The Importance of Sibling Relationships for Children in Foster Care

R. M. A. Shafi, MBBS, BSc (Hons), Eric R. Pease, DO, MBA, Magdalena Romanowicz, MD, Megan Baker, MD, Sarah Wakefield, MD, Wynne S. Morgan, MD, and Mary Lynn Dell, MD, DMin, MHA

There are approximately 500,000 children in the foster care system in the United States of America. With exposure to chronic and cumulative trauma, they constitute a population with an increased risk of developing mental health concerns and adverse outcomes in later life, including contact with the forensic system. Legislative frameworks that have been developed to facilitate improved outcomes are outlined, although these vary between states, and the focus is often on the parental relationship. Several studies have emphasized the importance of sibling relationships and that placing siblings in the same foster home is associated with higher rates of placement stability, reunification, adoption and guardianship, and fostering positive sibling relations. The multifaceted role of the clinician in promoting recovery from trauma, enhancing resiliency, and thoughtfully prescribing and advocating for familial relationships is discussed.

J Am Acad Psychiatry Law 51(2) online, 2023. DOI:10.29158/JAAPL.230029-23

Key words: child & adolescent; community forensic psychiatry; trauma; stress

At any given time, there are just under half a million children in the foster care system in the United States, and many of these children have siblings.[1–3] The majority are in a nonrelative foster family (44%), followed by relative foster family (35%), institutions (5%), and the remaining (<5% each) in trial home visits, group homes, pre-adoptive homes, or independent living, or are runaways (1%).[3]

Most of these children have experienced multiple losses, adversity, and trauma related to the reasons that brought them into the child welfare system. With exposure to chronic and cumulative trauma, this is a population with specialized medical and mental health needs of which clinicians should be aware. Approximately one-fifth of children in the general population have a diagnosed mental disorder, but nearly one-half (47.9%) of children involved with child welfare agencies have emotional, behavioral, or developmental disorder diagnoses necessitating mental health intervention. Despite this high need, only one-fourth of children within the child welfare system with mental health needs have access to care, with Black and Hispanic children having the least access.[4]

Children in foster care may be at higher risk of mental health disorders related to traumatic family histories and life experiences; 70 percent of children in care reported five or more adverse childhood experiences.[5,6] Of those children with a psychiatric diagnosis, the most common include disruptive behavior disorders and attention-deficit hyperactivity disorder (54%), anxiety disorders (10%), mood disorders

Published online June 7, 2023. This is an updated version of the article that posted originally on May 31, 2023; it corrects the degree of an author.

Dr. Shafi is Assistant Professor of Psychiatry, Mayo Clinic, Department of Psychiatry and Psychology, Rochester, MN, and Consultant Psychiatrist, Department of Psychiatry, Cairns and Hinterland Hospital and Health Service, Cairns, Queensland, Australia. Dr. Pease is Assistant Professor of Psychiatry, Mayo Clinic, Department of Psychiatry and Psychology, Rochester, MN. Dr. Romanowicz is Child and Adolescent Fellowship Director, and Assistant Professor of Psychiatry, Mayo Clinic, Department of Psychiatry and Psychology, Rochester, MN. Dr. Baker is Consultant Child and Adolescent Psychiatrist, Momentum for Health, San Jose, CA. Dr. Wakefield is Department Chair of Psychiatry, Director of Child and Adolescent Psychiatry Services, Texas Tech University Health Sciences Center, Lubbock, TX. Dr. Morgan is Assistant Professor of Psychiatry, UMass Chan Medical School, Department of Psychiatry, Worcester MA. Dr. Dell is Division Chief of Child and Adolescent Psychiatry, Professor of Psychiatry and Neurobehavioral Sciences, University of Virginia, Charlottesville, VA. Address correspondence to: Mary Lynn Dell, MD, DMin, MHA. E-mail: dellml@outlook.com

Disclosures of financial or other potential conflicts of interest: None.

(7%), and post-traumatic stress disorder (PTSD; up to 20%).[7,8] Children in foster care also have high rates of neurodevelopmental disorders, including fetal alcohol spectrum disorders (6%) and cognitive disorders (25%).[9,10] Given the high prevalence of psychiatric disorders in this population, children in foster care are three times more likely to be prescribed a psychotropic medication than children in the general population.[11] Children in foster care are also likely to be prescribed three or more psychotropics simultaneously, and being in foster care is a predictor for the prescribing of antipsychotic medication.[12,13]

The roles of the treating clinician and of the forensic evaluator are vital for informing the welfare system, including the courts when applicable, to promote recovery from trauma and enhance resiliency in children. Accurate and thoughtful diagnosis and treatment, as well as advocacy for familial connections and relationships, when possible, are key considerations in the care of children involved in child welfare systems. An understanding of important legislative frameworks can also help treating clinicians working with foster care children and forensic evaluators working with welfare systems to improve advocacy efforts for those in their care.

Foster Care Placement Outcomes

Primary goals of child welfare services include establishment of permanency and reunification where possible. An accurate understanding of recent studies regarding foster care placements and their stability can contribute to effective advocacy by both treating clinicians and forensic evaluators.

Rates and Reunification

According to the most recent data available from the Adoption and Foster Care Analysis and Reporting System (AFCARS), there were 606,031 children served in the U.S. foster care system, with 206,812 entering and 214,971 exiting throughout 2021.[3] Just over half of children had a case goal of reunification with their parents or primary caretaker, and of those who exited foster care, fewer than half (47%) were reunified. More than a quarter (28%) of children in foster care had a case goal of adoption, and of those who exited 25 percent were adopted. Most children (65%) who exited had been in care for 12 months or longer.

Placement Stability and Impact of Siblings

Many factors affect a child's experience of foster care, including but not limited to duration of time in care, number and type of placements, and stability of important relationships, including siblings. Placement instability, with moves that do not result in a child's permanent placement,[14] is typical of the experience in the child welfare system,[15] and contributes to depressive, anxious, and aggressive symptoms in children.[16] One-third of children in foster care have three or more placement changes,[17] and one-third of children in foster care have eight or more changes.[18] Placement stability is critical for mental health of children in foster care regardless of type, severity, or frequency of their maltreatment experiences.[19] Placement with kin and placement with siblings have both been identified as protective against placement instability.[20–22] One meta-analysis identified risk factors for placement instability to be older age, externalizing behaviors, previous residential care, and number of previous placements.[23] Adolescents have the greatest risk of placement disruption, regardless of reason.[24]

Positive ties with siblings can mitigate negative effects of maltreatment and entry into foster care.[25] Separation from a sibling can result in feelings of worry and confusion, loss of identity, and decreased self-esteem and sense of belonging.[26] Separation can also be associated with difficulty adjusting to a new placement.[27] Placing siblings in the same foster home is associated with higher rates of reunification, adoption, and guardianship,[11,28] and fostering positive sibling relations has been identified as a protective factor for children's mental health.[11,29]

Foster Care Outcomes and Long-Term Impact

Although some studies have demonstrated that children placed in institution-based settings have improved caregiver-rated physical health and emotional coping,[30] it has also been noted that children in out-of-home placements in residential settings are affected by increased prevalence of internalizing behaviors (social withdrawal, somatic complaints, anxiety, or depression) and externalizing behaviors (hyperactivity, delinquency, or aggression) compared with children in community-based placements.[31] Family foster care allows for a more individualized approach to each child, delivering a home-like environment that has been associated with more positive perceptions toward caregivers compared with children in alternative placement environments, such as residential settings.[31]

Foster care placement has been associated with longer-term social, emotional, and health consequences. In a review of young adults formerly in foster care, Pecora *et al.*[32] found elevated rates of mental health and substance use disorders compared with the general population, with rates varying greatly among different studies, ages, and populations. In one study, nearly 75 percent of children reported a lifetime prevalence of a mental health disorder.[32] Three studies of foster care alumni found a 12-month rate of PTSD of 25 percent, 21.5 percent, and eight percent; the first two rates being about five times the rate of PTSD in the general population and higher than seen in some studies of combat veterans.[32,33] Whereas maltreatment itself has been associated with long-term consequences within academic, behavioral, and emotional domains, these impairments are particularly pronounced in children with both maltreatment histories and out-of-home placements.[34]

The Northwest Foster Care Alumni Study interviewed 479 foster care alumni (average age, 24 years) previously placed in a child welfare system for 12 months or more between the ages of 14 and 18 years.[35] Interviewees had an average of 6.5 placements, spent 6.1 years in foster care, and changed placements 1.4 times per year; almost one-third experienced eight or more placements. Within one year of leaving care, 22 percent experienced some duration of homelessness. While in care, 65 percent of alumni experienced seven or more school changes. They completed high school at similar rates (84.8%) as the general population but were more likely to earn a GED than a standard high school diploma (28.5% versus 5%). Although many enrolled in higher education, college degree completion (B.A. degree) was lower than in the general population (2.7% versus 24.4%). Foster care alumni were in fragile economic situations; one-third reported household incomes that were at or below the poverty level, and one-third had no health insurance. The employment rate among the alumni eligible for work was 80.1 percent, substantially lower than the national average of 95 percent.[35]

Foster care placement has been associated with increased criminality. In one cohort of young adults in California, up to 9.4 percent of those arrested had a history of placement.[36] Fourteen percent of those incarcerated in California had previous engagement in the foster care system.[37] Rates of involvement in the criminal justice system are higher among those children who have a history of experiencing maltreatment. An analysis of 10 years of data from an Illinois cohort demonstrated that involvement with the child welfare system more than doubled the rate of delinquency charges.[38] The increased frequency of maltreatment has been associated with greater rates of delinquency.[39] Children and adolescents with maltreatment histories and out-of-home placements or those who received mental health treatment have been shown to have a greater likelihood of judicial confinement in a juvenile justice facility compared with youth with a maltreatment history alone, as shown in a study examining outcomes of more than 17,000 individuals in a Pennsylvania cohort who had child welfare involvement.[40] Fortunately, there are mitigating factors for youth within child welfare systems. Children who have child welfare involvement at a young age (compared with later adolescence) as well as those who have greater placement stability and fewer physical placements overall have been shown to have an overall decrease in involvement with the criminal justice system.[41]

Growing awareness of these outcomes has led to local, state, and federal policy changes that address the care in child welfare systems. In many states, the past decade has seen significant reform to the process of screening for mental health conditions, providing treatment to children in care, and offering voluntary extension of foster care services and associated support past age 18. Owing to the role that sibling relationships and the impact out-of-home placement with a sibling can have on placement stability,[29,31] efforts have been made to maintain sibling relationships for those placed within the child welfare system. Policy changes vary by state, and the outcomes of these policies on long-term outcomes will need to be clarified.

Legislative Frameworks

The child welfare system is tasked with providing safety, permanency, and well-being in children and families they serve. Much of the focus of the child welfare system is on the child relationship with the parent figure to help secure permanency through reunification or adoption. But another key relationship is too often overlooked and can be a key stabilizing factor to promote child well-being: the sibling relationship. The sibling relationship is a lifelong relationship. In the context of the child welfare system, the sibling can be the one support a child has with a shared experience as the child travels through the child welfare system. Foster care too often

disrupts this relationship, with children being separated as they enter or exit care, coupled with poor follow-through on sibling visitations while in care. This disruption can leave children at risk for destabilization, both in their placement and at school.[26,42–44]

Over the years, federal legislation has been passed to help ensure the sibling relationship is preserved within child welfare systems. The Fostering Connections to Success and Increasing Adoptions Act of 2008[45] is the first federal law to address the importance of keeping siblings together, requiring states to make reasonable efforts to place siblings in the same foster, adoption, or guardianship placement unless contrary to the child's safety and well-being. If the children must separate, then frequent visitations or ongoing contact must be provided.[45] This effort was further strengthened by the passage of the Preventing Sex Trafficking & Strengthening Families Act in 2014,[46] which mandated that states must notify kinship parents of siblings when a child needs placement. More recently, the Family First Prevention Services Act of 2018,[47] which is one of the largest reforms to child welfare of our time, also demonstrated support for keeping siblings together by allowing the number of children in a foster home to exceed the approved numerical limit to keep children together. This decision made it easier for large sibling units to be able to stay together in the same home.

Although there have been multiple efforts to maintain and strengthen the sibling relationship in foster care placement, there is great variability across states as to how they interpret The Fostering Connections to Success and Increasing Adoptions Act of 2008, specifically regarding what justifies reasonable efforts. In 37 states, Washington, DC, and Guam there are regulations or statutes requiring child-placing agencies to make reasonable efforts to place siblings in the same home or document why placement is not possible. In only 29 states are there statutes directing policy and practices for both prioritizing placement with a sibling and ensuring visitation with siblings, leaving significant variability across the country and U.S. territories. These variations across states have direct impact on children and to whom they stay connected. States identify siblings in different ways. Siblings may be defined rigidly as children who have birth parents in common, but other states may have a broader definition to include close relatives or even nonrelatives. For example, in Alaska a sibling is defined as a relative by blood, adoption, or marriage, whereas in Illinois siblings are defined as sharing one parent. Children may also have varying relationships with siblings; some may live in other extended-family homes and others may have never met. One best practice comes from California, where the policy calls for a sibling social study report to define, identify, and preserve these relationships. Another best practice comes from Massachusetts, where the policy also incorporates the child's voice into who is defined as a sibling.[48]

There are points as the child moves through the child welfare and court proceedings where the sibling relationship is at risk. Termination of parental rights can also in some states end the legal relationship between siblings. Subsequently, the Fostering Connections Act and any requirement to make reasonable efforts to maintain the sibling relationship are no longer applicable, and the child welfare agency is no longer required to provide this support. Sibling adoption is another point in the child welfare system pathway where the relationship can be frayed. Sibling units may be split apart and adopted into different families or remain in care while only one sibling is adopted. There are also post-adoption contact agreements where the adoptive parents can decide who from the family of origin can have contact following the adoption. The agreements' enforceability vary by state. One state, Iowa, provides training to prospective adoptive parents about the importance of maintaining sibling relationships, and this may be a practice to encourage in other state and county child welfare agencies.[48]

Importance to Forensic Practice

Clinicians working with children in the foster care system are in a key position to advocate for sibling connections, and understanding state and federal laws can help improve efficiency of these efforts. Treating clinicians and forensic evaluators alike have a unique opportunity to explore the importance of sibling relationships of the children they are evaluating and treating, and define for the welfare system whom the child identifies as a sibling and other key supports for the child's emotional welfare and development. Treating clinicians can also bring this important concept into therapeutic interactions with the child, identifying ways the child can stay connected to siblings even if visits are not currently supported.

Clinicians can help inform the court what is in the best interest of the child in terms of sibling relationships and how valuable these relationships are to the child's resiliency and well-being. Clinicians may also consider requesting services like a Court Appointed

Special Advocate (CASA) worker whose role is to help advocate for the best interest of the child in court.[49] Clinicians can help child welfare teams build their services targeting the needs of the individual child and focusing on ensuring sibling placement and visitation. More is needed with regard to reporting on sibling placements to hold child welfare systems accountable and track data about siblings' placements to better inform consistent and effective policy and practices across our nation.

Diagnosis, Treatment, and Advocacy

There are no differences in criteria for diagnoses in the DSM-5 for children and adolescents who are involved in a child welfare system. Clinicians must be careful in this population, however, owing to both overlap in symptoms across diagnoses and frequent gaps in the history of symptom development. Traumatic stress in childhood can present with symptoms one might expect in depression, such as self-injurious behaviors, social withdrawal, affective numbing, and impaired sleep.[50] The most unique stressors for children involved in the child welfare system are those related to placement. As previously outlined, placement stability is a critical factor in the mental health of children in child welfare systems, but it is also important for the accuracy and reliability of the information obtained in a diagnostic interview and examination. If a diagnostician is not vigilant during information gathering, a child's reaction to the stressors of placement changes (including separation from nonabusive supports such as siblings, teachers, school counselors, friends, and familiar neighborhoods), can be misinterpreted as depression, anxiety, attentional difficulties, or hyperactivity. The careful diagnostician will seek previous records and obtain information from various settings, including schools attended, acting with the assumption that the child has experienced traumas whether or not the child is able to adequately articulate those experiences. The diagnostician can seek reliable background information through collaboration with the child welfare agency.

Child welfare agencies differ across regions. Some are state-sanctioned and supported, and others are privately operated. One child may be served by multiple child welfare agencies over time, presenting further difficulties in obtaining reliable information about the child's history. It is important for the diagnosing and treating clinician to understand the various agencies that might serve the child and to collaborate with these agencies whenever possible. Through collaboration, the clinician can better understand the child's functioning and response to services.[43,51] Placement changes are often related to a mismatch in behavioral and medical needs of the child and the skill set of the placement.[52,53] Through collaboration, the clinician may also provide input on therapeutic placement among the available options to promote placement permanence and enhanced well-being.[50,54]

Further work will need to compare the rates of psychotropic medication discontinuation between co-placed siblings and siblings who are placed apart. It is well documented that children in foster care are prescribed medications at a substantially higher rate than children not in foster care. It is vital that clinicians assess a child's medication profile and assure that each medication is indicated and not duplicative. In response to increasing polypharmacy for children involved in child welfare systems, the Fostering Connections to Success and Increasing Adoptions Act of 2008 requires states to develop plans for oversight and coordination of health care services for these children. The Child and Family Services Improvement and Innovation Act of 2011 specifies that states must have "protocols for the appropriate use and monitoring of psychotropic medications" (Ref. 55, Sec. 101). A thoughtful and safe plan for medication discontinuation is as important as a thoughtful and safe plan for starting medications.[56] Although clinicians should not stop or decrease obviously effective medications that are safe for long-term use, clinicians should aggressively assess the risks associated with individual psychotropics and the cumulative risk of using multiple medications.[57] In addition, clinicians should recommend and advocate for evidence-based nonpharmacologic treatments to decrease reliance on psychotropics and improve long-term prognosis.

Clinicians should advocate especially for trauma-informed care as part of clinical diagnostic assessment and therapeutic intervention services and also in the general approach of the child welfare agency. A history of child maltreatment also negatively affects treatment response, correlating with decreased response to both cognitive behavioral therapy (CBT)[58–60] and antidepressant pharmacotherapy.[61] CBT, eye-movement desensitization and reprocessing therapy (EMDR), narrative therapy, and supportive therapy, when provided after a trauma, are all correlated with lower rates of diagnosis of PTSD and fewer PTSD symptoms.[62] Trauma-Focused Cognitive Behavioral Therapy (TF-

CBT) is a recommended intervention for children with trauma resulting from child maltreatment.[63] TF-CBT has demonstrated efficacy for effective delivery in multiple settings and for various populations, including preschool-aged children,[64,65] children in residential settings,[66] and those treated via telehealth modalities.[67] The California Evidence-Based Clearinghouse for Child Welfare (CEBC) is a searchable database of evidence-based interventions to increase permanency for children and families involved in the foster care system.[68] Comparing outcomes of these interventions between co-placed siblings and siblings who are placed apart could further inform treatment strategies and advocacy efforts for children involved in the foster care system.

When serving children in a child welfare system, a clinician should pay particular attention to principles outlined in the American Academy of Child and Adolescent Psychiatry Code of Ethics. In addition to using a developmental perspective, promoting the welfare of the child, and minimizing harm, a clinician must navigate the challenges of autonomy and confidentiality within a system in which others often know more about the child's past than the child does and in which the child may not have a consistent advocate. To develop trust in the treatment relationship, children should play a role in treatment and placement decision-making within the bounds of their capacity to do so. The clinician must also take care to prioritize patients' needs above those of the system in which they may be involved, including minimizing exposure to injustice and advocating for maintenance of fundamental ties to family. Such attention to ethics and advocacy, especially pertaining to sibling relationships, can lead to higher rates of placement stability, reunification, adoption or guardianship, and the fostering of positive sibling relations.

Conclusion

Children involved in the child welfare system bear unique challenges that will benefit from a holistic and collaborative model of care whenever possible. The role of the clinician is not limited to diagnosis and treatment; it also includes advocating for and promoting the welfare of all children in our care. Legislative frameworks and clinical practice parameters have been developed to facilitate improved outcomes, including an emphasis on maintaining family connections, sibling placements, and careful consideration of pharmacotherapy.

References

1. U.S Department of Health and Human Services. The Adoption and Foster Care Analysis and Reporting System Report #27; 2019. Available from: https://www.acf.hhs.gov/cb/report/afcars-report-27. Accessed March 4, 2022
2. U.S Department of Health and Human Services. The Adoption and Foster Care Analysis and Reporting System Report #28; 2020. Available from: https://www.acf.hhs.gov/cb/report/afcars-report-28. Accessed March 4, 2022
3. U.S Department of Health and Human Services. The Adoption and Foster Care Analysis and Reporting System Report #29; 2022. Available from: https://www.acf.hhs.gov/sites/default/files/documents/cb/afcars-report-29.pdf. Accessed March 4, 2022
4. Burns B, Phillips S, Wagner HR, *et al*. Mental health need and access to mental health services by youths involved with child welfare: A national survey. J Am Acad Child Adolesc Psychiatry. 2004; 43(8):960–70
5. Bruskas D, Tessin DH. Adverse childhood experiences and psychosocial well-being of women who were in foster care as children. Perm J. 2013; 17(3):e131–e141
6. Child Welfare Information Gateway. Postadoption contact agreements between birth & adoptive families [Internet]; 2019. Available from: https://www.childwelfare.gov/pubPDFs/cooperative.pdf. Accessed March 4, 2022
7. Garland A, Hough R, McCabe K, *et al*. Prevalence of psychiatric disorders in youths across five sectors of care. J Am Acad Child Adolesc Psychiatry. 2001; 40(4):409–18
8. Kolko DJ, Hurlburt MS, Zhang J, *et al*. Posttraumatic stress symptoms in children and adolescents referred for child welfare investigation: A national sample of in-home and out-of-home care. Child Maltreat. 2010; 15(1):48–63
9. Lange S, Shield K, Rehm J, Popova S. Prevalence of fetal alcohol spectrum disorders in child care settings: A meta-analysis. Pediatrics. 2013; 132(4):e980–e995
10. Casaneueva C, Ringeisen H, Wilson E, *et al*. NSCAW II baseline report: Child well-being. US Department of Health and Human Services [Internet]; 2011. Available from: https://www.acf.hhs.gov/opre/report/nscaw-ii-baseline-report-child-well-being-final-report. Accessed May 21, 2023
11. Jones C. Sibling relationships in adoptive and fostering families: A review of the international research literature. Child Soc. 2016; 30 (4):324–34
12. Zito JM, Safer DJ, Sai D, *et al*. Psychotropic medication patterns among youth in foster care. Pediatrics. 2008; 121(1):e157–e163
13. Vanderwerker L, Akincigil A, Olfson M, *et al*. Foster care, externalizing disorders, and antipsychotic use among Medicaid-enrolled youths. Psychiatr Serv. 2014; 65(10):1281–4
14. Fisher PA, Mannering AM, Van Scoyoc A, Graham AM. A translational neuroscience perspective on the importance of reducing placement instability among foster children. Child Welfare. 2013; 92(5):9–36
15. Farmer EMZ, Wagner HR, Burns BJ, Richards JT. Treatment foster care in a system of care: Sequences and correlates of residential placements. J Child Fam Stud. 2003; 12(1):11–25
16. Newton RR, Litrownik AJ, Landsverk JA. Children and youth in foster care: Disentangling the relationship between problem behaviors and number of placements. Child Abuse Negl. 2000; 24 (10):1363–74
17. Rubin DM, Alessandrini EA, Feudtner C, *et al*. Placement stability and mental health costs for children in foster care. Pediatrics. 2004; 113(5):1336–41
18. Pecora PJ, Kessler RC, Williams J, *et al*. Improving Family Foster Care: Findings from the Northwest foster care alumni study.

Casey Family Programs [Internet]; 2015. Available from https://www.casey.org/northwest-alumni-study/. Accessed May 21, 2023
19. McGuire A, Cho B, Huffhines L, *et al*. The relation between dimensions of maltreatment, placement instability, and mental health among child in foster care. Child Abuse Negl. 2018; 86:10–21
20. Steen JA, Harlow S. Correlates of multiple placements in foster care: A study of placement instability in five states. J Public Child Welf. 2012; 6(2):172–90
21. Rock S, Michelson D, Thomson S, Day C. Understanding foster placement instability for looked after children: A systematic review and narrative synthesis of quantitative and qualitative evidence. British J Soc Work. 2015; 45(1):177–203
22. Connell CM, Vanderploeg JJ, Flaspohler P, *et al*. Changes in placement among children in foster care: A longitudinal study of child and case influences. Soc Serv Rev. 2006; 80(3):398–418
23. Oosterman M, Schuengel C, Slot NW, *et al*. Disruptions in foster care: A review and meta-analysis. Child youth Serv Rev. 2007; 29 (1):53–76
24. Sattler KMP, Font SA, Gershoff ET. Age-specific risk factors associated with placement instability among foster children. Child Abuse Negl. 2018; 84:157–69
25. Aguiniga DM, Madden EE. Foster care placement process and settings. In Trejos-Castillo E, Trevino-Schafer N, editors. Handbook of Foster Youth. New York: Routledge; 2018. p. 20–40
26. Stevenson Wojciak A, McWey LM, Waid J. Sibling relationships of youth in foster care: A predictor of resilience. Children Youth Serv Rev. 2018; 84:247–54
27. Affronti M, Rittner B, Semanchin Jones AM. Functional adaptation to foster care: Foster care alumni speak out. J Public Child Welfare. 2015; 9(1):1–21
28. Akin BA. Predictors of foster care exits to permanency: A competing risks analysis of reunification, guardianship, and adoption. Children Youth Serv Rev. 2011; 33(6):999–1011
29. McBeath B, Kothari B, Blakeslee J, *et al*. Intervening to improve outcomes for siblings in foster care: Conceptual, substantive, and methodological dimensions of a prevention science framework. Child Youth Serv Rev. 2014; 39:1–10
30. Whetten K, Ostermann J, Whetten RA, *et al*. A comparison of the wellbeing of orphans and abandoned children ages 6–12 in institutional and community-based care settings in 5 less wealthy nations. PLoS ONE. 2009; 4(12):e8169
31. Dongdong L, Chng G, Meng Chu C. Comparing long-term placement outcomes of residential and family foster care: A meta-analysis. Trauma Violence Abuse. 2019; 20(5):653–64
32. Pecora PJ, Jensen PS, Romanelli LH, *et al*. Mental health services for children placed in foster care: An overview of current challenges. Child Welfare. 2009; 88(1):5–26
33. Salazar AM, Keller TE, Gowen LK, Courtney ME. Trauma exposure and PTSD among older adolescents in foster care. Soc Psychiatry Psychiatr Epidemiol. 2013; 48(4):545–51
34. Romano E, Babchishin L, Marquis R, Fréchette S. Childhood maltreatment and educational outcomes. Trauma Violence Abuse. 2015; 16(4):418–37
35. Pecora PJ, Kessler RC, O'Brien K, *et al*. Educational and employment outcomes of adults formerly placed in foster care: Results from the Northwest Foster Care Alumni Study. Children and Youth Services Review. 2006; 28(12):1459–81
36. Eastman A, Foust R, Prindle J, *et al*. A descriptive analysis of the child protection histories of youth and young adults arrested in California. Child Maltreat. 2019; 24(3):324–9
37. McCarthy S, Gladstone M. State Survey of California Prisoners: What percentage of the state's polled prison inmates were once foster care children? Policy matters. California Senate Office of Research [Internet]; 2011. Available from: https://sor.senate.ca.gov/sites/sor.senate.ca.gov/files/Foster_Care_PDF_12-8-11.pdf. Accessed November 3, 2022
38. Models for Change Research Initiative. Is there a link between child welfare and disproportionate minority contact in juvenile justice? [Internet]; 2011. Available from: https://www.modelsforchange.net/publications/317/. Accessed November 11, 2022
39. Smith CA, Thornberry TP. The relationship between childhood maltreatment and adolescent involvement in delinquency. Criminology. 1995; 33(4):451–81
40. Goodkind S, Shook JJ, Kim KH, *et al*. From child welfare to juvenile justice: Race, gender, and system experiences. Youth Violence Juv Justice. 2013; 11(3):249–72
41. Office of Juvenile Justice and Delinquency Prevention. Intersection of juvenile justice and child welfare systems [Internet]; 2021. Available from: https://ojjdp.ojp.gov/model-programs-guide/literature-reviews/Intersection-Juvenile-Justice-Child-Welfare-Systems. Accessed March 4, 2022
42. Richardson SM, Yates TM. Siblings in foster care: A relational path to resilience for emancipated foster child. Child Child Serv Rev. 2014; 47:378–88
43. Lee T, Fouras G, Brown R, American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Quality Issues (CQI). Practice parameter for assessment and management of youth involved with the child welfare system. J Am Acad Child Adolesc Psychiatry. 2015; 54(6):502–17
44. Child Welfare Information Gateway. Sibling issues in foster care & adoption: Bulletin for professionals [Internet]; 2019. Available from: https://www.childwelfare.gov/pubPDFs/siblingissues.pdf. Accessed March 4, 2022
45. Child Welfare Information Gateway. Fostering Connections to Success and Increasing Adoptions Act of 2008 (P.L. 110-351). Available from: https://www.childwelfare.gov/topics/systemwide/laws-policies/-federal/fosteringconnections/. Accessed May 21, 2023
46. Preventing Sex Trafficking and Strengthening Families Act. PL 113-183 [Internet]; 2014. Available from: https://www.congress.gov/bill/113th-congress/house-bill/4980. Accessed May 21, 2023
47. Family First Prevention Services Act. HR 1892 [Internet]; 2018. Available from: https://www.childwelfare.gov/topics/systemwide/laws-policies/federal/family-first/. Accessed May 21, 2023
48. Child Welfare Information Gateway. Placement of Children with Relatives. State Statutes [Internet]; 2018. Available from: https://www.childwelfare.gov/pubPDFs/placement.pdf. Accessed March 4, 2022
49. Advocates CAS. Court appointed special advocates. Available from: https://nationalcasagal.org/our-work/. Accessed March 4, 2022
50. Griffin G, Mg Holzberg M, Stolbach B, *et al*. Addressing the impact of trauma before diagnosing mental illness in child welfare. Child Welfare. 2011; 90:69–89
51. American Academy of Child & Adolescent Psychiatry. A guide for community serving child agencies on psychoatropic medications for child & adolescents [Internet]; 2012. Available from: https://www.aacap.org/App_Themes/AACAP/docs/press/guide_for_community_child_serving_agencies_on_psychotropic_medications_for_children_and_adolescents_2012.pdf. Accessed March 4, 2022
52. Seltzer RR, Johnson SB, Minkovitz CS. Medical complexity and placement outcomes for children in foster care. Child Child Serv Rev. 2017; 83:285–93
53. James S. Why do foster care placements disrupt? An investigation of reasons for placement change in foster care. Social Serv Rev. 2004; 78(4):601–27
54. Ka M. Future direction in childhood adversity and child psychopathology. J Clin Child Adolesc Psychol. 2016; 45:361–82
55. Child and Family Services Improvement and Innovation Act. HR 2882 [Internet]; 2012. Available from: https://www.congress.gov/bill/112th-congress/house-bill/2883. Accessed May 21, 2023

56. American Academy of Child & Adolescent Psychiatry. Practice parameter on the use of psychotropic medication in children and adolescents. J Am Acad Child Adolesc Psychiatry. 2009; 48 (9):961–73
57. Scott IH, Reeve E, Potter K, *et al*. Reducing inappropriate polypharmacy: The process of deprescribing. JAMA Intern Med. 2015; 175(5):827–34
58. King CA, Merchant CR. Social and interpersonal factors relating to adolescent suicidality: A review of the literature. Arch Suicide Res. 2008; 12(3):181–96
59. Dunn EC, McLaughlin KA, Slopen N, *et al*. Developmental timing of child maltreatment and symptoms of depression and suicidal ideation in young adulthood: Results from the National Longitudinal Study of Adolescent Health. Depress Anxiety. 2013; 30(10):955–64
60. Lewis C, Simons A, Nguyen L. Impact of childhood trauma on treatment outcome in the Treatment for Adolescents with Depression Study (TADS). J Am Acad Child Adolesc Psychiatry. 2010; 49:132–40
61. Shamseddeen W, Asarnow JR, Clarke G, *et al*. Impact of physical and sexual abuse on treatment response in the Treatment of Resistant Depression in Adolescent Study (TORDIA). J Am Acad Child Adolesc Psychiatry. 2011; 50(3):293–301
62. Gillies DM, Bhandari AP, Taylor F, *et al*. Psychological therapies for children and adolescents exposed to trauma. Cochrane Database Syst Rev. 2016; 10:CD012371
63. Gillies D, Taylor F, Gray C, *et al*. Psychological therapies for the treatment of post traumatic stress disorder in children and adolescents. Evid Based Child Health. 2013; 8(3):1004–116
64. Cohen JA, Mannarino AP. A treatment outcome study for sexually abused preschool children: Initial findings. J Am Acad Child Adolesc Psychiatry. 1996; 35(1):42–50
65. Scheeringa MS, Weems CF, Cohen JA, *et al*. Trauma-focused cognitive-behavioral therapy for posttraumatic stress disorder in three-through six year-old children: A randomized clinical trial. J Child Psychol Psychiatry. 2011; 52(8):853–60
66. Cohen JA, Mannarino AP, Jankowski K, *et al*. A randomized implementation study of trauma-focused cognitive behavioral therapy for adjudicated teens in residential treatment facilities. Child Maltreat. 2016; 21(2):156–67
67. Stewart RW, Orengo-Aguayo RE, Cohen JA, *et al*. A pilot study of trauma-focused cognitive-behavioral therapy delivered via telehealth technology. Child Maltreat. 2017; 22(4):324–33
68. California Evidence-Based Clearinghouse for Child Welfare; 2018. Available from: http://www.cebc4cw.org/. Accessed March 4, 2022