ADAPT© MANUAL

I. Introduction

ADAPT© is a convenient, multi-dimensional mental health screening, tracking, and planning tool for use with children in alternative care (i.e. in foster care, kinship placement) or with children who have been adopted from foster care. An online instrument, ADAPT© can be filled out by the child's or youth's foster, kinship, adoptive parent and/or caseworker in about twenty minutes, and an integrated summary report will be generated instantly.

In brief, ADAPT uses an in-depth questionnaire to identify a child's strengths, psychological and behavioral health problems, urgent concerns that pose risk to self or others, individual trauma history, risk of placement instability, psychiatric symptoms, psychotropic medication usage, and general medical concerns.

II. Demonstration of Need/Background:

In the following section, we discuss the need for a screening tool that addresses health and mental health issues for the highly vulnerable group of children in out-of-home care, disproportionate numbers of whom suffer from a variety of problems. Indeed, children and youth in foster care are considered to have "special health care needs" (Lopez & Allen, 2007), i.e. as a group they "have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally" (Child and Adolescent Health Measurement Initiative, 2012).

A. Need for Mental Health Screening Tool

There is an ongoing need for an effective, multi-faceted mental health screening tool for children in out-of-home care (Huber et al. 2004). Between 50 and 80 percent of children in foster care suffer from moderate to severe mental health problems. The prevalence of psychological problems in this group is three to seven times greater than the norm. The lack of a foster care-specific mental health screening tool has been documented elsewhere (Tarren-Sweeney, 2009).

State child welfare agencies are subject to federal requirements for screening and assessment of children and youth entering foster care. Fostering Connections to Success and Increasing Adoptions Act of 2008 (PL 110-351) mandates that each state build a strategy to ensure access to health, mental health and dental care for foster children. A "coordinated

strategy and oversight plan" must outline: a schedule for initial and follow-up screening and monitoring of prescription medicines.

Additionally, specific guidelines from the American Academy of Pediatrics recommends that within 30 days of foster care placement, children and youth have a detailed, comprehensive evaluation that includes mental health. The Council on Accreditation (COA, 2008) recommends initial screening within 72 hours of a child's entry into foster care to identify the need for immediate medical or mental health care. COA also recommends follow-up assessments within 30 days of foster care entry to help child welfare agencies determine the most appropriate placement for a child.

B. The Importance of Traumatic Childhood Events' Impact on Children and Youth in Care

Trauma, Traumatic Childhood Events or Adverse Childhood Experiences (ACEs) are closely related terms referring to early life exposure to events which have short and long-term impact on individuals' physical and mental health. Typically, ACEs include 10 childhood *family-level* experiences: emotional abuse, physical abuse, sexual abuse, emotional neglect, physical neglect, violent treatment towards mother, household substance abuse, household mental illness, parental separation or divorce, and having an incarcerated household member (Felitti et al., 1998). More recent research on ACEs has expanded risk factors to include witnessing community violence, discrimination, unsafe neighborhoods, experiencing bullying, and placement in foster care (Cronholm et al., 2015). These additional five factors include risks found at the *community level*. Children in standard foster care, treatment foster care, as well as juvenile justice populations have been found to have significantly higher rates of exposure to ACEs (Cronholm et al., 2015; Jamora et al., 2009).

Children in foster care are particularly likely to have experienced adverse family events (Bramlett et al., 2014). According to a national health care report (National Survey of Child and Adolescent Well-being, Stambaugh et al, 2013) children in foster care were particularly likely to have had multiple types of adverse experiences; almost one-half of them had had four or more. More than one-half of children in foster care had experienced caregiver violence or caregiver incarceration and almost two-thirds had lived with someone who had an alcohol or drug problem.

C. Need to Track Psychotropic Medication Utilization

Nearly one in three states have identified the oversight of psychotropic medication use in state foster care populations as one of the most pressing issues facing their child welfare systems. Medicaid records from the State of Texas in 2004 revealed that 43% of children in foster care were using three or more medications concomitantly, and 22% were duplicating medications within the same pharmacologic class. At the federal level, the Administration of Child and Family seeks to reduce the over-reliance on drugs and increase the use of appropriate screening, assessment, and psychosocial interventions. More recently, the Child and Family Services Improvement and Innovation Act (PL 112-34) requires states to establish protocols for the appropriate use and monitoring of psychotropic medications prescribed to children in foster care. Additionally, the American Academy of Child and Adolescent Psychiatry (AACAP) recommends robust oversight of psychotropic medication use with foster children and underscores the need for employing a bio-psychosocial framework to guide the use of psychotropic medications with this population (AACAP, 2015).

D. Need to Identify Risk of Placement Instability

Placement disruptions have adverse effects on foster children (Fisher et al., 2011). Despite the critical role of placement stability in children's and youth's healthy growth and development while in foster care (Sudol, 2009), placement stability remains elusive for foster children and youth. In one study over an 18-month period, nearly 30% of foster children experience placement instability (Rubin et al, 2008). A class action suit in Texas revealed that as of August 2011, 35 percent of children in foster care over a year had been in five or more placements.

A growing body of research has identified numbers of child characteristics and conditions that are associated with placement disruptions and multiple foster care placements. Case in point: children are more likely to experience placement instability when they are older when they enter foster care (Eggersten, 2008). Importantly, children's emotional and behavioral problems are linked to placement instability (Barber et al, 2001). Additionally, the existence of a mental health problem doubled the likelihood of a child experiencing 3 or more foster care placements (Eggersten, 2008). In cascading fashion, placement disruptions produce emergence of new behavior problems or exacerbation of existing problems, which in turn increase likelihood of subsequent disruptions as well as other negative outcomes (e.g. movement to higher, more restrictive level of care). Importantly, federally mandated Child and Family Service Review summaries have identified the need for a screening instrument that can predict risk of disruption and instability, which might allow prevention of same.

E. Health and Medical Problems

Nearly 60 percent of children in foster care experience a chronic medical condition, and one-quarter suffer from three or more chronic health conditions. Developmental delays, asthma and other respiratory problems top the list. Roughly 35 percent of these children have significant oral health problems (Simms et al. 2000). State child welfare agencies are subject to federal requirements for screening and assessment of children and youth entering foster care. Fostering Connections to Success and Increasing Adoptions Act of 2008 (PL 110-351) mandates that each state devise a strategy to ensure access to health and mental health and dental care for foster children. A "coordinated strategy and oversight plan" must outline a schedule for initial and follow-up screening and monitoring of prescription medicines.

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F. Inclusion of Strengths

Children and youths' strengths are "emotional and behavioral skills, competencies, and characteristics that create a sense of personal accomplishment; contribute to satisfying relationships; enhance the ability to deal with adversity and stress; and promote personal, social, and academic development." (Epstein et al, 2004).

Child welfare interventions for children and families have increasingly adopted a strengths-based model of practice as a complement to a strictly risk-based model of practice. This model, which focuses upon screening for, assessing and building upon a youth's strengths, is viewed as critical for healthy child and adolescent development and well-being. More specifically, this strengths approach to mental health screening can pinpoint how children and youth can be supported by parents and practitioners in ways that advance healthy development and well-being while reducing the impact of traumatic, adverse childhood experiences. Incorporating strengths into mental health screening orients case planning towards a proactive stance and positive direction. Thus, mental health screening of children accordingly should include the identification of the positive individual attributes, skills, and interests of children which can mitigate risk exposure and spur positive

outcomes. Screening instruments should inventory existing or developing abilities to regulate emotions and behavior; engage with others in socially competent ways; plan a head and problem-solve; seek out and make positive social connections; and become engaged in positive activities (ACYF, 2014). Inclusion of and emphasis on strengths is consistent with new legislation on "normalcy" which mandates involvement by foster children in activities which are age-appropriate and growth inducing (P.L. 113-183, 2015). The emphasis is on fostering the development of prosocial skills and supportive relationships, both of which promote short- and long-term positive outcomes for children in child welfare.

III. ADAPT Nine (9) Components:

There are nine (9) components in ADAPT which address the needs summarized above.

A. **Demographics component:** includes the child's age, gender, interests, goals, placement type and number of past out-of-home placements.

B. **Traumatic Childhood Events:** consists of ten (10) items which are modeled after ACE and NSCAW studies, and includes information on the child's exposure to interpersonal trauma (e.g. abuse, neglect) and risk events (e.g. parental incarceration).

C. **Psychological/Behavioral Health Problems:** consists of one hundred-and-four (104) items, including externalizing and internalizing behavior problems.

D. **Urgent Concerns:** consists of forty-seven (47) items, drawn from the psychological and psychiatric components, which expose a potential threat to the child or foster family (e.g. fire-setting, suicidal ideation, going off with strangers).

E. **Placement Instability Risk:** consists of forty (40) items tapping into risk and protective factors. The relative risks (low, moderate, high) of placement instability and disruption are identified.

F. **Psychiatric Screening:** consists of one hundred-eighteen (118) items which are modeled upon the DSM-V. Endorsement and analysis of items (signs and symptoms) leads to identification of potential psychiatric disorders.

G. **Psychiatric Medications:** collects information about current psychotropic medications the child is taking and identifies potential inappropriate utilization.

H. **Medical Concerns:** gathers and reports information on the child's physical health history.

I. **Child's/Youth's Strengths:** consists of fifteen (15) items related to resiliency and recovery.

J. IV**. ADAPT Psychometrics**

A. ADAPT Validity. Initial study of validity was undertaken by having parents fill out ADAPT followed by the Strengths and Difficulties Questionnaire (SDQ). The results of two concurrent validation studies (i.e. ADAPT alpha studies) are summarized next.

1. Concurrent Validation Study One (Office practice study):

An alpha test of ADAPT was completed during a one week period in March, 2015. Parents (47 biological and 13 adoptive) who had been referred to and whose children were patients at an outpatient psychiatry office (of ADAPT co-developer, James Kagan, M.D.) in a western state volunteered to participate. ADAPT was filled out online on 60 children (37 boys and 23 girls) by either mother or father but not both. Parents worked on ADAPT from home. An online version of the SDQ was filled out directly after the completion of ADAPT. The age range of the children was 4-20 years old with a mean of 14.2.

Coded data were used to protect the identity of parents and children from researchers. Data on correlation is summarized in four figures which are presented next.

Figure 1.1 shows the correlation between ADAPT Psychological/Behavior Health Problems and the SDQ (correlation = .56).

Figure 1.2 shows the correlation between ADAPT Psychiatric Component and SDQ (correlation = .51).

Figure 1.3 shows the correlation between ADAPT Traumatic Childhood Events and SDQ (correlation = .27).

Figure 1.4 shows the correlation between ADAPT Total (Psychological/Behavioral Health and Psychiatric components) with the SDQ (correlation = .58).

Figure 1.1 Correlation of ADAPT Psychological/Behavioral Health Problems and the Strengths and Difficulties Questionnaire in Outpatient Psychiatry Practice

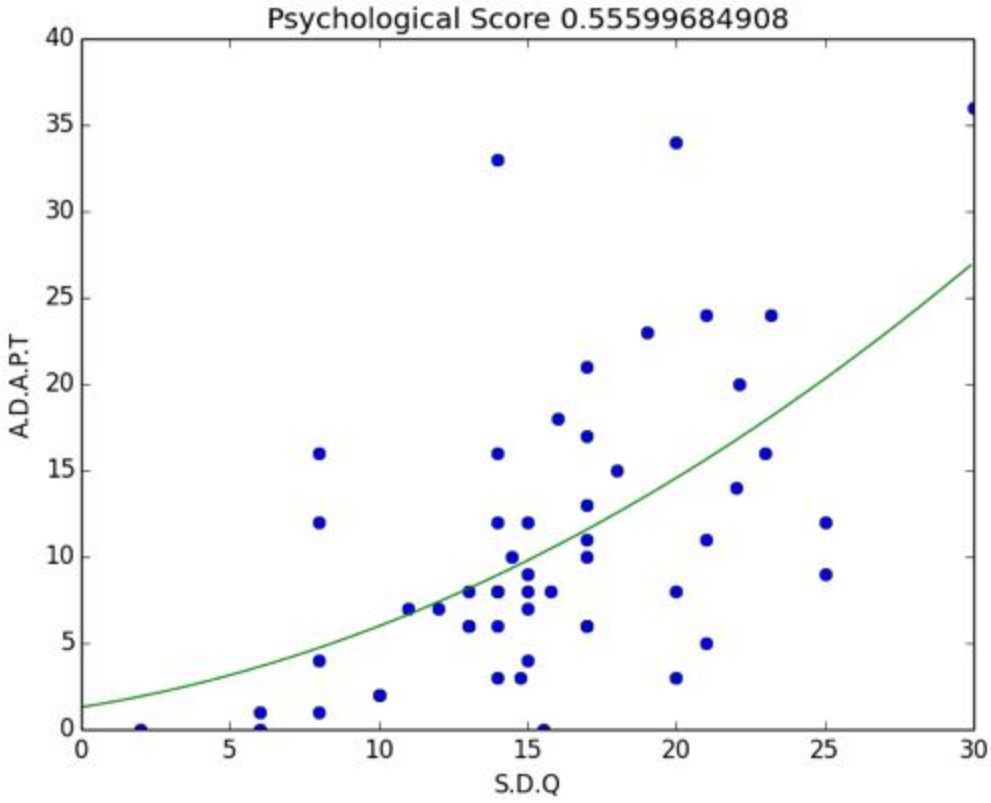


Figure 1.2 Correlation of ADAPT Psychiatric component and the Strengths and Difficulties Questionnaire in Outpatient Psychiatry Practice

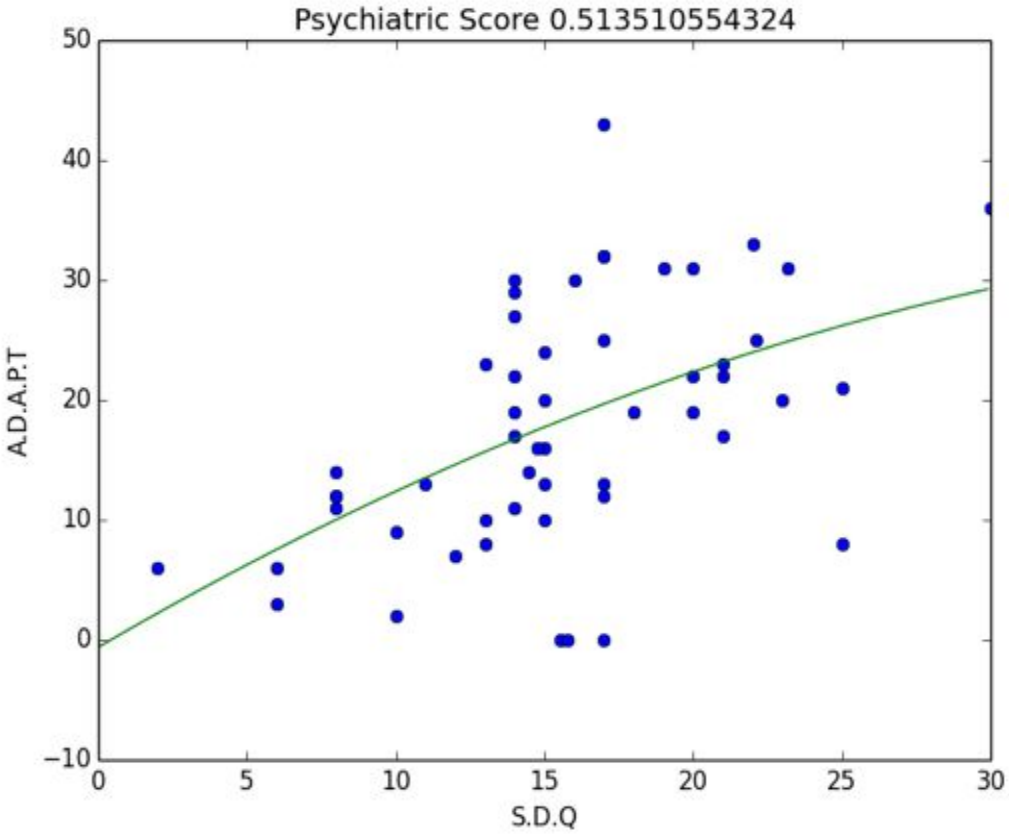


Figure 1.3 Correlation of ADAPT Traumatic Childhood Events (Adverse Score) and the Strengths and Difficulties Questionnaire in Outpatient Psychiatry Practice

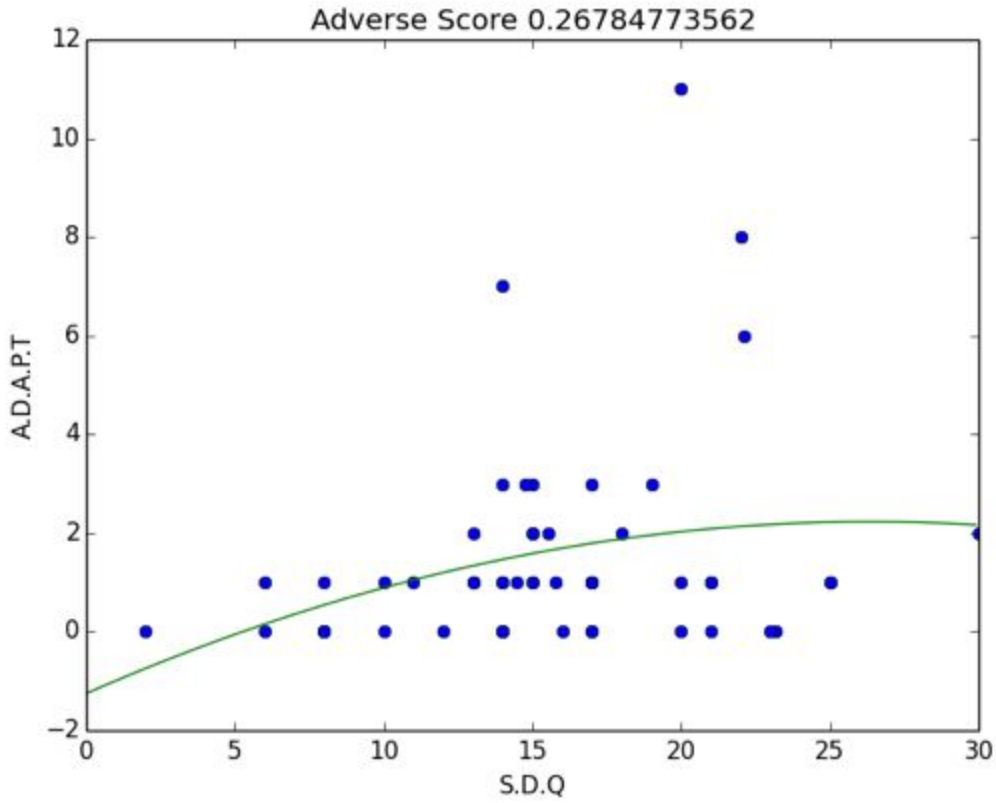
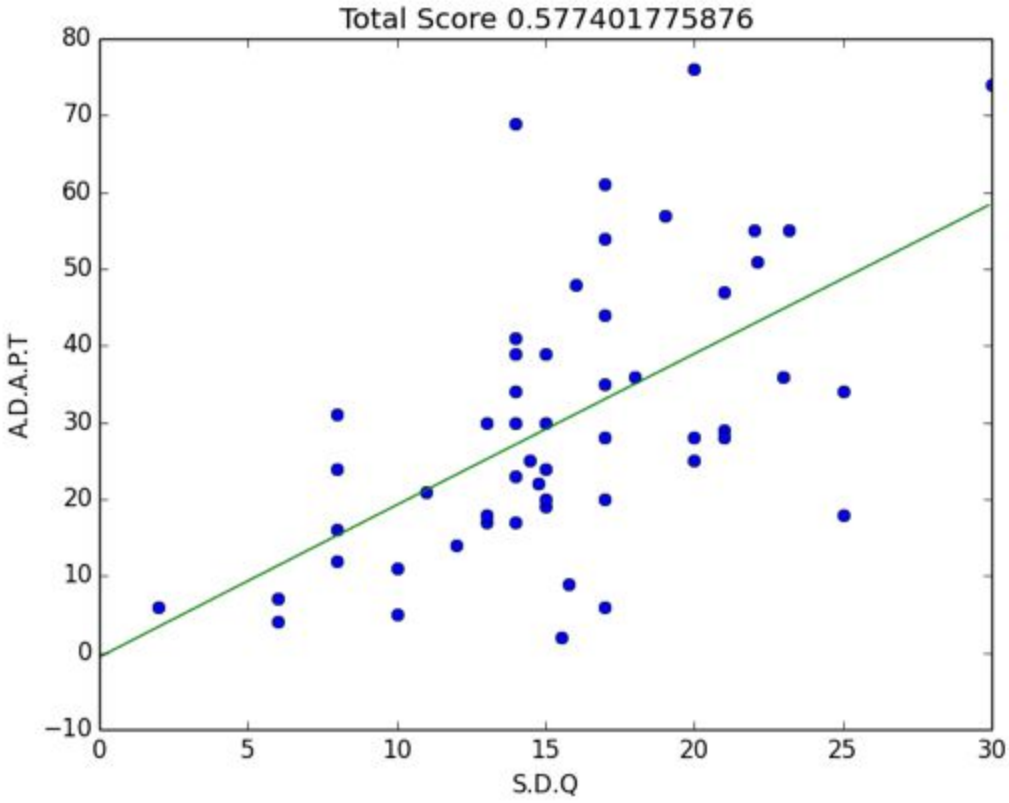


Figure 1.4 Correlation of ADAPT Total (Psychological/Behavioral Health and Psychiatric components) with the Strengths and Difficulties Questionnaire in Outpatient Psychiatry Practice



2. Concurrent Validation Study Two (Therapeutic Foster Care study).

A second alpha test of ADAPT was completed with foster parents from a private, non-profit therapeutic foster care program in the upper Midwest. Parents were asked to complete ADAPT online in May, 2015. Each foster parent was assigned and provided with a username and password for the ADAPT web site by the agency. ADAPT was completed online on 43 treatment level foster children by one or the other foster parent. The Strengths and Difficulties Questionnaire (SDQ) was administered immediately after the completion of the ADAPT. The age range of the children was 4 to 17 years of age.

Coded data were used to protect the identity of parents and children from researchers. Data on correlation is summarized in four figures which are presented next.

Figure 2.1 shows the correlation between ADAPT Psychological/Behavior Health Problems and the SDQ (correlation = .67).

Figure 2.2 shows the correlation between ADAPT Psychiatric Component and SDQ (correlation = .52).

Figure 2.3 shows the correlation between ADAPT Traumatic Childhood Events and SDQ (correlation = .14).

Figure 2.4 shows the correlation between ADAPT Total (Psychological/Behavioral Health and Psychiatric components) with the SDQ (correlation = .71).

Figure 2.1 Correlation of ADAPT Psychological/Behavioral Health Problems and the Strengths and Difficulties Questionnaire in Therapeutic Foster Care Study

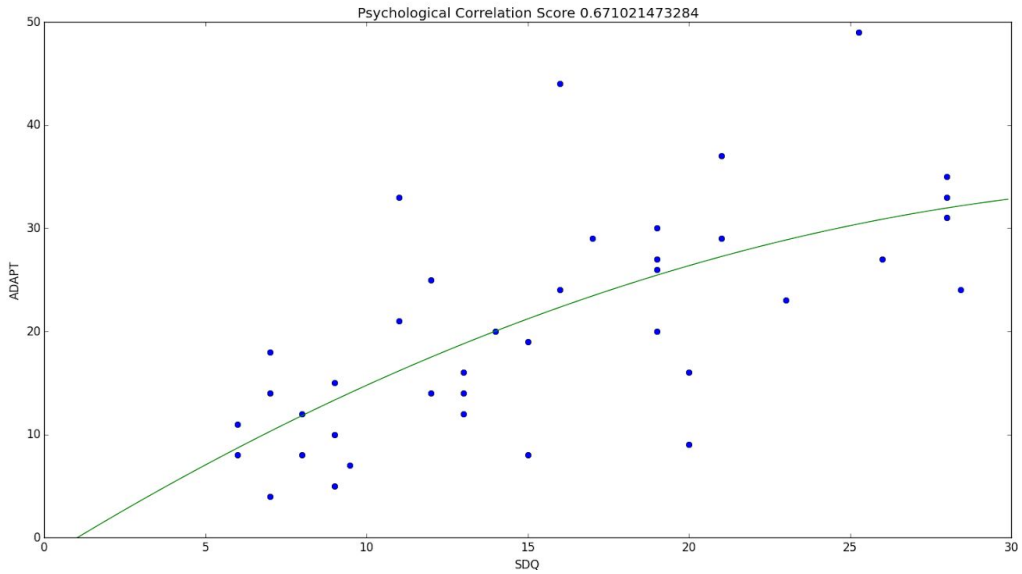


Figure 2.2 Correlation of ADAPT Psychiatric component and the Strengths and Difficulties Questionnaire in Therapeutic Foster Care Study

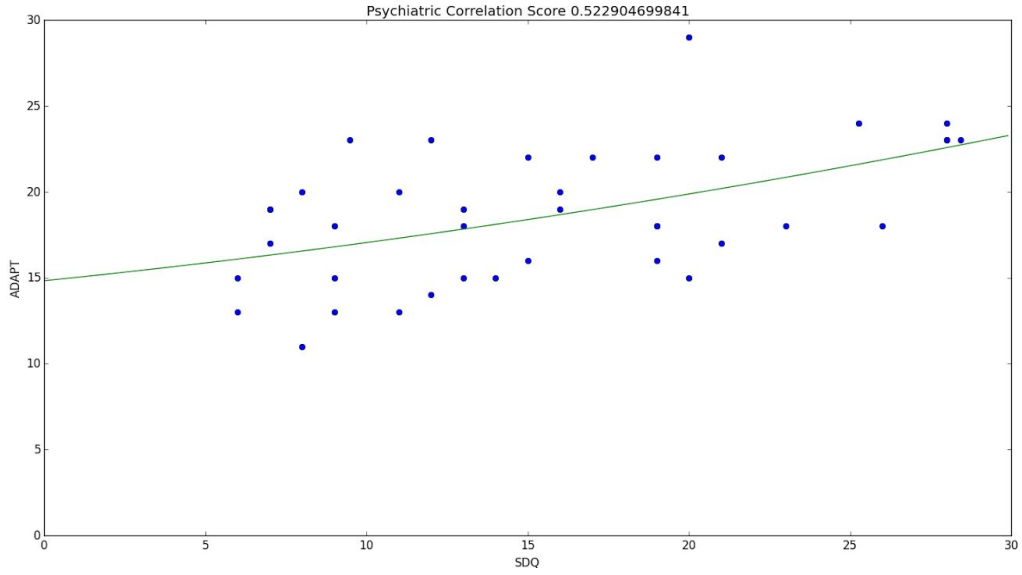


Figure 2.3 Correlation of ADAPT Traumatic Childhood Events (Adverse Score) and the Strengths and Difficulties Questionnaire in Therapeutic Foster Care Study

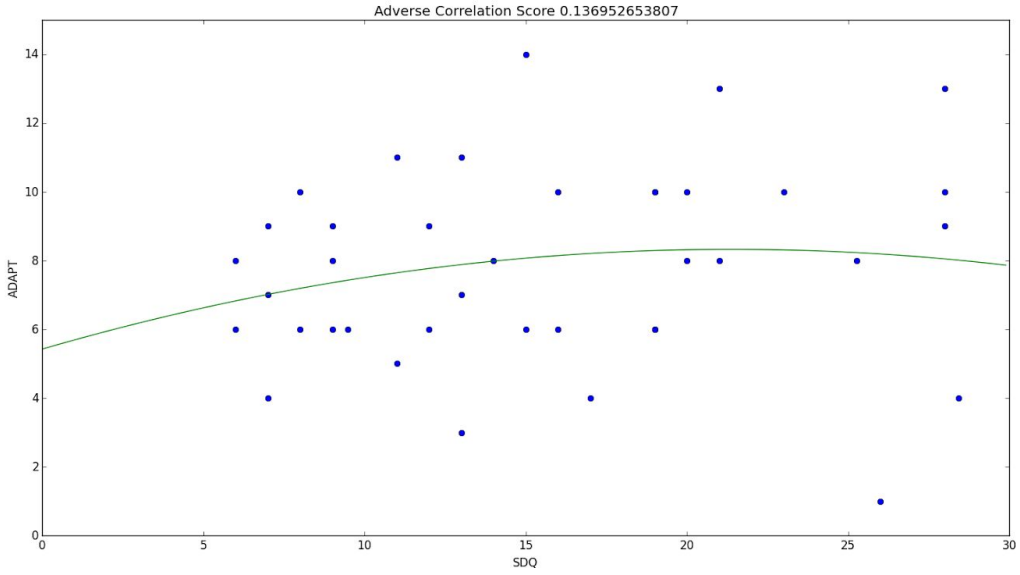
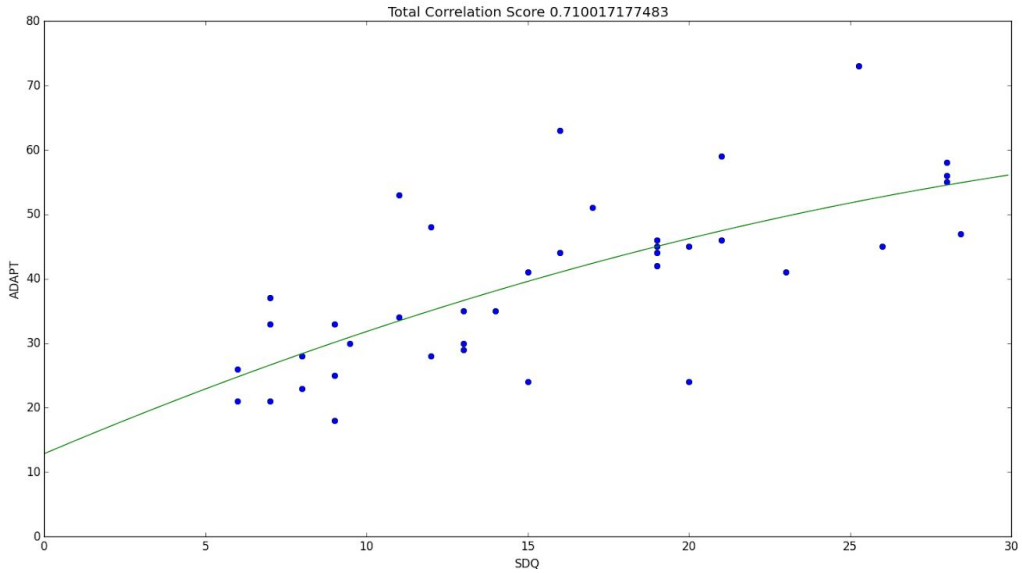


Figure 2.4 Correlation of ADAPT Total (Psychological/Behavioral Health and Psychiatric component) with the Strengths and Difficulties Questionnaire in Therapeutic Foster Care Study



A. **ADAPT Reliability and Validity**
Based upon the highly encouraging results from the alpha tests on ADAPT, beta testing will be undertaken to focus on not only further validation study but also on ADAPT reliability.

V. Summary Report

Upon completion of ADAPT a summary report based upon the following criteria is instantly generated:

A. *Integrated Family Assessments* are recommended when:
the child receives a Traumatic Childhood Events score of 4 or more. NOTE: The rating of low, moderate or high refers to the sheer number of event categories of trauma (physical abuse, sexual abuse, or one of the eight other categories) to which the child has been exposed. Some children may exhibit mental health problems when they have a low TCE score while other children may exhibit no mental health problems though they have a moderate or high TCE score. ADAPT automatically recommends a full psychological evaluation whenever the child receives a high TCE.

B. An *assessment by a mental health professional* is recommended when:

1. there is a "high" score of 23 or more reported psych/behavioral problems.
2. there are one or more urgent concerns.
3. a child of any age is suspected of having: Oppositional Defiant Disorder, Conduct Disorder, Intellectual Disability, Specific Learning Disorder, Reactive Attachment Disorder, Disinhibited Social Engagement Disorder, and/or Phobia.
4. a child under the age of five (5) is identified as at risk for the following disorders: Post Traumatic Stress Disorder, Reactive Attachment Disorder, Disinhibited Social Engagement Disorder, Separation Anxiety Disorder, Autistic Spectrum Disorder, and/or Intellectual Disability.

C. *A recommendation for medication utilization review* is made when there is:

1. Absence of an ADAPT identified risk of a DSM-5 diagnosis in a child taking psychoactive medication.

2. Four or more psychiatric medications being taken concurrently.
3. Three or more ADHD medications being taken concurrently.
4. Two or more antidepressant/antianxiety medications being taken concurrently.
5. Two or more sleep/anxiety medications being taken concurrently.
6. Two or more mood stabilizers being taken concurrently.
7. One or more psychotropic medications being taken under four years of age.

D. *A recommendation is made for communication between primary care physician and psychiatric medication prescriber (if different)* when there is/are:

One or more medical problems AND one or more psychiatric medications.

REFERENCES

Administration for Children, Youth and Families (ACYF) (2014). Protective Factors Approaches in Child Welfare. Retrieved at: ttps:www.childwelfare.gov/pubs/issue_briefs/protective factors.pdf

American Academy of Child and Adolescent Psychiatry. (2015) AACAP Position Statement on Oversight of Psychotropic Medication Use for Children in State Custody: A Best Principles Guideline. Retrieved at: https://www.aacap.org.

Barber, J.G., & Delfabbro, P.H., & Cooper, L.L. (2001).The Predictors of Unsuccessful Transition to Foster Care. The Journal of Child Psychology and Psychiatry, 42,785-790.

Bramlett, M. D., & Radel, L. F. (2014). Adverse Family Experiences Among Children in Nonparental Care 2011–2012. National Health Statistics Reports, 74, 1–8.

Child and Adolescent Health Measurement Initiative (2012). Overview of adverse child and family experiences among U.S. children. Data Resource Center for Child & Adolescent Health. Available from: http://www.childhealthdata.org/docs/drc/aces-data-rief_version-1

Child and Family Services Improvement and Innovation Act (P.L. 112-34); Titles IV-B, IV-E and section 1130 of the Social Security Act; Promoting Safe and Stable Families Program; Child Welfare Services Program

Council on Accreditation (COA), foster care services 3 (2008), available at http:// www.coastandards.org/pdf/makepdf.php?id=74.

Cronholm, P. F., Forke, C. M., Wade, R., Bair Merritt, M. H., Davis, M., Harkins Schwarz, M., ... & Fein, J.A. (2015). Adverse Childhood Experiences: Expanding the Concept of Adversity. American Journal of Preventive Medicine, 49(3), 354361.

Eggersten, L. (2008). Primary factors related to multiple placements for children in out-of-home care. Child Welfare, 87(6): 71-90.

Epstein, M., Mooney, P., Ryser, G.,Pierce, C. (2004).Validity and Reliability of the Behavioral and Emotional Rating Scale (2ndEdition):Youth Rating Scale. Research on Social Work Practice, 14,5, 353-367.

Felitti VJ, Anda RF, Nordenberg D, Williamson DF, Spitz AM, Edwards V, Koss MP, et al. (1998) The Relationship of Adult Health Status to Childhood Abuse and Household Dysfunction. American Journal of Preventive Medicine. 14:245258.

Fisher, Philip A.; Stoolmiller, Mike; Mannering, Anne M.; Takahashi, Aiko; Chamberlain, Patricia (2011). Foster Placement Disruptions Associated with Problem Behaviors: Mitigating a Threshold Effect. Journal of Consulting and Clinical Psychology, Vol 79(4), 481487. http://dx.doi.org/10.1037/a0024313

Fostering Connections to Success and Increasing Adoptions Act of 2008 (PL 110351)"H.R. 6893 —110th Congress: Fostering Connections to Success and Increasing Adoptions Act of 2008." www.GovTrack.us. 2008. December 4, 2016 <https://www.govtrack.us/congress/bills/110/hr6893>

Huber, J., & Grimm, B.(2004). Child & Family Services Reviews, Part V: Most States Fail To Meet the Mental Health Needs of Foster Children. Youth Law News,25(4),1-13.

Jamora, M.S., Brylske, P.D., Martens, P., Braxton, D., Colantuoni, E., & Belcher, H.M.E. (2009). Children in Foster Care: Adverse Childhood Experiences and Psychiatric Diagnoses. Journal of Child & Adolescent Trauma, 2, 198-208.doi 10.1080/19361520903120491

Lopez, P., & Allen, P. J. (2007). Addressing the Health Needs of Adolescents Transitioning out of Care. Pediatric Nursing, 33(4), 345-355.

Preventing Sex Trafficking and Strengthening Families Act (P.L. 113-183) (2014) ACYF-CB-IM-14-03

Rubin, D. M., Downes, K. J., O'Reilly, A. L. R., Mekonnen, R., Luan, X., & Localio, R. (2008). Impact of kinship care on behavioral well-being for children in out-of-home care. Archives of Pediatrics & Adolescent Medicine, 162(6), 550–556. http://dx.doi.org/10.1001/archpedi.162.6.550.

Simms, M. D., Dubowitz, H., & Szilagyi, M. A. (2000). Health care needs of children in the foster care system. Pediatrics, 106, 909-918.

Stambaugh, L.F., Ringeisen, H., Casanueva, C.C., Tueller, S., Smith, K.E., & Dolan, M. (2013). Adverse childhood experiences in NSCAW. OPRE Report #2013-26, Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. Available at: National Data
Archive on Child Abuse and Neglect (NDACAN), Cornell University, ndacan@cornell.edu

Sudol, T. (2009). Information packet: Racial disproportionality in child welfare. Retrieved from the National Resource Center for Family-Centered Practice and Permanency Planning's website: http://www.hunter.cuny.edu/socwork/nrcfcpp/info_services/Sudol_Info%20pack_Disproportionality_July% 202009.pdf

Tarren-Sweeney, Michael. (2009). Attachment- and trauma-related psychopathology among children in alternate care. Paper presented at the Annual Conference of the Faculty of Child & Adolescent Psychiatry, Royal Australian & New Zealand College of Psychiatrists – RANZCP, Queenstown, New Zealand.

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