

Dismantling Placement Barriers for Youth with Severe Conduct Pathology

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Abstract: Youth diagnosed with Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD) represent one of the most underserved and systemically excluded populations across the child welfare, mental health, and juvenile justice spectra. Characterized by severe externalizing behaviors, property destruction, and physical aggression, these high-acuity youth frequently experience chronic placement instability, institutional rejection, and early criminalization. This paper examines the systemic mechanisms perpetuating this crisis through critical synthesis of federal statutory frameworks, state-level implementation divides, professional ethics, and workforce training models. Analysis reveals how federal statutory policies, including the Adoption and Safe Families Act (ASFA), the Medicaid Institution for Mental Diseases (IMD) exclusion, and state execution of the Family First Prevention Services Act (FFPSA), unintentionally incentivize placement breakdowns and default behaviorally complex youth into punitive juvenile justice containment. Examining state-level Qualified Residential Treatment Program (Q RTP) implementation illustrates how restricted residential capacity without high-acuity alternatives drives crisis cycles. Furthermore, applying the NASW and ACA Codes of Ethics alongside CSWE (2022) and CACREP (2024) accreditation standards uncovers a profound disconnect: institutional diagnostic discrimination and facility-level rejections are reinforced by systemic gaps in generalist clinical higher education, workforce preparation, and professional licensure gatekeeping. To advance social justice and human rights, this paper operationalizes an ecological empowerment framework and phased MST model, recommending specialized residential care expansion, upstream pediatric screening, and policy-driven workforce reforms to guarantee dignified, evidence-based care for high-acuity youth and their families.

Keywords: Oppositional Defiant Disorder, Conduct Disorder, High-Acuity Behavioral Health, Systemic Exclusion, Qualified Residential Treatment Programs, Family First Prevention Services Act, Workforce Readiness, Professional Gatekeeping, Social Work Ethics, Child Welfare Pipeline.

DISMANTLING PLACEMENT BARRIERS FOR YOUTH WITH SEVERE CONDUCT PATHOLOGY

Diagnostic Framework and Prevalence of ODD and CD

Youth diagnosed with Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD) represent one of the most underserved and systemically excluded populations across the child welfare, mental health, and juvenile justice continuums. Diagnostic criteria define ODD as a persistent pattern of angry or irritable mood, argumentative or defiant behavior, and vindictiveness toward authority *et al.*ures lasting at least six months across multiple settings (American Psychiatric Association [APA], 2022). Affected youth frequently exhibit temper outbursts, rule violations, and spiteful behaviors (APA, 2022). When symptoms escalate in severity to include serious violations of societal norms, such as physical aggression, property destruction, deceitfulness, and theft, the diagnosis progresses to CD (APA, 2022). Affecting between 3%

and 10% of children and adolescents, ODD and CD are among the most prevalent childhood behavioral conditions (APA, 2022).

Research indicates a strong developmental pathway between ODD and CD, particularly when compounded by environmental risk factors such as poverty, trauma exposure, family stress, neighborhood disadvantage, and deviant peer associations (Goetz *et al.*, 2023). Prior to entering formal systems of care, many affected youths experience chronic instability, abuse, neglect, domestic violence exposure, and parental substance use (Goetz *et al.*, 2023). These acute environmental stressors significantly amplify externalizing antisocial behaviors, demonstrating that conduct pathology is not merely an individual deficit, but rather a response deeply interconnected with social and structural conditions (Goetz *et al.*, 2023).

System Disparities, Service Exclusion, and Regulatory Constraints

These structural inequities disproportionately affect youth ages 8 to 18 involved in child welfare, foster care, and juvenile justice pathways, systems they are often funneled into when community-based therapeutic

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supports prove insufficient. Youth in foster care experience elevated rates of ODD and CD while facing systemic barriers to receiving adequate and consistent services (Engler *et al.*, 2022). These service barriers contribute to out-of-home placement instability and an increased likelihood of juvenile justice involvement, as youth cycle through foster homes, group homes, psychiatric facilities, and detention settings when their behaviors are deemed too difficult to manage safely in less secure environments. Furthermore, racial and socioeconomic disparities significantly shape diagnostic and placement trajectories. Black and Hispanic youth are disproportionately overrepresented in child welfare and juvenile justice settings, where their distress is more frequently interpreted through a punitive lens as aggression or delinquency rather than a clinical need for mental health intervention (Goetz *et al.*, 2023). Applying an Anti-Racism, Diversity, Equity, and Inclusion (ADEI) lens is therefore essential when examining diagnostic practices, placement determinations, and equitable service access (Goetz *et al.*, 2023).

When clinical care needs conflict with facility capacity, placement breakdowns occur rapidly. Due to high-risk behavioral manifestations, youth with ODD and CD are routinely denied admission to residential treatment centers and psychiatric facilities that lack the specialized staffing structure or physical containment required to maintain safety. Consequently, youth are either returned to unequipped home environments, leaving caregivers and siblings vulnerable to ongoing violence, or pushed into juvenile justice settings that prioritize behavioral containment over rehabilitation (Burns *et al.*, 2003). This chronic placement instability unmask a profound human rights and social justice issue rooted in unequal service access, systemic policy gaps, and the criminalization of untreated behavioral health needs. Addressing these complex behavioral profiles requires cross-system collaboration to establish unified definitions of "high acuity" and develop trauma-informed care pathways that target root emotional trauma rather than exclusively reacting to externalizing conduct behaviors (Casey Family Programs Youth with Unmet Complex Care Needs Workgroup [Casey Family Programs], 2024).

In alignment with Substance Abuse and Mental Health Services Administration (SAMHSA) behavioral health guidelines and child welfare frameworks, this paper uses *high acuity* to denote clinical severity and required intensity of care. Conversely, consistent with Office of Juvenile Justice and Delinquency Prevention

(OJJDP) research, *at-risk* is reserved to describe systemic vulnerability to placement breakdown and juvenile justice processing when specialized behavioral settings are unavailable. To safely serve youth presenting with severe externalizing conduct pathology, systems must balance high-acuity clinical needs with regulatory standards. SAMHSA (2025) defines acuity as "the level of severity and complexity of an individual's mental health or substance use condition" (p. 83). While hospital-based emergency stabilization units and moderate-intensity crisis centers possess the specialized infrastructure, continuous clinical monitoring, and risk-mitigation capacities necessary for high-acuity admissions, lower-intensity crisis residential programs are structurally unequipped due to lower staff-to-patient ratios (SAMHSA, 2025). Within community crisis frameworks, Mobile Response and Stabilization Services (MRSS), via Mobile Crisis Teams, aim to deliver "time-limited, intensive community-based services designed to support high acuity children and youth in a systems-based approach" (SAMHSA, 2025, p. 87).

When these youth enter the child welfare continuum, however, child-serving agencies encounter rigid structural limitations under the Family First Prevention Services Act (FFPSA) of 2018, which restricts non-family group placements to trauma-informed Qualified Residential Treatment Programs (QRTPs; Casey Family Programs, 2020). FFPSA mandates a formal assessment by a "qualified individual" within 30 days and judicial approval within 60 days to prevent inappropriate congregate placement (Casey Family Programs, 2020). Beyond placement standards, financial reimbursement creates additional operational friction. As outlined in joint federal guidance by the Centers for Medicare & Medicaid Services and the Administration for Children and Families (CMS & ACF, 2019), ACF establishes placement and child safety standards (e.g., QRTP requirements under FFPSA), while CMS regulates the Medicaid reimbursement rules that determine how those specialized residential settings are funded.

Subsequent policy guidance and advocacy introduced heightened oversight regarding youth rights in non-family settings, specifically targeting psychotropic overmedication and chemical restraint, physical safety protocols, human trafficking protections, and geographic proximity to home communities (National Policy Council, 2020). Critically, the National Policy Council (2020) established that QRTP implementation must ensure placement entry remains

fair and appropriate while guaranteeing that residential programs serve "the needs of the 'tough' kids, and not just those with the easiest to meet needs" (p. 3). To further support high-acuity youth, the U.S. Department of Health and Human Services (HHS) has provided specific coordination opportunities between the Health Resources and Services Administration (HRSA), SAMHSA, CDC, ACF, the Administration for Community Living (ACL), and CMS to support the complex mental health needs of children (Casey Family Programs, 2024).

Examining this critical social justice issue through the combined lenses of social work and counseling core values, educational standards, state and national policy frameworks, and empowerment practice highlights the urgent necessity for specialized, treatment-focused responses that prioritize safety, dignity, equity, and long-term well-being for high-acuity youth and their families.

COMMUNITY DYNAMICS AND THE ECOLOGY OF CONDUCT-RELATED BEHAVIORAL HEALTH

Youth with severe conduct-related behaviors exist within interconnected systems that continuously influence one another. Families, schools, peer networks, neighborhoods, child welfare agencies, behavioral health providers, and juvenile justice institutions do not operate independently; decisions made within one system can alter the functioning of every other system. A school's response to behavioral escalation may influence child welfare involvement, while child welfare placement decisions may disrupt school continuity, peer relationships, and access to community-based providers. Similarly, when behavioral health providers lack the staffing or infrastructure to safely treat a youth, responsibility for managing the behavior may shift to caregivers, schools, law enforcement, or juvenile justice institutions.

From an ecological and community-based perspective, placement instability is therefore not simply an individual or family outcome. It can represent a breakdown in coordination among interconnected community systems. Although youth behavior may contribute to system involvement, institutional responses also shape the youth's subsequent trajectory. Repeated school removals, disrupted placements, changes in providers, and movement between treatment and justice settings can weaken family relationships, interrupt educational participation, reduce community connections, and increase distrust

of institutions (Huang & Ryan, 2014; Zajac *et al.*, 2015). Understanding these reciprocal relationships is essential to developing interventions that address not only youth behavior but also the community conditions surrounding it.

Interdisciplinary Lenses on Conduct Pathology

An interdisciplinary perspective further demonstrates why placement instability cannot be addressed through clinical treatment alone. Social work emphasizes ecological practice, social justice, and advocacy; community psychology emphasizes empowerment, prevention, and strengthening community capacity; sociology provides a framework for understanding institutional labeling and the social consequences of criminalization; public health emphasizes early identification and prevention before behavioral crises escalate; and education highlights the role of school exclusion and academic disruption in shaping developmental trajectories. Together, these perspectives support a shift from viewing severe conduct pathology solely as an individual clinical problem toward understanding it as a community systems issue requiring coordinated intervention across settings.

POLICY & STATUTORY FRAMEWORKS

The systemic failure to provide accessible, high-acuity residential treatment for youth diagnosed with Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD) is deeply rooted in federal statutory mandates, funding mechanisms, and state-level administrative barriers. Rather than functioning as cohesive safety nets, intersecting federal legislation and state policy frameworks often create conflicting pressures that default high-risk, behaviorally complex youth into juvenile justice containment or unstable child welfare cycles. Analyzing these structural mechanisms reveals how statutory policy gaps incentivize institutional rejection and perpetuate chronic placement breakdown.

ASFA

Although major federal child welfare laws are designed to safeguard child well-being, several contain statutory gaps or unintended consequences that severely restrict access to intensive therapeutic care. The Adoption and Safe Families Act (ASFA) of 1997 established strict federal timelines to eliminate "foster

care drift," most notably mandating that state child welfare agencies file for the termination of parental rights (TPR) when a child has been in foster care for 15 of the preceding 22 months (Adoption and Safe Families Act, 1997). While intended to accelerate permanency, ASFA's rigid timeframe creates extreme friction for youth with ODD and CD. Because these youth experience frequent placement disruptions due to behavioral acuity and residential facility rejections, child welfare agencies routinely fail to achieve reunification or stable adoption within the 15-month window. Consequently, statutory pressures frequently force child welfare systems to accelerate legal custody transfers, push premature TPR, or surrender jurisdiction to juvenile justice settings rather than securing specialized, long-term therapeutic care.

Policy-to-Community Pathway

These policy constraints are experienced locally through the community systems responsible for implementing them. Federal legislation may establish placement requirements or funding restrictions, but the practical consequences are experienced by families, schools, child welfare agencies, behavioral health providers, and juvenile justice systems within individual communities. When policy limits the availability or reimbursement of specialized treatment, responsibility for managing high-acuity youth is redistributed across already strained community systems. Caregivers may be left to manage severe behaviors without adequate support, schools may become informal behavioral health providers, emergency departments may become recurring points of crisis stabilization, and law enforcement may become involved when community providers cannot safely respond.

This creates a policy-to-community pathway in which structural decisions can contribute to local placement instability. A youth who cannot access an appropriate residential or community-based treatment setting may experience repeated crisis interventions, school disruption, placement changes, and increased contact with law enforcement. Each system responds to an immediate need, but without coordinated treatment, the underlying behavioral and environmental drivers remain unresolved. Consequently, policies intended to protect children or control institutional spending may produce unintended community-level consequences when adequate treatment infrastructure is not available to support implementation.

Statutory Protections and Gaps: ICWA and JJDPA

Federal statutory protections designed to preserve cultural and family integrity are similarly strained by nationwide shortages of specialized behavioral care. The Indian Child Welfare Act (ICWA) of 1978 mandates "active efforts" to prevent the breakup of Native American families and establishes strict placement preferences prioritizing extended family, tribal members, and Indian foster homes (Indian Child Welfare Act, 1978). For Native youths presenting with severe conduct pathology, however, the profound lack of culturally grounded, high-acuity residential beds on or near tribal lands routinely compromises compliance with federal law. State child welfare and juvenile justice systems frequently bypass ICWA placement hierarchies, transferring Native youth to non-compliant commercial facilities or defaulting to local juvenile detention centers under the guise of emergency safety interventions.

Similarly, statutory frameworks within the juvenile justice system fail to guarantee essential mental health care. The Juvenile Justice and Delinquency Prevention Act (JJDPA) establishes federal standards designed to protect justice-involved youth and promote community-based alternatives (Coalition for Juvenile Justice, 2024). Although, the JJDPA lacks enforceable mental health treatment mandates for facilities housing juveniles (Coalition for Juvenile Justice, 2024). Consequently, detention centers frequently act as de facto behavioral health providers despite lacking adequately trained clinical staff or evidence-based treatment models. Furthermore, while the JJDPA mandates the Deinstitutionalization of Status Offenders (DSO), the lack of community-based residential resources causes non-criminal externalizing behaviors, such as running away, truancy, and incorrigibility, to be formally recategorized as delinquent acts. This statutory workaround effectively bypasses federal DSO protections and funnels youth directly into correctional settings.

Medicaid and Commercial Financing: The IMD Exclusion and Reimbursement Caps

A major structural barrier to high-acuity residential treatment is the Institutions for Mental Diseases (IMD) exclusion, a federal Medicaid rule that prohibits federal reimbursement for inpatient or residential care in facilities exceeding 16 beds (King *et al.*, 2024). This funding restriction drastically limits state treatment infrastructure. National data indicate that only

approximately 57% of adolescent residential treatment facilities accept Medicaid, and far fewer have immediate bed availability for high-acuity admissions, leaving public agencies with severely restricted placement options (King *et al.*, 2024).

Financial barriers extend equally to privately insured families. Provider acceptance of private commercial insurance varies widely across residential facilities, particularly between non-profit and for-profit programs. This variation leads to out-of-network costs, restrictive reimbursement caps, and extensive waitlists. Even when residential services are covered by insurance, many programs require significant upfront costs that families cannot afford. Consequently, access to intensive residential treatment is frequently determined more by family insurance status and socioeconomic resources than by true clinical need (King *et al.*, 2024).

State-Level QRTP Implementation: South Carolina vs. North Carolina

The statutory execution of the Family First Prevention Services Act (FFPSA) of 2018 illustrates how federal mandates manifest at the state level through Qualified Residential Treatment Program (QRTP) provisions. While FFPSA intended to curb unnecessary institutionalization by imposing strict clinical assessment and judicial review requirements, state-level implementation highlights significant statutory and operational divides.

In South Carolina, QRTP placements are governed by S.C. Code Ann. § 63-7-1730 *et seq.* (2021), which mandates that within 30 days of placement in a QRTP, a qualified individual must complete a formal assessment, and a family court judge must formally approve or disapprove the placement within 60 days. While intended to guarantee judicial oversight, South Carolina faces an acute shortage of licensed, in-state QRTP beds equipped to handle high-acuity externalizing behaviors (South Carolina Department of Social Services [SC DSS], 2023; South Carolina Legislative Audit Council, 2022). As a result, the South Carolina Department of Social Services (DSS) and Department of Juvenile Justice (DJJ) experience severe systemic bottlenecks. Youth with ODD and CD who are rejected by existing QRTP providers are routinely housed in temporary emergency shelters, hotel rooms, or local DSS county offices while awaiting court hearings or out-of-state placements. When behavioral dysregulation escalates in these unequipped, non-therapeutic environments, local law

enforcement is called, completing the pipeline from child welfare to DJJ detention centers.

In contrast, North Carolina executes QRTP placements under N.C. Gen. Stat. § 7B-903.1 (2021), operating within a system shaped historically by the *Willie M.* class-action litigation, which legally mandated specialized, state-funded treatment for violently aggressive youth. North Carolina utilizes a regional Local Management Entity/Managed Care Organization (LME/MCO) structure alongside specialized "Tailored Plans" designed specifically for high-needs behavioral health populations (N.C. Gen. Stat. § 7B-903.1, 2021; North Carolina Department of Health and Human Services [NC DHHS], 2023). While North Carolina still contends with QRTP bed shortages and strict FFPSA judicial review timelines, its statutory integration of behavioral health managed care offers greater infrastructure for interagency funding blending than South Carolina's structure.

Despite these administrative differences, both states illustrate a critical statutory flaw: FFPSA and state QRTP laws restrict bed availability without building alternative high-acuity residential capacity. These differences are experienced locally as differences in community capacity. A statutory framework is only as effective as the network of providers, schools, behavioral health organizations, child welfare agencies, and community resources available to implement it. When a state lacks sufficient specialized placements, the burden does not disappear; it is redistributed across local systems. Caregivers may become responsible for managing dangerous behaviors without adequate support, schools may assume behavioral health responsibilities for which they are not equipped, emergency departments may become points of repeated stabilization, and law enforcement may be called when behavioral crises exceed the capacity of caregivers or community providers. Residential capacity should therefore be understood not solely as a child welfare resource, but as a component of community infrastructure. Without specialized facilities capable of safely managing severe physical aggression and property destruction, youth with ODD and CD remain caught in a legislative gap where child welfare systems cannot legally house them, residential facilities refuse to admit them, and juvenile justice systems ultimately absorb them.

Altogether, these legislative frameworks and policy barriers demonstrate that rather than initiating early,

intensive intervention, current policies actively funnel high-acuity youth toward punitive systems. This structural failure leaves families without safety nets and reinforces systemic disparities linked to race, income, and geographic location. These recurring patterns highlight the urgent necessity for a practice framework that moves beyond individual behavioral management to directly challenge the structural conditions limiting equitable care, a demand directly addressed through empowerment theory.

COMMUNITY-LEVEL CONSEQUENCES OF PLACEMENT INSTABILITY

Institutional Strain and Cumulative Disruption

The consequences of placement instability extend beyond individual youth and families and can affect the functioning of interconnected community institutions. When youth repeatedly move between foster homes, psychiatric facilities, emergency settings, residential programs, and juvenile detention, schools, child welfare agencies, behavioral health providers, and justice systems must repeatedly respond to unresolved behavioral health needs. Schools may experience disrupted educational continuity, emergency departments may become recurring points of crisis stabilization, child welfare agencies may expend substantial resources coordinating successive placements, and law enforcement may become involved when behavioral crises exceed the capacity of caregivers or community providers. These repeated responses can consume limited community resources without necessarily addressing the conditions driving the behavior. From a community-systems perspective, this creates a cycle in which institutions remain focused on crisis response rather than prevention, treatment continuity, and family stabilization (Huang & Ryan, 2014; Zajac *et al.*, 2015).

Placement instability may also disrupt the relationships and institutional connections that support healthy development. Research has linked exclusionary responses within schools to subsequent delinquent behavior and justice-system contact, suggesting that repeated removal from supportive institutions may contribute to, rather than resolve, behavioral difficulties (Novak, 2018). Similarly, research examining child welfare placement and neighborhood conditions demonstrates that the environments in which youth are placed can intersect with delinquency risk, reinforcing the importance of considering placement decisions within broader community

contexts (Huang & Ryan, 2014). Families who repeatedly experience service denial, placement disruption, or conflicting expectations across agencies may consequently encounter increasing difficulty maintaining stable relationships with schools, providers, and other community institutions. Rather than viewing system involvement as a series of isolated encounters, community-based practice requires understanding how repeated institutional responses accumulate across the youth's developmental trajectory

Public Health Implications and Prevention Infrastructure

From a public health and community development perspective, these patterns represent a challenge to community capacity for prevention and early intervention. Resources may become concentrated around crisis response after behavior has escalated rather than around accessible services that allow families to receive support earlier. Evidence from school-based prevention research demonstrates that interventions designed to reduce exclusion can improve short-term school outcomes, supporting the broader principle that strengthening preventive and supportive systems can reduce reliance on exclusionary responses (Valdebenito *et al.*, 2019). Strengthening community behavioral health infrastructure therefore has implications beyond individual treatment outcomes; coordinated services can support educational continuity, reduce unnecessary justice-system involvement, preserve family and community relationships, and improve the ability of local institutions to respond to behavioral health needs before crises escalate.

EDUCATIONAL & ETHICAL FRAMEWORKS

The systemic exclusion and criminalization of youth diagnosed with Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD) represent a dual crisis of ethical compliance and professional preparation. Across child welfare, mental health, and juvenile justice systems, clinicians and administrators encounter profound ethical dilemmas when severe externalizing behaviors lead to placement rejection. Examining these dynamics through the professional codes of ethics of the National Association of Social Workers (NASW, 2021) and the American Counseling Association (ACA, 2014), alongside the educational accreditation standards of the Council on Social Work Education (CSWE, 2022) and the Council for Accreditation of

Counseling and Related Educational Programs (CACREP, 2024), reveals a critical structural reality: institutional diagnostic discrimination is maintained, in part, by systemic gaps in practitioner education, workforce preparation, and licensure gatekeeping (Sejuit *et al.*, 2025). As Sejuit *et al.* (2025) demonstrate in their comparative analysis of social work and counseling frameworks, gatekeeping mechanisms across educational accreditation and professional licensure standards directly shape professional competence, credentialing pipelines, and the delivery of equitable care to vulnerable populations.

Ethical Imperatives and Administrative Discrimination

When residential treatment facilities and psychiatric centers refuse admission to youth with ODD and CD, clinicians are forced into ethical compromises. Comparing the NASW Code of Ethics and the ACA Code of Ethics underscores the interdisciplinary consensus regarding practitioner obligations, client rights, and systemic advocacy.

At its core, the NASW Code of Ethics provides social workers with six core values in its Preamble: service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence (NASW, 2021). Two stand out as particularly salient when working with youth, presenting severe externalizing behaviors: social justice and the importance of human relationships.

Social workers are called to challenge social injustice and advocate for vulnerable populations experiencing systemic barriers to services and opportunities (NASW, 2021). Youth with ODD and CD are routinely excluded from residential treatment programs, disproportionately funneled into juvenile justice systems, and restricted by Medicaid and commercial insurance limitations. Structural inequities tied to race and socioeconomic status further shape access to care, with marginalized youth more likely to experience punitive responses rather than therapeutic intervention (Goetz *et al.*, 2023). When youth are denied access to appropriate treatment, placed in environments focused primarily on control, or returned home without adequate support, their potential for growth and change is severely hindered.

The value of the importance of human relationships highlights the role of connection in facilitating change (NASW, 2021). Evidence-based interventions such as

Multisystemic Therapy (MST) are grounded in strengthening relationships between youth, caregivers, and broader support systems (Sandler *et al.*, 2015). When services fail or are unavailable, however, families experience repeated disruptions, including psychiatric hospitalizations, placement breakdowns, and system involvement. This "revolving door" pattern, where youth with ODD and CD cycle between acute stabilization, short-term placements, and home without sustained improvement, reflects a systemic reliance on short-term crisis management rather than comprehensive treatment. Constant displacement is associated with worsening behavioral outcomes and emotional distress over time (Rubin *et al.*, 2007), placing severe strain on families who must navigate ongoing safety concerns without sufficient institutional backing.

Specific Ethical Standards and Administrative Discrimination

The challenges associated with treating youth with Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD) raise significant ethical concerns regarding specific provisions in professional codes across both social work and counseling. Under NASW Standard 1.01 (Commitment to Clients), social workers' primary professional responsibility is to promote the well-being of clients (NASW, 2021), a directive echoed in ACA Section A.1.a (Primary Responsibility), which mandates that counselors respect client dignity and promote welfare (ACA, 2014). When residential facilities reject youth with severe conduct pathology to protect census metrics or lower operational liability, clinicians are often forced to return youth to unequipped home environments or default them to juvenile detention settings. This cycle directly violates foundational ethical mandates to safeguard client welfare by exposing youth and their families, including siblings, to unmanaged violence, trauma, and systemic harm.

Systemic placement rejection based strictly on a diagnosis of ODD or CD constitutes a form of administrative discrimination that intersects directly with professional gatekeeping mechanisms (Sejuit *et al.*, 2025). Although ACA Section C.5 (Nondiscrimination) explicitly prohibits counselors from condoning or engaging in discrimination based on arbitrary barriers to care (ACA, 2014), categorically blacklisting youth with externalizing behavioral histories operates as institutional diagnostic discrimination. As Sejuit *et al.* (2025) note in their comparative analysis of helping professions, gatekeeping processes must balance

regulatory standards with institutional accountability; when facilities implement diagnostic exclusions without evaluating individual therapeutic potential or behavioral support needs, they deprive vulnerable youth of equitable access to medically necessary residential care.

Navigating these constrained clinical options also complicates ethical mandates surrounding informed consent and client assent. Ethical Standard 1.03 (Informed Consent) requires transparency, particularly when disempowered caregivers are presented with false choices between repeated acute hospitalizations or juvenile justice processing (NASW, 2021). Concurrently, ACA Section A.2.a (Informed Consent) establishes that consent is an ongoing process granting clients the freedom of choice, while Sections A.2.c (Developmental and Cultural Sensitivity) and A.2.d (Inability to Give Consent) require counselors working with minors to seek assent from youth in a culturally and developmentally appropriate manner alongside legal guardian consent (ACA, 2014).

NASW and ACA Code of Ethics

Both professional codes mandate active advocacy to dismantle organizational barriers to care. NASW Standard 3.09 (*Commitment to Employers*) requires social workers to challenge organizational policies that prevent service delivery, complemented by NASW Standard 6.04 (*Social and Political Action*) to ensure equitable resource distribution (NASW, 2021). While evidence-based practices like Multisystemic Therapy (MST) are effective, they are not universally successful for complex or severe behavioral presentations (McLeod *et al.*, 2009). When community-based interventions are exhausted, the absence of high-acuity residential beds leaves families stranded. Aligning with ACA Section A.7.a (*Advocacy*), which directs clinicians to advocate at institutional and societal levels (ACA, 2014), practitioners carry an explicit ethical and professional mandate to challenge facility-level exclusion policies, address gatekeeping barriers, and advocate for expanded residential infrastructure (Sejuit *et al.*, 2025).

Workforce Preparation: CSWE EPAS (2022) and CACREP (2024) Standards

While ethical codes establish obligations to treat and advocate for high-acuity youth, workforce readiness determines whether clinical systems can operationalize these mandates. The widespread

reluctance of residential treatment facilities to admit youth with Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD) stems significantly from a generalist educational gap: higher education training pipelines often fail to equip emerging clinicians and residential staff with the specialized competencies required to manage severe conduct pathology safely.

CSWE 2022 EPAS Alignment and Empowerment Frameworks

Empowerment theory serves as a central social work framework, shifting clinical focus from deficit-based diagnostic labeling toward resilience, skill development, and resource access (Zimmerman, 2000). Youth with ODD and CD are frequently defined by their behaviors and managed through control-based systems, such as school exclusion, crisis holds, and juvenile justice detention. Empowerment theory reframes these youth as individuals shaped by trauma, environmental hardships, and family instability rather than inherently refractory clients (Goetz *et al.*, 2023). Interventions aligned with empowerment principles, focusing on emotional regulation, active youth participation, and caregiver coaching, reduce oppositional behaviors and build self-efficacy (Kaur *et al.*, 2022; Sandler *et al.*, 2015). Increasing caregiver confidence is particularly critical in cases involving sibling violence, where family preservation without adequate behavioral support creates severe safety risks for all household members.

The Council on Social Work Education (CSWE) 2022 Educational Policy and Accreditation Standards (EPAS) frame core competencies around human rights, equity, and evidence-informed practice. Under CSWE Competency 2 (Advance Human Rights and Social, Racial, Economic, and Environmental Justice), programs are mandated to train students to understand how institutional policies systematically exclude vulnerable populations. The criminalization of externalizing behavior represents a structural failure, requiring social work curricula to explicitly address mechanisms that divert youth from healthcare settings into justice facilities (Council on Social Work Education [CSWE], 2022). Furthermore, CSWE Competencies 4 and 5 (Engage in Practice-Informed Research, Research-Informed Practice, and Policy Practice), alongside NASW Standard 4.01, require grounding clinical intervention in empirically supported methodologies (Finne *et al.*, 2020; NASW, 2021). For youth with CD, practice-informed research is critical, as poorly matched or purely generalist interventions risk

exacerbating behavioral escalation. Competency 5 additionally requires preparing graduates to analyze and advocate for systemic policy changes, such as navigating federal funding constraints like the Medicaid Institution for Mental Diseases (IMD) exclusion and advocating for state-level resource alignment toward specialized treatment settings (CSWE, 2022).

CACREP 2024 Standards Alignment

The Council for Accreditation of Counseling and Related Educational Programs (CACREP) 2024 Standards similarly emphasize advanced clinical assessment, risk management, and specialized practice. Specifically, CACREP Section 5.C (Clinical Mental Health Counseling Standards) requires clinical mental health counseling programs to address the etiology, diagnosis, and treatment of severe mental and behavioral disorders, alongside robust crisis intervention and risk management protocols (Council for Accreditation of Counseling and Related Educational Programs [CACREP], 2024).

Despite these accreditation mandates, generalist counseling curricula frequently emphasize internalizing disorders, such as anxiety and depression, while providing minimal clinical training in severe externalizing behaviors, physical de-escalation, sibling violence management, or structured behavioral containment strategies.

Bridging Education, Ethics, and Systemic Practice

When graduate education in social work and counseling provides broad generalist preparation without specialized, high-acuity behavioral management training, new practitioners enter residential and child welfare settings underprepared for severe physical aggression or property destruction. This educational shortfall fosters organizational fear, high employee turnover, and over-reliance on restrictive interventions, such as physical restraints or law enforcement calls, rather than evidence-based behavioral containment.

To align clinical practice with professional ethics, higher education accreditation bodies and graduate training programs must bridge this gap (Sejuitt *et al.*, 2025). Integrating specialized coursework on juvenile conduct pathology, cross-system policy advocacy, and interdisciplinary behavioral methodologies into CSWE and CACREP curricula is an essential prerequisite for dismantling diagnostic discrimination and ensuring that

youth with ODD and CD receive dignified, treatment-focused care.

Behavioral Interventions, Specialized Practice, and Licensure Training Gaps

Emerging developmental and longitudinal research underscores the urgent imperative for early, specialized clinical intervention when addressing oppositional and conduct-related behaviors in youth. When Conduct Disorder (CD) symptoms emerge during childhood and remain untreated, longitudinal findings demonstrate a significantly increased trajectory toward persistent adult antisocial behavior, chronic relational impairment, substance abuse, and justice system involvement (Özbay *et al.*, 2024). Because early childhood behavioral patterns and family relational dynamics remain malleable, delivering evidence-based clinical interventions during this developmental window is critical. Delayed, generalist, or purely punitive responses not only fail to interrupt externalizing trajectories but routinely accelerate institutional marginalization and system involvement.

Youth diagnosed with Oppositional Defiant Disorder (ODD) and CD require specialized, evidence-based frameworks that simultaneously target individual, family, and environmental drivers of conduct pathology. While foundational cognitive-behavioral interventions and social skills training help youth build emotional regulation, anger management, and impulse control (Kaur *et al.*, 2022), these office-based modalities often prove insufficient when unaddressed family instability, peer contagion, or community violence reinforce antisocial behaviors. Similarly, family-centered parent management training enhances caregiver confidence, supervision, and communication (Sandler *et al.*, 2015), a vital protective factor when addressing severe home safety concerns like sibling violence.

Multisystemic Therapy (MST) as an Ecological Community Intervention

Among evidence-based models, Multisystemic Therapy (MST) represents one of the most rigorously evaluated systemic interventions for severe youth conduct pathology. Grounded in ecological systems theory, MST targets the interconnected micro- and mesosystems shaping youth behavior, including family dynamics, peer networks, academic settings, and community contexts (see Appendix A). Recent empirical literature consistently validates MST's efficacy in reducing externalizing behaviors, decreasing youth emotional distress, and improving systemic

family functioning among high-risk populations (Buderer *et al.*, 2025; Henggeler *et al.*, 2025). Furthermore, strict practitioner adherence to MST treatment principles (see Appendix B) correlates directly with long-term reductions in adolescent delinquency and justice system recidivism (Nuntavisit & Porter, 2025).

The community-based nature of MST is particularly important because intervention occurs within the environments that shape and reinforce youth behavior. Rather than isolating treatment within an outpatient office, MST therapists work directly with caregivers, schools, peers, and other community stakeholders. A therapist may help a caregiver develop a structured supervision plan, collaborate with school personnel to address attendance or behavioral concerns, assist the family in identifying prosocial activities, or help caregivers establish boundaries around delinquent peer associations. These interventions are not independent treatment tasks; together, they strengthen the network surrounding the youth and increase the community's capacity to respond to behavioral needs without immediately relying on institutional or punitive systems.

MST can therefore function as more than an intervention for individual conduct symptoms. By strengthening caregiver skills, improving school engagement, disrupting harmful peer relationships, and connecting families with supportive community resources, MST addresses the relationships and environments that maintain behavioral problems. This aligns with an ecological understanding of community health in which individual well-being is influenced by the strength, accessibility, and coordination of surrounding systems. However, the community-based strength of MST also reinforces the central argument of this manuscript: intensive family-based intervention cannot compensate for communities that lack sufficient residential, crisis, educational, and behavioral health infrastructure when a youth's needs exceed what can safely be managed in the home.

Translating MST and similar intensive evidence-based models into broad community practice, however, reveals a stark disconnect between clinical necessity, professional gatekeeping, and workforce preparation. Delivering intensive systemic care requires advanced clinical specialization, low caseload limits (typically 4–6 families), structured fidelity monitoring, and high-level behavioral risk management, competencies that are largely absent from standard master's level generalist curricula and entry-level licensure examinations. As

Sejuit *et al.* (2025) demonstrate in their comparative analysis of helping professions, regulatory gatekeeping mechanisms must evolve beyond generalist competencies to ensure emerging clinicians are adequately prepared for high-stakes, specialized clinical practice. Without intentional educational integration and post-graduate licensure specialization in high-acuity behavioral interventions, workforce shortages persist, leaving community agencies underprepared and vulnerable youth without access to essential care.

Executing intensive, evidence-based models like MST within social work and counseling practice requires a structured, multi-phase helping process comprising intentional engagement, comprehensive ecological assessment, targeted community-based intervention, and continuous outcome evaluation (Hepworth *et al.*, 2017). Broadening workforce training and professional gatekeeping requirements around these specific phases is essential to ensuring clinicians can operationalize complex behavioral health frameworks ethically and effectively.

Phase 1: High-Stakes Engagement and Systemic Trust-Building

Engagement forms the foundational prerequisite for clinical change, particularly when working with families who have navigated years of system involvement, diagnostic labeling, and institutional rejection. Caregivers of youth with severe externalizing behaviors frequently enter treatment burdened by chronic strain, public stigma, and deep-seated mistrust toward child welfare, educational, and mental health authorities. Within an advanced MST and empowerment framework, engagement intentionally reframes caregivers from source problems into essential expert partners in the change process. Clinicians prioritize radical transparency, cultural humility, and collaborative goal setting to establish the therapeutic alliance necessary to sustain intensive treatment (Buderer *et al.*, 2025; Nuntavisit & Porter, 2025). Developing this level of engagement competence requires targeted clinical training in family resistance, trauma-informed joining, and defensive communication, areas where generalist education and gatekeeping standards frequently fall short (Sejuit *et al.*, 2025).

Phase 2: Multi-Systemic Ecological Assessment

In accordance with Bronfenbrenner's ecological systems theory (see Appendix B), clinical assessment

for severe conduct pathology must transcend individual diagnostic checklists to evaluate the dynamic, interacting contexts surrounding the youth (Budzyrna & Buckley, 2023). Social workers and counselors conduct comprehensive multi-systemic assessments across the youth's family, peer, academic, and neighborhood domains through direct observation, school collaboration, collateral interviews, and historical analysis. Assessment identifies specific ecological drivers maintaining conduct problems, such as inconsistent parental monitoring, association with delinquent peers, academic failure, or severe unaddressed trauma (Henggeler *et al.*, 2025). Simultaneously, practitioners assess family strengths and protective factors, leveraging empowerment principles to validate parental resilience and build systemic capacity. Teaching emerging practitioners how to synthesize complex, multi-systemic data into actionable behavioral formulations demands explicit curriculum and gatekeeping emphasis within graduate accreditation and licensing standards (CSWE, 2022; CACREP, 2024; Sejuit *et al.*, 2025).

Phase 3: Real-Time Community-Based Intervention

Intervention within specialized behavioral frameworks shifts the locus of care from traditional, outpatient office settings directly into the homes, schools, and communities where behavioral crises naturally occur. Guided by MST's nine treatment principles, (see Appendix B) practitioners deliver individualized, action-oriented interventions designed to modify environmental conditions and strengthen caregiver management strategies (Henggeler & Schaeffer, 2016). Clinicians coach caregivers in real time to establish consistent behavioral boundaries, implement structured safety plans (particularly in cases involving physical aggression or sibling violence), improve family communication, and restrict exposure to negative peer influences while fostering prosocial community activities.

Because MST therapists maintain small caseloads to support rapid crisis response and continuous skill coaching, the model demands exceptional clinician autonomy, advanced de-escalation mastery, and sophisticated risk management skills (Henggeler & Schaeffer, 2016). When graduate programs and licensing boards fail to mandate specialized coursework and supervised field placements in high-acuity behavioral management, emerging clinicians enter high-stress residential and intensive community

settings underprepared, ultimately driving clinician burnout, high turnover, and improper reliance on law enforcement or physical restraints.

Phase 4: Continuous Practice-Informed Evaluation and Accountability

Continuous evaluation is both an ethical mandate and a hallmark of research-informed clinical practice (NASW, 2021). Rather than relying solely on post-treatment summative measures, specialized models mandate real-time, multi-informant progress monitoring throughout the therapeutic lifecycle (Henggeler & Schaeffer, 2016). Practitioners systematically aggregate caregiver reports, youth self-reports, academic behavioral records, and direct observations to evaluate key indicators of change, including reductions in physical aggression, improved parental consistency, school re-engagement, and avoidance of justice system contact.

Ongoing tracking allows clinicians to rapidly modify interventions when progress stalls, operationalizing practice-informed research by generating empirical feedback on what strategies work for specific behavioral profiles. Training social workers and counselors to utilize data-driven feedback loops ensures clinical accountability, protects client welfare, and strengthens the systemic evidence base required to advocate for expanded funding, policy reform, and specialized licensure pathways in juvenile behavioral health.

FUTURE RECOMMENDATIONS

The critical shortage of accessible, specialized treatment options for youth diagnosed with Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD) presents profound ethical and practical challenges for social workers and professional counselors. Currently, youth presenting high-acuity behavioral disorders are regularly funneled into fractured service systems that prioritize short-term crisis containment or punitive institutional control over sustained, developmentally appropriate therapeutic intervention. Although gold-standard, evidence-based models like Multisystemic Therapy (MST) demonstrate robust empirical outcomes, they are not a universal panacea. When intensive community-based interventions prove insufficient, or when youth present high-acuity safety risks such as severe physical aggression or sibling violence, families face a severe drought of viable, higher-level care options.

Examining this service deficit through the lens of both the NASW Code of Ethics (2021) and the ACA Code of Ethics (2014) highlights an undeniable professional obligation: social workers and counselors must actively challenge macro-level systemic failures that deny vulnerable youth and families appropriate, dignified care. Bridging this expansive treatment gap requires a tri-fold approach focused on workforce training, family support, and policy-driven system expansion.

Specialized Workforce Training and Accreditation Alignment

A primary driver of the current treatment gap is the mismatch between generalist professional education, and the complex demands of high-acuity behavioral practice. Emerging clinicians frequently enter high-acuity child and adolescent settings without specialized training in advanced de-escalation, family-systems coaching, or complex trauma integration. Regulatory bodies, accreditation standards (e.g., CSWE, CACREP), and graduate programs must integrate specialized coursework and clinical practicums focused on severe conduct pathology and ecological interventions. Equipping clinicians with robust, specialized competencies reduces practitioner burnout, prevents early turnover, and ensures that evidence-based interventions are delivered with fidelity and safety.

Expanding Specialized Residential and Crisis Continuum Infrastructure

While community-based models like MST aim to keep youth in the home, a comprehensive system of care must account for families navigating chronic safety concerns and severe environmental instability (McLeod *et al.*, 2021). Policymakers, healthcare systems, and child-serving agencies must prioritize funding and developing specialized, trauma-informed residential treatment facilities (RTFs). Rather than acting as institutional warehouses, these specialized residential settings must integrate high-intensity behavioral therapy, dialectical strategies, and continuous family engagement. This ensures youth receive stabilization in a safe, structured environment while actively preserving family bonding and preparing for step-down community reintegration.

Upstream Screening, Early Intervention, and Primary Care Integration

Waiting for conduct problems to escalate into adolescent juvenile justice involvement is both clinically

sound and economically wasteful. Longitudinal evidence clearly indicates that untreated childhood conduct problems significantly increase adult trajectories of chronic delinquency, substance dependence, and severe relational impairment (Özbay *et al.*, 2024). Strengthening early screening and preventative behavioral interventions within pediatric primary care, early childhood education, and school-based mental health clinics allows social workers and counselors to interrupt externalizing trajectories before behaviors become deeply entrenched.

Through coordinated interprofessional advocacy, targeted program development, and policy reform, social workers and counselors can build an integrated network of care. Transforming youth behavioral healthcare requires moving beyond passive containment to deliver proactive, multi-systemic support.

CONCLUSION

The systemic gaps defining the treatment landscape for youth with ODD and CD represent a significant institutional failure across health, child welfare, and justice systems. When evidence-based interventions are structurally unavailable, underfunded, or rigidly applied without regard for individual family acuity, youth are trapped in a revolving door of psychiatric holds, short-term crisis stabilization, out-of-home placements, and juvenile detention. This cycle destabilizes family units, inflicts secondary trauma, and reflects a fundamental social justice issue: unequal access to medically necessary, high-quality mental healthcare.

This manuscript contributes a community-systems perspective by demonstrating how structural policies, institutional practices, family environments, and community resources interact to produce placement instability and justice-system involvement. Placement instability is not simply the consequence of severe youth behavior; it can also emerge when policies restrict available services, institutions lack the capacity to respond, families are left without adequate support, and community systems operate without coordinated alternatives. Once established, this instability can further disrupt education, family relationships, community participation, and institutional trust, creating a cycle that becomes increasingly difficult to interrupt.

Social workers and professional counselors therefore have a responsibility to address both individual behavioral health needs and the structural

conditions that shape access to care. Evidence-based interventions such as MST demonstrate the potential of coordinated, community-based practice to strengthen caregiver capacity, improve school and peer relationships, and reduce reliance on punitive systems. However, MST cannot independently resolve shortages in residential care, crisis services, workforce preparation, or community behavioral health infrastructure.

Ultimately, addressing severe conduct-related behavioral health needs requires communities to move

from fragmented crisis response toward coordinated systems of prevention, treatment, stabilization, and reintegration. Expanding treatment capacity, strengthening interdisciplinary workforce preparation, improving early identification, and developing connected community-based services are not separate solutions but interconnected components of a sustainable continuum of care. For youth with severe behavioral needs, the measure of a community's behavioral health system should not be whether it can contain a crisis, but whether it can provide a pathway back to safety, connection, treatment, and belonging.

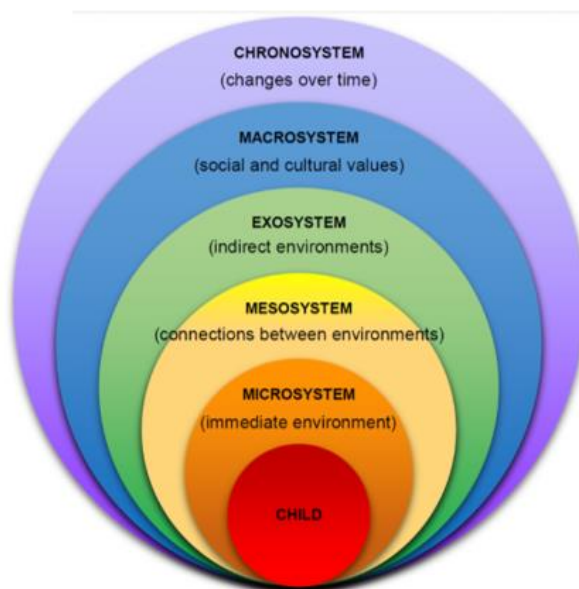
LIST OF ABBREVIATIONS

Abbreviation	Full Form
ACA	American Counseling Association
ACF	Administration for Children and Families
ACL	Administration for Community Living
ADEI	Anti-Racism, Diversity, Equity, and Inclusion
APA	American Psychiatric Association
ASFA	Adoption and Safe Families Act of 1997
CACREP	Council for Accreditation of Counseling and Related Educational Programs
CD	Conduct Disorder
CDC	Centers for Disease Control and Prevention
CMS	Centers for Medicare & Medicaid Services
CSWE	Council on Social Work Education
DJJ	Department of Juvenile Justice (South Carolina)
DSO	Deinstitutionalization of Status Offenders
DSS	Department of Social Services (South Carolina)
EPAS	Educational Policy and Accreditation Standards (CSWE)
FFPSA	Family First Prevention Services Act of 2018
HHS	United States Department of Health and Human Services
HRSA	Health Resources and Services Administration
ICWA	Indian Child Welfare Act of 1978
IMD	Institution for Mental Diseases (Medicaid Exclusion)
JJDPA	Juvenile Justice and Delinquency Prevention Act
LME/MCO	Local Management Entity / Managed Care Organization (North Carolina)
MRSS	Mobile Response and Stabilization Services
MST	Multisystemic Therapy
NASW	National Association of Social Workers
NC DHHS	North Carolina Department of Health and Human Services
ODD	Oppositional Defiant Disorder
OJJDP	Office of Juvenile Justice and Delinquency Prevention
QRTP	Qualified Residential Treatment Program
RTF	Residential Treatment Facility
SAMHSA	Substance Abuse and Mental Health Services Administration
TPR	Termination of Parental Rights

APPENDIX A

Urie Bronfenbrenner's Ecological Theory

This theory is also known as the Human Ecology Theory. Ecological Theory showcases how human development is affected by varying types of environmental systems. Originally created by Urie Bronfenbrenner (1917 - 2005), this theory helps to explain why individuals act differently in varying social situations. The theory explains that there are multiple systems at play including the microsystem, the mesosystem, the exosystem, the macrosystem, and the chronosystem, which is essential when working with youth diagnosed with ODD and CD (Budzyrna & Buckley, 2023).



Appendix B

MST Nine Treatment Principles

Principle 1: Finding the Fit

An assessment is made to understand the “fit” between identified problems and how they play out and make sense in the entire context of the family's environment. Assessing the “fit” of youth and parent successes also helps guide the treatment process.

Principle 2: Focusing on Positives and Strengths

Multisystemic therapy therapists emphasize the positives they find and use strengths as levers for positive change. Focusing on family strengths has numerous advantages, such as building on strategies the family already use, instilling hope, identifying protective factors, decreasing frustration, and enhancing caregivers' confidence.

Principle 3: Increasing Responsibility

Interventions are designed to promote responsible behavior and decrease irresponsible actions by all family members.

Principle 4: Present-Focused, Action-Oriented, and Well-Defined

Interventions deal with what's happening now in the family's life. Therapists look for action that can be taken immediately, targeting specific and well-defined problems. Family members are expected to work actively toward goals by focusing on present-oriented solutions, rather than gaining insight or focusing on the past. When the clear goals are met, the treatment can end.

Principle 5: Targeting Sequences

Interventions target sequences of behavior within and between the various interacting systems—family, peers, teachers, home, school, and community—that sustain the identified problems.

Principle 6: Developmentally Appropriate

Interventions are set up to be appropriate to the youth's age and fit his or her developmental needs.

Principle 7: Continuous Effort

Interventions require daily or weekly effort by family members so that the youth and family have frequent opportunities to demonstrate their commitment and practice skills. Advantages of intensive regular efforts to change include more rapid problem resolution, earlier identification of when interventions need fine-tuning, continuous evaluation of outcomes, more frequent corrective interventions, and more opportunities for family members to experience success.

Principle 8: Evaluation and Accountability

Intervention effectiveness is evaluated continuously from multiple perspectives, with MST team members being held accountable for overcoming barriers to successful outcomes. MST does not label families as “resistant, not ready for change or unmotivated.” This approach avoids blaming the family and places the responsibility for positive treatment outcomes on the MST team.

Principle 9: Generalization

Interventions are designed to invest the caregivers with the ability to address the family's needs after the intervention is over. The caregiver is viewed as the key to long-term success. Family members drive the change process in collaboration with the MST therapist. (Henggeler & Schaeffer, 2016)

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