—have been tested and found to be effective for them. This resulted in the identification of one more program, the incredible years, and two treatments that did find positive results but haven't published the findings: multidimensional treatment foster care and TF-CBT. (It is unclear why the positive findings haven't been published.) Of these three treatments (incredible years, multidimensional treatment foster care, and TF-CBT), only incredible years was reported to be able to address all ten essential issues. Again, foster care children—an important consumer of mental health treatments—are for the most part not being purposefully

Table 4. How Many Category 3 Therapies (n=48) Were Reported by Program Developers to Be Able to Address the Ten Essential Issues?

	N	%
Promoting secure attachments with caregivers	37	77.1
Training in affect regulation skills	43	89.6
Social-interpersonal skills training	41	85.4
Parenting skills of caregivers of child clients	35	72.9
Working with multiple caregivers	31	64.6
Integrating and coordinating with social service agencies and child's social environment	25	52.1
Conducting trauma work around physical, sexual, and emotional abuse and neglect	30	62.5
Engaging in family work to improve attachment relationships	32	66.7
Facilitating family reunification for children in out-of-home care	18	37.5
Reducing family conflict and promoting family cohesion	33	68.8

Missing=1

included in randomized controlled trials testing the efficacy of various treatment protocols. This means that for the majority of evidence-based mental health treatments, it remains unknown whether the therapies would be effective for children in foster care.

Finally, we examined the remaining evidence-based mental health treatments for children and found that of the 49 treatments, 11 reported to be able to address all ten topics/elements: attachment, self-regulation and competency; circle of security, cognitive behavior therapy (anger control training with stress inoculation); functional family therapy; honoring children/mending the circle; intergenerational trauma treatment model; interventions for children with sexual behavior problems—research, theory, treatment; safety, mentoring, advocacy, recovery, and treatment; sanctuary; trauma outcome process assessment (TOPA) model; and trauma-focused integrated play therapy. These treatments were neither designed nor evaluated with children in foster care but report to be able to address the essential issues for treatment of this population. As previously noted, it is unknown whether any or all of these are in fact essential for the effective delivery of mental health treatments for children in foster care, and this should be addressed in future research.

Limitations

All data collected for this project were by self-report. This is particularly relevant for understanding the data regarding the ability of the program to address the ten issues. It seems possible that a treatment could have been rated as being able to address a certain issue but that in reality the treatment really cannot do so without modification to the treatment protocol. It is possible that these ratings represent the ideal or hypothetical rather than the reality, or what the developers of the treatment interventions *believe* not necessarily what they *know* based on empirical findings. For example, many treatments were rated as being able to integrate with other service systems, but we know from experience that this is often quite time consuming and challenging and that in reality this often does not occur as often or as consistently as it should. Likewise, working with multiple caregivers (an essential element that was endorsed by 19 of the 22 Category 2 treatments and 31 of the 49 Category 3 treatments) is in reality quite complicated and cumbersome. We are not aware of any guidelines or practice wisdom available for child welfare agencies who want to implement these treatments for a child welfare population.

Table 5. How Many of the Ten Essential Issues Could Category 3 Treatments (n=46) Address Without Modification, as Reported by Treatment Developers?

	N	%
0	0	0.0
1	0	0.0
2	1	2.2
3	8	17.4
4	1	2.2
5	4	8.7
6	10	21.7
7	3	6.5
8	2	4.3
9	6	13.0
10	11	23.9

Missing=3

Implications and Directions for Future Treatment and Research

The data collected, despite these limitations, highlight several directions for future work in this area. First, it would be important to determine whether the Category 2 treatments are effective specifically for children in foster care. This would involve not just including foster care children in the sample of a RCT but analyzing the data separately to ensure that the positive results are applicable for this subsample. Second, it is important to determine whether the Category 3 treatments are effective for children in foster care by following a similar approach of conducting randomized controlled trials with children in foster care included in the sample to a large enough extent that these data can be analyzed separately.

An additional direction for future research would be to ascertain (of the sample of effective treatments) whether the full range of possible treatment needs are covered. For example, are there treatments to treat various internalizing and externalizing disorders across the various age groups, are there treatments to address attachment-bonding issues in various age groups, and so forth. Significant gaps (e.g., no dyadic treatment for anxiety in school-aged children) could then be the focus of treatment development options. Yet another direction for the future would be to ascertain whether the ten essential issues are in fact essential and which treatments are able to actually address them. Taken together, these suggested directions reflect an ambitious program of treatment development and program evaluation that would require a long-term commitment of time, energy, and resources. Children living in foster care settings face multiple and complex environmental, social, biological, and psychological risk factors that may require specially designed interventions to meet their unique mental health and environmental needs. Children in foster care deserve nothing less.

References

Barlow, J., Smailagic, N., Ferriter, M., Bennett, C., & Jones, H. (2010). Group-based parent-training programs for improving emotional and behavioral adjustment in children from birth to 3 years old. *Cochrane Database Systematic Reviews, 17*(3). doi: 10.1002/14651858.CD003680.pub2

Barth, R. P. (2008). The move to evidence-based practice: How well does it fit child welfare services? *Journal of Public Child Welfare, 2*(2), 145–177.

Bernard, K., Dozier, M., Bick, J., et al. (2012). Enhancing attachment organization among maltreated children: Results of a randomized clinical trial. *Child Development, 83*(2), 623–636.

Chaffin, M., & Friedrich, B. (2004). Evidence-based treatments in child abuse and neglect. *Children and Youth Services Review, 26,* 1097–1113.

Chambless, D. L., & Hollon, S. D. (1998). Defining empirically supported therapies. *Journal of Consulting and Clinical Psychology, 66*(1), 7–18.

Clausen, J. M., Landsverk, J., Ganger, W., Chadwick, D., & Litrownik, A. (1998). Mental health problems of children in foster care. *Child Abuse & Neglect, 18,* 923–932.

Cochrane, A. L. (1999/1972). *Effectiveness and efficiency: Random reflections on health services.* London: Nuffield Provincial Hospitals Trust. Reprinted in 1989 in association with the BMJ. London: Royal Society of Medicine Press, 1-85315-394-X.

Cosgrove, S., Frost, C., Chown, R., & Anam, T. (2013, May). *Strengthening health outcomes for foster care children.* Report submitted to the Wisconsin Department of Children and Families Madison, WI.

dos Reis, S., Zito, J. M., Safer, D. J., & Soeken, K. L. (2001). Mental health services for youths in foster care and disabled youths. *American Journal of Public Health, 91*, 1094–1099.

Fanshel, D., Finch, S. J., & Grundy, J. F. (1989). Foster children in life-course perspective: The Casey Family Program experience. *Child Welfare*, *68*, 467–478.

Goldhaber-Fiebert, J. D., Babiarz, K. S., Garfield, R. L., Wulczyn, F., Landsverk, J., & Horwitz, S. M. (2013). Explaining variations in state foster care maintenance rates and the implications for implementing new evidence-based programs. *Children and Youth Services Review*. Available at: **http://dx.doi.org/10.1016/j.childyouth.2013.10.002**

Goldman, F. J., Lloyd, S. W., Murphy, R. A., Crowson, M. M., Casanueva, C., Zolotor, A., Coker-Schwimmer, M., Letourneau, K., Gilbert, A., Swinson Evans, T., Crotty, K., & Viswanathan, M. (2007). *Child exposure to trauma: Comparative effectiveness of interventions addressing maltreatment*. Comparative effectiveness review no. 89. (Prepared by the RTIUNC Evidence-Based Practice Center under Contract No. 290-2007-10056-I.) AHRQ publication No. 13-EHC002-EF. Rockville, MD: Agency for Healthcare Research and Quality. April 2013. Available from: **www.effectivehealthcare.ahrq.gov/reports/final.cfm**

Halfon, N., Mendonca, A., & Berkowitz, G. (1995). Health status of children in foster care: The experience of the Center for the Vulnerable Child. *Archives of Pediatric and Adolescent Medicine, 149*(4), 386–392.
Halfon, N., Zepeda, A., & Inkelas, M. (2002). *Mental health services for children in foster care.* Policy statement no. 4. CWLA Center for Healthier Children, Families, and Communities. Los Angeles: University of California at Los Angeles. Retrieved December 1, 2013.
Handwerk, M. L., Friman, P. C., Mott, M. A., & Stairs, J. M. (1998). The relationship between program restrictiveness and youth behavior problems. *Journal of Emotional and Behavioral Disorders*, *6*(3), 170–179.
Huber, J., & Grimm, B. (2004). Child and family services reviews, part V: Most states fail to meet the mental health needs of foster children. *Youth Law Review, 25*(4), 1–13.
JBS International, Inc. (2011, December 16). *Child and Family Services Reviews aggregate report: Findings for round 2 fiscal years 2007–2010.* North Bethesda, MD: Author.
Kolko, D. J., & Swenson, C. C. (2002). *Assessing and treating physically abused children and their families.* Thousand Oaks, CA: Sage.
Landsverk, J. A., Burns, B. J., Stambaugh, L. F., & Rolls Reutz, J. A, (2006). *Mental health care for children and adolescents in foster care: A review of the literature*. Seattle: Casey Family Programs. Available at: **www.casey.org/Resources/Publications/pdf/MentalHealthCareChildren.pdf**.
Lyons, J. (2001) *The health and mental health needs of children in child welfare in New York City, Report to the Administration for Children's Services*. New York: NYC Administration for Children's Services.
Marsenich, L. (2002). *Evidence-based practice in mental health services for foster youth*. Sacramento, CA: California Institute for Mental Health.
Pecora, P. J., Jensen, P. S., Romanelli, L., Jackson, L. J., & Ortiz, A. (2009, January-February). Mental health services for children placed in foster care: An overview of current challenges. *Child Welfare, 88*(1), Special Issue.
Perry, B. D. (2002). Childhood experience and the expression of genetic potential: What childhood neglect tells us about nature and nurture. *Brain and Mind, 3,* 79–100.
Perry, B. D. (2006). Applying principles of neurodevelopment to clinical work with maltreated and traumatized children. Reprinted from N.B. Webb (2006). *Working with traumatized youth in child welfare.* New York: Guilford Press.
Pilowsky, D. (1995). Psychopathology among children placed in family foster care. *Psychiatric Services*, *46*(9), 906–910.
Polihronakis, T. (2008). *Mental health care issues of children and youth in foster care* [Information packet]. New York: Hunter College School of Social Work.
Stahmer, A. C., Leslie, L. K., Hurlburt, M., Barth, R. P., Webb, M. B., Landsverk, J., & Zhang, J. (2005). Developmental and behavioral needs and service use for young children in child welfare. *Pediatrics, 116,* 891–900.
van der Kolk, B., Pelcovitz, D., Roth, S., Mandel, F., McFarlane, A., & Herman, J. (1996). Dissociation, somatization, and affect dysregulation: The complexity of adaptation to trauma. *American Journal of Psychiatry, 153*, 83–93.

Acknowledgement
The authors gratefully acknowledge all those who completed the survey, reviewed their program charts, or both.

About the Authors
Amy J. L. Baker, PhD, is Director of Research at the New York Foundling Vincent J. Fontana Center for Child Protection. She is the author of several books and over 90 articles on topics related to parent-child relationships, child maltreatment, and mental health services for children in the child welfare system. Contact: **amyb@nyfoundling.org**

Elissa J. Brown, PhD, is Professor of Psychology and Executive Director of the Child HELP Partnership at St. John's University. Her primary clinical and research interests include the prevention and treatment of child trauma and posttraumatic stress disorder. She has participated in research on the assessment and treatment of sexual assault, child physical abuse, and bereavement related to traumatic circumstances (such as September 11, 2001), with specific interest in adaptations for culturally diverse families. She is Director of a Category III affiliate site of the National Child Traumatic Stress Network and a member of several national organizations dedicated to improving mental health services for traumatized children. Contact: **Browne@stjohns.edu**

Mel Schneiderman, PhD, is Senior Vice President, Mental Health Services at the New York Foundling and is Cofounder and Senior Advisor and Chair of the Research Advisory Committee at the Vincent J. Fontana Center for Child Protection. He is past president of the American Professional Society on the Abuse of Children-–New York. He has served on several nonprofit boards and presented at over 50 conferences and workshops. He is the recipient of numerous grants and has published several articles in peer-reviewed journals. Contact: **mels@nyfoundling.org**

Komal Sharma-Patel, PhD, is Assistant Director of Research for the Child HELP Partnership at St. John's University, overseeing the daily research and clinical operations of a clinical-research program and an affiliate site of the National Child Traumatic Stress Network (Brown, PI) based in the Department of Psychology at St. John's University that focuses on providing evidence-based treatments to youths with maltreatment histories and their caregivers. She also has been closely involved in the conceptualization and implementation of a 3-year project on trauma-specific treatment for foster care youth. Contact: **Sharmak@stjohns.edu**

Lauren M. Berrill, BA, served as a research intern under Dr. Amy J. L. Baker at the Vincent J. Fontana Center for Child Protection. She received her Bachelor's degree from Smith College in 2013. She is currently a Master's degree candidate at Teachers College, Columbia University, in the field of clinical psychology. Contact: **lmb2247@tc.columbia.edu**