# BEST PRACTICES IN THERAPEUTIC FOSTER CARE
## REVIEW OF NATIONAL LITERATURE AND LOCAL PRACTICES IN THE STATE OF KANSAS

October, 2003

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# Best Practices in Therapeutic Foster Care

## *Executive Summary*

**NATIONAL LITERATURE REVIEW**

Since the 1970s, Therapeutic Foster Care (TFC), also known as "treatment foster care," "family-based treatment," or "specialized foster care," has emerged as an alternative form of care for children and youth with serious emotional and behavioral disorders (SED). Although programs and empirical studies vary widely, there is some evidence that TFC can be an effective form of out of home care, and can serve as a less costly, family-based alternative to residential group treatment for children and youth with SED. Though TFC was initially thought of as a short-term, transitional placement, it appears that TFC today is usually a longer-term placement for many children and youth who frequently remain in TFC for more than one year.

TFC programs vary considerably in their individual intervention approaches (including behavior management, social learning, eco-systems, problem-solving, and psychodynamic). Some studies suggest that the main benefit of TFC placements over residential group care may be the higher level of adult supervision and higher levels of positive peer interactions. TFC programs typically share seven main features: (1) Care is provided within a family setting, (2) the program targets children with special needs otherwise placed in more restrictive settings, (3) the program is committed to individualized and community-based treatment, (4) foster care providers are especially trained and members of the treatment team, (5) providers usually care for no more than one or two TFC children and receive ongoing support and training, (6) caseworkers' caseloads are limited to 10-15 children, and (7) TFC families are reimbursed at higher rates than general foster care.

The Foster Family-based Treatment Association (FFTA), an organization of more than 300 TFC agencies in the US and Canada, has put forth standards for TFC programs. Though research has not yet been able to establish clear empirical support linking standards and positive outcomes, FFTA standards are currently used to guide TFC programs in 20 states, including Kansas. FFTA standards, and the programs reviewed require 20-30 hours of pre-service training for TFC families, and annual training of at least 24 hours. TFC families are thought of as essential and professional members of the treatment team. TFC parents serve as advocates for the child in the community, receive 24/7 crisis support, ongoing supervision (at least once a week, usually more often), respite care, partake in support groups. Contact and continued involvement with biological families is an espoused value of TFC programs but inconsistently implemented.

Existing TFC programs target a great variety of populations including children referred from child welfare agencies, those leaving psychiatric hospitals, youth with aggressive behavior disorders, including chronic and violent juvenile offenders, pre-school age children identified for early intervention, as well as children and youth with developmental and medical disabilities. The majority of children served in studies were male, Caucasian adolescents. Research has only begun to address the psychosocial and demographic characteristics of TFC populations but findings indicate that TFC children

appear similar to residential group care populations. Findings of gender differences call for more attention and modifications of current TFC programs and training to better meet the needs of girls. Girls in TFC tend to have significantly more histories of trauma (especially sexual abuse), higher rates of attempted suicide and run away behaviors. Girls' TFC placements also disrupt more often which may be related to differences in girls' relational patterns with TFC parents.

While outcome studies indicate largely positive effects of TFC on the restrictiveness and stability of placements, placement disruption and the need for re-placing children is still a common occurrence in TFC. Disruption rates range from 38% up to 70%, with most disruptions occurring within the first six months.

Characteristics of best current practices in TFC suggest that a promising TFC program
  (1)    defines and follows standards of care such as those provided by the FFTA;
  (2)    consistently implements and monitors a specific and defined model for TFC that includes behavioral management, social learning, an eco-systemic approach and/or a strengths approach that minimizes restrictive parenting techniques;
  (3)    places no more than one or two TFC children to a family;
  (4)    assigns no more than 12 cases to a caseworker;
  (5)    provides caseworkers with 24/7 back-up supports;
  (6)    recruits foster parents through a variety of sources, including the pool of general foster care providers, word-of-mouth, and creative advertisements;
  (7)    recruits foster parents who bring high levels of commitment, flexibility, and financial and emotional stability;
  (8)    enhances the "fit" between foster families and foster children by attending to and matching needs, strengths, cultural, religious and other preferences;
  (9)    provides a maximum of honest information about the child's strengths and needs to the TFC family prior to placement;
  (10)  provides foster parents with at least 20 hours of pre-service training and at least 24 annual hours of ongoing training. At its best, training is individualized to the specific needs and strengths of the foster family;
  (11)  provides supports for foster families including 24/7 crisis intervention, respite care, close (at least weekly) in-home supervision, parent support groups, and assistance in helping foster parents address their own needs and those of their own biological children;
  (12)  considers and treats foster parents as full professional members of the treatment team;
  (13)  trains and supports foster parents to negotiate other systems in the community (schools, MH systems, clubs, etc.) and serve as advocates for the child;
  (14)  emphasizes the role of and frequently involves biological families in the TFC process
  (15)   provides assistance for foster families to consistently engage with biological families;
  (16)  provides for aftercare for TFC families and biological families;
  (17)  allows for career opportunities for TFC parents within the program;
  (18)  provides resources for independent and transitional living for older TFC youth

(19) consistently gathers and reviews data on children, TFC families, biological families, and the various components of the TFC process and outcomes.

(20) frequently seeks the input of TFC families, biological families, children and professionals.

In an attempt to identify local practices of Therapeutic Foster Care in the state of Kansas, a number of key informants from all five service regions were contacted. The picture of TFC provided in the state of Kansas in many ways resembles the one that emerged in the national literature review:

Although guided by FFTA standards, TFC services in Kansas are provided with high levels of variation. No one intervention model could be identified as predominant, little is known about the demographic and psycho-social characteristics of target populations, and even less information is available about provider families. Recruitment and retention of provider families is usually considered a problem as is the frequent disruption of placements.

The "match" between national best practices, uncovered in the national literature review, and the situation in Kansas, is not a perfect one; yet, Kansas' situation does have some positive strengths. Chief among these is that standards for therapeutic foster care in Kansas are based on those of the national Family Foster-based Treatment Association (FFTA). All therapeutic foster parents receive training in Model Approach to Partnership Parenting (MAPP) and 40 hours of ongoing training per year. Support services include case management and 24-hour on-call crisis services.

Based on the national best practices review, consideration should be given to the following potential areas of improvement in the Kansas system:

1. Ensure that children who need therapeutic foster care receive it within their region. There is wide variation in the number of children served by therapeutic foster care across the 5 regional contracts, ranging from 1 to 30, and not all are placed within their region.
2. Improve consistency and continuity of service statewide. Although all programs are based on FFTA standards, there is no uniform model of therapeutic foster care. Several national models exist, and the State should consider adopting one model for all of the State.
3. Improve training for therapeutic foster parents. Include new or additional content on understanding SED children, crisis management, working with biological families, understanding/navigating the system, and the strengths perspective. Offer in-home training that allows individualized and hands-on learning.
4. Improve gender-specific programming. National studies indicate that girls present a very different spectrum of needs and require different programming from boys.
5. Collect better data and adjust the outcome standard. Data on length of stay, reasons for disruptions, and reunifications should be collected separately for children in therapeutic foster care, not aggregated with all foster children. In

light of studies nationwide that report disruption rates from 28-70%, it may unrealistic to expect that 50% of children in therapeutic foster care will be reunified with families in one year. More likely, children will disrupt to other placements, move to a different planned placement, or remain in therapeutic foster care longer than one year.

6. <u>Clarify aftercare responsibilities of subcontractors.</u> When subcontractors provide therapeutic foster care, but contractors retain reunification services, too many layers of responsibility are created between SRS, the contractor, and the subcontractor, resulting in confusion at the child, family, and foster parent levels. Either the subcontractor or the contractor should be responsible for both the provision of therapeutic foster care and reunification/aftercare services.

7. <u>Enhance the role of Community Mental Health Centers in the provision of therapeutic foster care and related services.</u> 1. Explore more fully the system in North Carolina, where CMHCs are the main providers of therapeutic foster care. 2. Enhance the role of CMHCs in training foster parents about the different diagnoses and treatment of SED children, including medications.

8. <u>Initiate a pilot program with SRS' Children, Youth, and Families division to utilize Medicaid funding to pay for CMHC therapeutic "foster" homes as an alternative to foster care for SED children</u>. That is, therapeutic family homes can and should be used as one avenue to prevent state custody of children with serious emotional disorders.

## CONTENTS

# Best Practices in Therapeutic Foster Care

**INTRODUCTION**

Over the past thirty years, Therapeutic Foster Care (TFC) has emerged as a less costly, family-based alternative to residential group treatment for children and youth with serious emotional and behavioral disorders (SED) in child welfare and mental health systems. Initially intended as a short-term transitional placement on the continuum of community-based services, TFC functions as a step-down placement for children and youth leaving more restrictive settings such as juvenile justice centers or psychiatric hospitals, or as a step-up for those deemed too impaired to be served effectively in general foster care (Reddy & Pfeiffer, 1997). While the earliest roots of current TFC programs have been traced to the work of the New York Children's Aid Society of the late 19th century (Galaway, Nutter, & Hudson, 1995), today's version of therapeutic foster care for children with special needs began to evolve in the 1970s in the U.S. and Canada. Influenced by the deinstitutionalization movement, and by an increased emphasis on community-based services provided by the Child and Adolescent Service System Program (CASSP), TFC has grown rapidly since the 1980s (Hudson, Nutter & Galaway, 1994a, 1994b).

Given the increasing popularity of TFC, it behooves policy makers to review the state-of-the-art knowledge about current practices and effectiveness of TFC. This report first summarizes knowledge about best practices in TFC based on a review of national literature and, secondly, reports on current practices in the state of Kansas based on inquiries with local experts. The questions guiding the national literature review are:
  (1) Who are the children served in Therapeutic Foster Care?
  (2) What are the national standards of care?
  (3) What is the empirical evidence about the effectiveness of TFC?
  (4) What are the best documented models of TFC, and what research is available about their effectiveness?
  (5) What are promising practices for recruitment, training, and supporting therapeutic foster parents?
  (6) What are the best practices for involving biological families?
  (7) What are the perspectives of professionals and foster parents?

## NATIONAL LITERATURE REVIEW

The literature search for this review included a search of published articles and books using key words "therapeutic foster care," "treatment foster care," "specialized foster care," "foster family based treatment" in the databases of PsycInfo, Social Work Abstracts, and Social Services Abstracts. The search resulted in 109 potential articles, book chapters, and dissertation abstracts published since 1990. Review of reference lists resulted in an additional set of articles. After an initial review of abstracts, a total of 34 articles and book chapters were selected for this review. Included were (1) articles providing meta-analyses or systematic reviews of studies on TFC (see appendix Table B. for detailed summary of each article), (2) articles about individual studies of existing TFC

programs or models and articles providing program descriptions (see appendix Table C. for detailed summary of each article), and (3) empirical or conceptual articles addressing special factors related to TFC (see appendix Table D. for detailed summary of each article). In addition, relevant internet resources on the topic were included.

### DEFINITION AND KEY COMPONENTS

For the purposes of this report, "therapeutic foster care" will be used as a generic term encompassing other commonly used descriptors such as "treatment foster care," "family-based treatment," or "specialized foster care" (Hudson, Nutter, & Galaway, 1994a, #6, 1994b, #10) [1]. While there are no nationally binding definitions, these programs share a number of characteristics that set them apart from regular foster care and residential group care, respectively (Hudson et al., 1994b, #10; Bates, English, & Kouidou-Giles, 1997, #5):

(1) care is provided within a family setting and in the home of the foster care provider;
(2) the program targets children with specials needs such as SED who would otherwise be placed in more restrictive settings;
(3) the program has a philosophy that emphasizes community linkages, coordinated services, and individualized plans for treatment and education;
(4) providers are specifically selected and trained to care for children and youth with special needs (such as SED, developmental disabilities etc.) and are considered part of the professional treatment team;
(5) providers care for a limited number of foster children at a time (usually one or two) and receive higher levels of ongoing support, consultation, crisis intervention, and supervision from professionals;
(6) caseworkers carry a limited caseload of ten to fifteen children;
(7) and provider families receive higher reimbursement rates than "regular" foster families.

### WHO ARE THE CHILDREN IN THERAPEUTIC FOSTER CARE?

Data from various sources suggest that approximately 11% of all children with serious emotional disorders (SED) in out-of-home care live in TFC homes (James & Meezan, 2002, #1). TFC programs target a variety of special populations including juvenile offenders (Chamberlain & Moore, 1998, #11; Chamberlain & Reid, 1998, #12, 1994, #21), children and youth with SED in child welfare, especially those with aggressive psychiatric behavior disorders (Smith, Stormshak, Chamberlain, & Whaley, 2001, #13; Jivanjee, 1999a, #15, 1999b, #16; Reddy & Pfeiffer, 1997, #4; Meadowcroft, Thomlison, & Chamberlain, 1994; Bryant & Snodgrass, 1992, #23), children and youth leaving psychiatric hospitals (Chamberlain & Reid, 1991, #22), developmental or medical disabilities (Webb, 1988), and pre-school age children referred from child protective services for early intervention (Fisher & Chamberlain, 2000, #17; Fisher, Ellis, & Chamberlain, 1999, #18).

Many empirical studies fail to report even basic demographic information on their sample (Reddy & Pfeiffer, 1997: #4) and even fewer studies have examined the psycho-

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[1] Numbers indicated after references correspond to the number of the more detailed review for the article in the appendix tables A. through C.

social characteristics of TFC children (James & Meezan, 2002, #1). In a voluntary survey of 321 TFC program associated with the Foster-Family Based Treatment Association (FFTA), a voluntary association of more than 300 mostly private, non-profit TFC provider agencies and programs (for more details see FFTA section below), Hudson, Nutter and Galaway (1994a, #6) examined program and client characteristics. The majority of FFTA programs served mostly male (56%), Caucasian (65%), adolescent (66%) clients. The age of children in the samples of empirical TFC studies varies considerably (James & Meezan, 2002, #1) but the majority of samples also consist of adolescents, specifically adolescent boys.

**Gender**

Although boys make up the vast majority of samples in empirical studies, and treatment models often import the gender biases inherent in dominant developmental theories (Chamberlain, 1996, #19; Walter & Peterson, 2002), gender is slowly receiving more attention as a significant factor in TFC. Chamberlain and Reid (1994, #21) analyzed gender differences in risk factors and adjustment of 51 young juvenile offenders who participated in a program under the auspices of the Oregon Social Learning Center (OSLC).  They found that gender differences in this population are present <u>before, during and after</u> treatment. Pretreatment differences show that males tend to be younger at time of first arrest, have more total arrests, and more felony arrests than females. Girls, on the other hand, were placed outside home more often, and had a 49% rate of being sexually abused (<u>over four times</u> the rate of boys). Moreover, girls were more likely to have attempted suicide, and have run away two or more times before entering the program, and are more likely to engage in runaway behavior while in TFC (Fasulo, Cross, Mosley, & Leavey, 2002, #30). While the overall number of arrests after treatment dropped for boys and girls, sexually abused girls continued to show higher numbers of total offenses, especially more status offenses.

Girls also seem to take a different path through the TFC program even though they overall completed the program at the same rate as their male counterparts. While boys' behaviors had improved or at least did not deteriorate by the time they had spent six months in TFC, girls—after comparatively few problems in the first six months after intake--showed increased behavior problems thereafter. This development seems to contribute to the frustration of girls' foster parents, who experience their efforts as failure over time. It is likely to increase the risk for girls to be rejected by foster parents and have the placement disrupt. Data suggested that this risk is further elevated for girls with a history of being sexually abused. The authors suggest that girls may need more time to build trusting relationships than boys, and only then begin showing problem behaviors.

Another OSLC study analyzed the disruption of placements for 90 children and youth with SED referred for TFC from child welfare services and showed similar results (Smith, Stormshak, Chamberlain & Whaley, 2001, #13): During the first six months (in which 70% of all disruption occurred), adolescent girls have by far the highest probability of disruption of placement (55%) followed by older boys (12.7% probability). The authors speculate that girls exhibit different forms of aggression (namely "relational" aggression) that becomes more subtle as they age. Chamberlain (1996; #19)

acknowledges that the OSLC "program has been designed on the basis of research that identified treatment needs of males" and that differences found for girls pose questions as to "the appropriateness of the model for treating adolescent females" (p. 76).

## Ethnicity

No study specifically examined ethnicity as a factor in the effectiveness of TFC (James & Meezan, 2002, #1). In fact, it appears that current TFC models are, by default, designed to target white children. The majority of samples in TFC studies is dominated by Caucasian children and youth although children of color tend to be overrepresented in the SED population overall, and make up the majority of children in general foster care (James & Meezan, 2002, #1). Placement matching standards put forth by the Foster-Family Based Treatment Association (see also section below) call for culturally sensitive procedures, yet the absence of research or even conceptual articles on cultural dimensions of therapeutic foster children, their families, and providers points to the relatively low priority granted to the issue. Many empirical studies lack descriptive information about the ethnicity of children, families, or providers. In the face of difficulties recruiting and retaining therapeutic foster parents (Farmer, Burns, Dubs & Thompson, 2002, #8), attention to ethnicity and culture may appear as luxuries in the everyday practice of TFC.

## Psychosocial Characteristics

Children and youth in TFC primarily exhibit disruptive behavior problems and diagnoses such as ADHD and conduct disorders. Many children (especially girls) arrive with significant histories of trauma including neglect, physical and sexual abuse. Some evidence suggests that TFC children resemble those in residential care more than their counterparts in general foster care populations, in that they have histories of complex and unstable multiple placements, and significant impairments in the education domain (James & Meezan, 2002, #1; Hudson et al., 1994b, #10). Berrick, Courtney and Barth (1993) compared behavioral, health, and educational characteristics of children in group home care with those in specialized foster care (SFC), using a sample of 196 licensed group care agencies, 48 SFC agencies, and 123 SFC homes in California. Children in both types of care exhibited problematic behaviors including acting out, aggression, sexual promiscuity, and substance abuse. However, the children in this SFC sample seemed to be less seriously disturbed, but rather have more medical problems. Reunification prospects for the both groups of children were poor.

To date, the relationship of children's age and psycho-social characteristics to program effectiveness remains unclear. While Hudson et al. (1994b, #10) found that TFC was more successful with younger children (below age 12), Chamberlain et al. (1994, #21, 1998, #11, #12, 2003) demonstrated that TFC can be a successful option for adolescents with SED. While hostile, negative, and passive aggressive behaviors have been correlated with less successful outcomes, initial differences in children's clinical difficulties have not yet been linked to service outcomes (James & Meezan, 2002, #1).

Currently under way is the ***"Odyssey Project,"*** the first national, descriptive, longitudinal study to examine the psychosocial characteristics and outcomes of children in out-of-home care with a particular focus on community factors that contribute to outcomes (Guterman, online). Under the auspices of the Child Welfare League of

America (CWLA), the "Odyssey Project" examines the characteristics of youth and children in the child welfare system who enter residential treatment, group homes, or therapeutic foster care (Curtis, Alexander, & Lunghofer, 2001, #2). Twenty-eight CWLA member agencies are participating in the project. All children are assessed (using the Achenbach Child Behavior Checklist) as they enter into service, reassessed at one-year intervals, and when they end service. They are then followed-up at six months, one year, and two years. No results have been published to date. (CWLA website: http://www.cwla.org/programs/groupcare/).

### WHAT ARE THE NATIONAL STANDARDS OF CARE?

Although there are no binding national standards of care in TFC, the ***Foster-Family Based Treatment Association (FFTA)*** has developed standards for TFC programs and practices that are currently used in 20 states, including the state of Kansas, and two Canadian provinces (Hudson, Nutter, & Galaway, 1994a, #6). The FFTA, is a voluntary association of more than 300 mostly private, non-profit TFC provider agencies and programs, was established in 1988. Three years later, in 1991, the FFTA put forth program standards and guidelines for the provision and administration of TFC (Blase & Schild, 1993).

FFTA Program Standards encompass three main domains: the program, treatment parents, and children, youth and their families (Hudson, Nutter, & Galaway, 1994a, #6; Farmer, Burns, Dubs, & Thomson, 2002, #8). For each domain, the standards specify certain criteria to be met. For instance, program standards call for a written program statement, documentation of services delivered, adequate program evaluations, staff training, supervision, caseloads and qualifications; for treatment parents, standards define qualifications, pre- and in-service training, support, record keeping, etc. and standards for children, youth and their families refer to criteria for preplacement activities, matching, children's rights, treatment, transition and permanency planning, family involvement etc.

In a voluntary survey of 321 TFC program associated with the FFTA, Hudson, Nutter and Galaway (1994a, #6) examined program characteristics. The majority of programs (73%) responding to the survey were private non-profit agencies (in fact it appears that the FFTA largely represents small private TFC agencies to the exclusion of many public agencies providing similar services). On average, programs required 25 hours of preservice training, 23 hours of yearly in-service; and 68% of programs mandated attendance in support groups for TFC parents. Overall, psychiatric and emotional problems prevailed as reasons for placement (for adolescents, contact with the justice system was a more frequent reason). Fifty-four percent of clients were discharged to less restrictive settings. Forty-seven percent of clients were discharged because they achieved set goals (with younger children being more successful than adolescents), 17% left the program due to insufficient progress, 28% of discharges were due to a breakdown of the TFC family-child relationship, and 6% due to administrative reasons.

A study by Farmer, Burns, Dubs and Thompson (2002, #8) assessed the conformity of all 46 TFC agencies associated with North Carolina's Willie M. program with FFTA standards. They found that 17% of programs fell below an average conformity level with FFTA standards while another 21% exceeded the average conformity. Programs widely

varied in their individual compliance. Program standards seemed best met in programs where supervisors oversee no more than five caseworkers, who in turn supervised no more than eight foster parents. Most agencies provided 24/7 support for parents, 87% of supervisors provided similar support for caseworkers, and in 55% of programs caseworkers made contacts with foster parents at least once a week.

The single largest problem in the treatment parent domain revolved around recruiting and retention. Seventy-eight percent of agencies reported having difficulties recruiting and retaining foster parents, often leading to a loosening of standards. Still 71% of agencies required at least 30 hours of pre-service training, 93% required some annual training, but only 21% met the FFTA standard of 24 hours of annual training. All programs attempted to match children with foster families taking into account children's needs and family strengths, as well as their demographics. Seventy-four percent of agencies reported being able to find appropriate matches in at least 75% of their cases. Sixty-two percent of agencies arranged at least one meeting between child and TFC provider before placement but only 31% reported having an overnight stay before placement.

The survey also revealed a lack of transition planning at the time of placement. Despite FFTA standards, 45% of programs did no planning in regards to respite care, discharge or after care, at the time of placement, and 17% only established a rough timeline. While initial treatment plans were written within the required 30 days, only 23% of programs were in full compliance with the required quarterly update and review of plans. Overall, the quality of parent training, supervision, or meeting child domain standards seemed unrelated to administrative structures with the exception that larger agencies had a better overall compliance rate and for-profit programs had a lower conformity level.

In a secondary analysis of survey data, Galaway, Nutter and Hudson (1995, #9) found no clear correlations between program characteristics and discharge outcomes that would clearly support the importance of FFTA standards. In a study of 210 TFC programs in the U.S. and Canada (reporting on a total of 1,521 former clients), the authors explored how factors such as program size, costs, caseloads, number of foster children per home, amount of payment, foster parent training, support, and treatment approach relate to the outcomes of planned versus unplanned discharge, and post-discharge living arrangements. Only programs on the extreme ends of the program spectrum showed meaningful differences in regards to planned discharges. That is, high-cost/low caseload programs had more planned discharges than low-cost/ high caseload programs. There were no differences in post-discharge living arrangements. Sixty-three percent of youth went to less restrictive placements, and 32% to more restrictive settings. Further research will be needed to empirically support the role of standards to secure positive outcomes for TFC programs.

**WHAT IS THE EMPIRICAL EVIDENCE ABOUT THE EFFECTIVENESS OF TFC?**

Although not uniequivocally established, there is some evidence that TFC can be an effective form of care for children and youth with SED. Reddy and Pfeiffer (1997; #4) conducted a meta-analysis of 40 outcome studies on TFC and concluded that, by and large, children completed TFC as planned and responded favorably. In order to pool results across studies, the authors used the rather crude measure of "positive," "negative," or "indifferent" outcomes for the areas of placement permanency, behavior problems, restrictiveness of placement at discharge, social skills and psychological adjustment. The largest positive effect was noted for placement permanency and social skills, and medium size positive effects on the reduction of behavior problems, a decreased level of restrictiveness in placement, and increased psychological adjustment. However, these results are neither uniformly positive nor particularly strong. Like other reviewers (James & Meezan, 2002, #1; Curtis, Alexander & Lunghofer, 2001, #2; Bates, English, Kouidou-Giles, 1997, #5; Hudson, Nutter, & Galaway, 1994A, #6), Reddy and Pfeiffer found their analysis hampered by the lack of methodological rigor in studies (such as small non-randomized samples, lack of control or comparison groups), a lack of longitudinal follow up data, and too little information about providers and interventions. To date, the strongest empirical support for TFC comes from more recent studies that have used randomized samples and generally support claims to the relative cost effectiveness and outcome effectiveness of TFC vis à vis residential group homes (James & Meezan, 2002, #1; Chamberlain & Moore, 1998, #11; Chamberlain, 2003).

James and Meezan (2002, #1) conclude in their thorough critique of current evaluations of TFC: "(a) TFC is delivered with such variability that conclusions about its effectiveness are difficult to draw; (b) many variables in the child's ecology that potentially confound the effects of the intervention remain unexamined; and (c) service impacts have been defined narrowly" (p. 233). The most commonly measured outcomes in TFC revolve around improvement of children's behavioral functioning. The next frequent measures are indicators of program success, such as planned discharge status, placement stability, and restrictiveness of living arrangement following TFC (James & Meezan, 2002). As James and Meezan (2002) point out, positive changes in placement status or other program related measures should not automatically be taken to mean improved outcomes for clients.

Chamberlain and Moore (1998, #11) provide the strongest empirical evidence to date for the claim that TFC programs can be a successful, less-costly alternative to residential group placements. A five-year study of randomly assigned violent juvenile offenders found that the TFC model of the Oregon Social Learning Center (OSLC, for more details of model see below) was more effective than group home treatment.

**Intervention Components**

The high variability with which TFC is delivered makes it difficult to measure its effectiveness (James & Meezan, 2002, #1). Because of the "program package" approach used by all TFC models, which all combine various interventions ranging from behavioral management and problem solving to educational services and support groups for children and adults, it is impossible to isolate which specific interventions are

particularly useful. Generally, interventions can be conceptualized as being composed of four interrelated parts: intervention types (what is being provided?), providers (who provides interventions?), the process (how is the intervention provided?), and treatment integrity (how consistently is it provided?) (James & Meezan, 2002, #1).

*Intervention Types*. While no one treatment approach has proven more successful than another, and no uniform theoretical concept is underlying TFC, the most common approaches to interventions in TFC are behavioral management techniques, social learning, problem-solving and eco-systems approaches, as well as psychodynamic theories (Hudson, Nutter, & Galaway, 1994a, #6) and various combinations of these approaches. Types of services frequently include special education, independent living skills, intensive case management, crisis intervention, as well as group and individual counseling and therapeutic services for children, foster families, and biological families.

Very little information, and no specific study is available about the *characteristics of TFC providers* and how they might impact treatment effectiveness. All TFC programs provide ongoing *support services* for TFC provider families including individualized weekly or biweekly consultations, phone contacts, respite, support groups for parents, crisis interventions, supervision, and annual in-services.

Because all TFC programs use a combination of intervention components, unpacking the *process* of TFC is difficult. Process variables that may very well impact outcomes include the quality of relationships and attachment to caregivers, the role of supervision and support, therapeutic alliances (Fasulo et al., 2002, #30), and influences from peers (Chamberlain, 1996, #19) or other ecological factors (James & Meezan, 2002, #1).

Finally, the degree of *consistency* with which interventions are implemented is often difficult to discern. A study of program adherence to the TFC standards provided by the Foster Family-based Treatment Association (see also section on organizations below) show only a moderate level of consistency (Farmer, Burns, Dubbs, & Thompson, 2002, #8) and have not yet established a clear picture for the effectiveness of FFTA standards.

**Placement Stability/ Disruption**

Data on the rates of placement disruptions in TFC is relatively sparse and far ranging. Anywhere between 38% and 70% of TFC placements disrupt (Stormshak, Chamberlain, & Whalen, 2001, #13). A study of 90 children and youth with SED referred for TFC from child welfare specifically examined variables related to the disruption of TFC placements (Smith, Stormshak, Chamberlain, & Whalen, 2001, #13). During the first year of placement a total of 25.5% of TFC placements disrupted. Most of the disruptions (70%) occurred during the first six months. Findings indicate that being older or female correlates with higher rates of disrupted placements (even when the rate of prior placements disruptions in the child's life is controlled for). Reasons for placement disruptions frequently include uncontrollable behaviors of the child, and relational difficulties between TFC parents and the child. The relative "fit" between TFC parent and child appears to be more predictive for outcomes than characteristics of the child or TFC provider alone (Smith et al. 2001).

One common form of placement disruption is ***runaway behavior***. A study of 147 adolescents in child welfare TFC examined characteristics and predictors of youth who either ran temporarily (two weeks or less) or permanently from their placements (Fasulo, Cross, Mosley, & Leavey, 2002, #30). Forty-four percent of the youth in the sample ran away at least once, 22% ran away permanently, making running away the most frequent outcome in this sample (compared to 19% reunifications, 18% leaving for more restrictive settings, 12% returning to general foster care, 12% moving into permanent settings like adoption or independent living, and 7% to other less restrictive settings). Two thirds of those who ran away began the behavior within the first six months of their placement. It appears that weather conditions may play a role in the timing of first runs as most of them occurred during spring and summer months. Thirty-two percent of youth who ran away temporarily eventually also ran away permanently.  Thus, running away at least once was significantly related to permanent disappearance from the TFC home.

A more significant predictor for run away behavior, however, was gender. Girls were three times as likely as boys to run away. The age group of 14 to 16 year-olds made up the majority of runaways (61.9%), with 16-year-olds having the highest rate of permanent runaways. A higher amount of therapy was negatively correlated and seemed to lessen the likelihood of runaway behavior. For a subsample of 23 youth who ran away for good researchers examined where youth most often ran away to. Findings indicate youth most often ran back to their biological families (44%), to a peer friend (39%), or to a friend of family member in the home community (17%). The factors of ethnicity and history of sexual abuse did not seem to hold predictive value for runaway behavior in this sample.

A study about the stability of placements in a sample of 244 children in a long-term TFC program (Staff & Fein, 1995, #14) examined the number of different placements arranged for these children over a period of five years. The authors found that a high number of placement arrangements had to be made. While about 75% of all the children who completed the program within the five year study period remained in their original placement and did not need to be re-placed or were re-placed only once, the other 25% needed several re-placements.  The authors conclude that TFC agencies, even when strongly committed to placement stability, should ***be well prepared to deal with a high number of placements and re-placement activities***. They recommend that training and support for TFC parents, workers and children should pay appropriate attention to the stress of re-placements. Given that the program was specifically designed for children whose adoption or reunification was deemed unlikely, the authors were surprised to find a relatively high number of children being re-unified with biological parents (17%) or adopted (35%). Subsequently, they recommend that TFC programs best pay attention to the ***ongoing need for aftercare for biological and adoptive families***. Similarly, with 28% of their children aging out of the program, they stress the ***need for TFC to offer resources for independent and transitional living.***

### WHAT ARE THE BEST DOCUMENTED MODELS OF TFC, AND WHAT DOES THE RESEARCH SAY ABOUT THEIR EFFECTIVENESS?

The ***Oregon Social Learning Center*** (OSLC) provides the best researched model to date. Established in the mid 1970s and funded by the National Institute of Mental

Health (NIMH), the OSLC initially set out to compare a parent training approach to family therapy with a "treatment as usual" approach for juvenile offenders (Chamberlain, 1996, #19). By 1983, the OSLC had developed and implemented a multidimensional TFC approach to serve juvenile offenders in the community in a way that minimized negative interactions with other struggling peers. In the following years, the OSLC adapted its model for children and youth with SED referred from hospitals or child welfare agencies, and for early intervention to preschoolers (Chamberlain, 2003; Chamberlain, Fisher & Moore, 2002; Smith, Stormshak, Chamberlain & Whaley, 2001, #13; Fisher & Chamberlain, 2000, #17; Fisher, Ellis, & Chamberlain, 1999, #18; Chamberlain & Moore, 1998, #11; Chamberlain & Reid, 1998, #12; Chamberlain, 1996, #19; Moore & Chamberlain, 1994, #20; Chamberlain & Reid, 1994, #21, Chamberlain & Reid, 1991, #22).

The OSCL model is based on the social learning parent-training model which requires foster parents to engage in daily predetermined activities specified in a plan analogous to an Individualized Education Plan (IEP). The plan specifies the individual child's needs in family living, social, academic, recreational and vocational areas. Interventions include individualized behavior management and modification approaches, and include a point and level system. The program includes seven basic components (Moore & Chamberlain, 1994, #20):

(1) *Foster Parent Recruitment and Screening*: A diverse set of people, including two-parent, and male or female single-parent families from different socio-economic backgrounds have successfully served as foster parents. The OSLC looks for providers who bring stability as well as skills to work "actively, consistently and cooperatively toward specific behavioral goals for the child" (Moore & Chamberlain, 1994, p. 23). Potential foster parents are recruited through newspaper advertisements, and word of mouth by other foster parents who receive a $100 Dollars finders fee for referring families who will eventually be trained.

(2) *Pre-service Training:* Foster parents complete 20 to 30 hours of pre-service training which introduces them to principles of social learning, reinforcement techniques, preventive teaching, clear and consistent limit setting, and the use of the daily chart system. Further topics include specific issues such as attachment, separation, sexual abuse, problem solving etc. Training also addresses the development of a professional way of working with biological families and other community resources.

(3) *Home Consultation:* Ongoing consultation with foster parents is considered the cornerstone of this model. Case consultants, trained in developmental psychopathology and social learning models, provide 24 hour crisis intervention, weekly consultations in groups for families, and informal daily consultation via the telephone. Daily phone contacts are also used to collect data on child symptoms and problems for the previous 24 hour period through the Parent Daily Report (PDR) checklist.

(4) *School Consultation:* Foster parents and agency staff are in ongoing consultation and coordination with schools. A daily school card provides information about the child's performance, and the point charts at home include sections for homework completion. Foster parents are encouraged to serve as advocates for the child and for his/her placement in the least restrictive environment. Agency staff, trained in

special education and school interventions, assists the effort through observations, and interventions at the school.

*(5) Individual Therapy:* Each child is assigned an individual therapist who is part of the OSCL program. The therapist meets with the child weekly and is available to the child a 24 hour basis. Because the therapist is intended to serve as an advocate for the child, the roles of case consultant and therapist are performed by different individuals.

*(6) Family Therapy* is provided for all children most of whom are expected to return to their biological families. The family therapist will attempt to teach the family the same point-and-level system the child uses while in TFC, assist with home visits, transitional crises, problem solving, communication etc. Home visits are regularly scheduled, beginning with brief visits and increasing over time toward overnight, weekend, and more extended visits.

*(7) Aftercare Support and Services* that have proven useful approximate a wraparound approach and include 24 hour crisis intervention, group and/or individual consultation and support, consultations and interventions with schools, individual and family therapy, backup consequences (such as time out at the center), money for transportation, and incentives for children and their families.

A five-year study of randomly assigned, violent juvenile offenders found that the OSCL model was more effective than group home treatment. Youth in TFC had significantly lower post-treatment arrest rates, spent fewer days in lock up settings, and a higher number of days living with parents or other relatives (Chamberlain & Moore, 1998, #11). The authors hypothesize that four factors account for the main differences between groups:

(1) the closeness of adult supervision
(2) high contact with caregivers
(3) highly consistent discipline
(4) and least possible association with other delinquent peers

Group home care seemed to provide relatively less adult supervision and a much higher rate of negative peer association (even when excluding the delinquent peers in the group home). These results clearly favor the structure of TFC but leave the question if the same results could be achieved in other settings if the same four factors are sufficiently supported. The study is also limited by the relatively small sample size (n=79) and the all male, mostly Caucasian make up of participants.

The OSLC model in the above study also achieved higher program completion rates (73%) than the group home control group (36%). Compared with other rates of TFC placement disruption, such as the FFTA survey (Hudson, Nutter & Galaway, 1994a, #6) which indicated a program completion rate of 47%, the various studies of the OSLC model indicate a relatively better rate of placement stability with less than 30% of placements disrupting during the first 12 months.

One study focused specifically on the effects of the OSCL approach on children and adolescents with SED who leave the state mental hospital in Oregon (Chamberlain & Reid, 1991, #22). The study randomly assigned children to an experimental TFC

intervention or to a control group offering the usual procedures for community placements (such as placements in residential, group home, or family settings) for twenty children deemed "ready to leave the hospital". TFC parents were recruited and trained according to the OSLC learning approach, received a case manager, individual therapist, family treatment, ongoing supervision and support for TFC parents. Outcome measures included levels of emotional disturbance, social competency, self-reported symptoms, reported behavior problems, and institutionalization rates. While all TFC children were placed in families, only four children in the control group were placed in family settings, and three even remained in the hospital. A significant difference was noted in the time that elapsed between referral to the study and placement in the community. While children referred to TFC were placed after 81 days, children in the control group spent 182 days in the hospital. Even if one excludes those three control group children who remained in the hospital, the average time spent after referral was still 103 days for the control group.

All children showed significant clinical impairments on ED baseline measure. Reported behavior problems dropped more rapidly in the TFC group during the first 3 months. Seven months after the baseline measure, the rates of the control group had also dropped though not to the level of TFC. However, the differences between groups did not reach statistical significance. Neither group showed significant improvements on social competency measures. No significant difference was found in regards to the days children spent in the community in the year following placement. TFC children spent an average 288 days (three were rehospitalized) and control group children 261 days (two were rehospitalized). The study is limited by the small number of subjects, and a lack of longer-term follow up past one year after placement. Still, the authors conclude that the results support the idea that TFC is a viable alternative to residential treatment for children and youth leaving the state hospital. The study indicates that children and youth with significant ED can be treated in TFC after leaving hospital and fare no worse than in those in residential treatment or other more restrictive community settings.

### *Willie M. Program, North Carolina*

Unlike the programs by the Oregon Social Learning Center, TFC programs associated with North Carolina's Willie M. program are not uniformly structured or administered. The Willie M. program resulted from a law suit against the state of North Carolina in 1979 to provide appropriate and least restrictive services for youth with psychiatric disorders and severe behavior problems. The program provides state-level funding for all youth who were determined eligible until they reach age 18, and, of special note, services *are provided by local area mental health centers*. No specific intervention model has been outlined for Willie M. TFC programs. However, all 46 Willie M. associated TFC programs are expected to adhere to the FFTA standards. They share common features such as focus on youth with special needs, the combination of intervention techniques from more restrictive settings along with an emphasis on the child's daily interactions with TFC parents, and standards for recruitment, training and support of foster parents. Still, a study by Farmer, Burns, Dubbs and Thompson (2002, #8) shows a wide variability between individual programs. The Willie M. TFC programs are not "model" programs but rather existing programs that operate in their "usual practice."

A recent study of long-term placement trajectories of 184 youth with severe psychiatric and aggressive disorders in Willie M. programs compared the placement of young people twelve months prior and twelve months after being placed in TFC (Farmer, Wagner, Burns, & Richards, 2003, #7). Outcomes were mixed at best. Most youth entered into TFC from more restrictive settings such as group homes (46%), or institutions such as hospitals, jails, or residential treatment centers (19%). About one third of youth (n=66) left within twelve months after being placed in TFC. Of those, 47% went to more restrictive settings immediately after TFC, and 45% to less restrictive places, mostly to their homes. Leaving TFC seemed not correlated with measures that approximated success but rather with being older and having more externalizing behavior problems. Not surprisingly then, many of the children who initially returned home had gone on to more restrictive placements by the end of the 12 months post-TFC window. By the end of the 12 months post-placement interval, group home placement rates were similar to pre-TFC baselines. The vast majority (64%) of youth remained in TFC for more than twelve months leading authors to point out that TFC as usually practiced here does <u>not</u> seem to be used or be useful as a short-term transitional placement.

### *People Places, Inc., Virginia*

One of the older existing TFC programs, People Places, Inc. was established in 1973 for children and youth with SED (Bryant & Snodgrass, 1992, #23). The program focuses on establishing continuity between providers, foster families, and biological families attempting to blend home-based and foster care services. To this end, all services are available for both foster <u>and</u> biological parents. Program components are based on social learning theory and include a daily behavioral chart system, parenting skills training, individual therapy, independent living skills groups, aides (akin to attendant care), home based services. Foster parents complete 24 hours of pre-service training, and are required to participate in an equal number of individualized annual training hours. They are in weekly phone contact with program managers, receive weekly or bi-weekly visits, 24/7 crisis response, and monthly parent support groups. In addition, People Places, Inc. provides its own alternative special education school and summer recreation programs for the children. Program managers hold a caseload of twelve children and share on-call duties with their colleagues. However, ***no empirical studies examining the effectiveness of the program were available.***

### *Phoenix Place, Alberta (Canada)*

While there is no empirical evaluation of the Phoenix Place program, its specific design as a transitional "step-down" program for children and youth who leave residential or hospital care offers some valuable ideas (Morrissette, 1992, #25). Using an eco-systems approach, the program emphasizes positive and collaborative involvement of biological families to reduce disruptions of foster placements and reinstitutionalizations. After an initial orientation meeting that introduces an ecosystems and strengths approach to potential TFC providers, the program uses a three-step screening procedure to select foster care providers who will not only foster relations with the child but with his/her biological family as well. Because of its explicit design as a transitional program, Phoenix Place carefully paces and plans the youngster's transition from the residential to

the TFC placement. Such planning includes anticipating apprehension, discussing foster placement ahead of time, and allowing for contacts to the TFC family before the youth leaves the residential home. Foster families, biological families and the child first meet informally, followed by an afternoon for foster parents and youth, coordinated day visits, and finally overnight stays. The slow transition period also allows TFC providers to discuss the youth's specific needs with caseworkers, and help ensure that as many social activities as possible can be continued.  Training modules for TFC families focus on a variety of topics but always include celebrations and acknowledgements of their achievements. The youth's transition to TFC is celebrated in a ritual that involves peers, staff, TFC families, and biological families.

### *Boys' Town, Omaha, Nebraska*

The Boys' Town Model of TFC stresses the importance of creating not only effective harm-free environments but also find ways to promote spiritual, emotional, intellectual, and physical growth (Daly & Dowd, 1992, #26). Boys' Town employs married couples ("family-teachers") with a full time assistant to provide family-style homes for eight or fewer children. TFC parents are considered the primary treatment. Supervisors (available 24/7) are usually former TFC parents who received special training. Boys' Town puts a strong emphasis on training and support for TFC parents, and the active control and discouragement of any use of restrictive responses such as time-out, quiet rooms, because caregivers will gravitate toward the convenience of their short term effectiveness unless such procedures are controlled, and self-monitored by the program. To these ends, Daly and Dowd (1992) recommend seven program components:

(1) *Caregiver support*: to avoid caregiver burnout child-adult ratios are kept low (no more than 4:1, and less for SED children). Caregivers receive training, relief time, responsive supervision, and are involved in all important decisions and planning. The program grants TFC parents professional status along with career opportunities.
(2) *Model of care*: programs need to have a well-defined set of procedures and practices that can be taught, and monitored via data collection
(3) *Focus of positive behaviors*: Boys' Town promotes a positive reinforcement and teaching approach that asks TFC parents to attend to at least four positive behavior of the child for each negative one and to teach children new skills rather than focusing on unwanted behaviors only. In addition, supervisors maintain tight administrative control over potentially aversive practices such as medication, restraint, group consequences, and time-out. The otherwise frequently found "quiet room," for instance, is prohibited by Boys' Town altogether.
(4) *Consumer orientation*: Boys' Town seeks out input from such as children, parents, teachers, coaches, neighbors, friends and employers, and adjusts the program based on feedback. They also emphasize the need to be open to scrutiny from people outside the treatment environment.
(5) *Training*: Boys' Town provides ongoing opportunities for development and training on what to do and what <u>not</u> to do. Parents receive one year pre-service training including a three week workshop, and on-the-job supervision (24 hrs available). Ongoing training that is not just classroom style but provided on-the-job, and modified according to specific needs of agency (i.e. training does not rely solely on outside training providers

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who offer standard packages). Feedback after training is considered as important as the training itself.

(6) ***Program Evaluation:*** The annual evaluation of over 30 outcome and process measures ensures the ongoing definition and maintenance of standards of care. Certification and pay raises for caregivers are contingent upon meeting evaluation criteria. Boys' Town also has an ongoing follow-up program to examine program effects. ***Results regarding the effectiveness of Boys' Town TFC were not reported.***

(7) ***Internal program audits***: In order to help prevent abusive or inappropriate practices Boys' Town has established a self-monitoring system of internal program audits. All complaints (regardless of source) are taken seriously and investigated by person not directly involved in day-to-day administration of program. Each use of restraint is investigated as to its necessity and appropriateness, and each child is annually and confidentially asked about incidences of inappropriate practices by caregivers (so far, the program has had no experiences of large "false positive" claims to inappropriate practices.)

## WHAT ARE PROMISING PRACTICES FOR RECRUITMENT, TRAINING, AND SUPPORT OF THERAPEUTIC FOSTER PARENTS?

Recruitment of TFC parents is a difficult undertaking because potential providers must not only fulfill the qualifications expected for general foster care but must also be prepared to live and work with a population of particularly challenging children and youth (Farmer, Burns, Dubs & Thompson, 2002, #8). TFC parents are typically recruited either from the pool of existing general foster care providers who wish to expand their parenting into a more professional realm, or through word-of-mouth. Other recruitment strategies include advertising and finder fees (Moore & Chamberlain, 1994, #20).

More so than regular foster parents, TFC parents are expected--and should be afforded the opportunity--to function as professional treatment providers who will fully participate in planning and consistent implementation of plans (Daly & Dowd, 1992, #26). In addition they are expected and encouraged to serve as advocates for the child and interface with biological families, schools, and other providers in the community. To these ends, TFC programs typically require 20 to 30 hours of pre-service training, and ongoing annual training of at least 24 hours as well as participation in support groups or consultations.

The Boys' Town model (Daly & Dowd, 1992, #26) emphasizes creating environments in which intensive training and support will also discourage the use of restrictive responses to difficult behaviors (including time outs, the use of quiet rooms etc.). The authors argue that unless the use of such procedures is continuously monitored and scrutinized, caregivers will gravitate to them because of their short-term effectiveness. In order to promote alternative responses, the Boys' Town model emphasizes on-the-job support and training rather than solely general classroom style training by outside consultants. Training on the job allows trainers to modify ideas and approaches according to the individual case and the agency's philosophy and needs. Schwartz (2002, #31) advocates a similarly individualized and pragmatic model for training and support which builds upon family resilience. Based on empowerment ideas the author suggests training

and support staff should understand themselves as experts on eliciting TFC families existing expertise and employ a six step solution-focused approach to specify goals, exceptions to the problem, and descriptions of solutions.

Typically, TFC programs provide an array of support services to TFC families such as 24 hour crisis support, respite care, weekly supervision, support groups, and therapeutic services. FFTA standards suggest that TFC parents should be selected based on their acceptance of and ability to carry out the program's treatment philosophy, their willingness and ability to accept the intense involvement and supervision by professionals. In addition, the FFTA standards specify such qualities as commitment, sense of humor, flexibility, tolerance and ability to adjust expectations, emotional and financial stability, cultural competence, having a reliable social support system, and ability to work with the child as part of their own family. Foster parents are asked to involve foster children in as many daily decisions as possible, serve as advocates, work with professionals and biological parents, and attend to their own biological children who may have additional needs related to the presence of a foster sibling.

Biological children of foster parents are rarely the subject of attention in the literature. Yet, there are indications that they can be negatively affected by TFC. Redding, Fried and Britner (2000, #3) urge that biological children in foster families require attention before, during, and after foster children live with them. This sentiment is echoed by McFadden (1996, #33) who advocates a family-systems approach when selecting foster families. The author recommends that attention be paid to the potential disruption of family balances and the roles of biological children when foster children are placed. She cautions that biological children's needs must be met as well as the needs for foster parents to spend time as a couple.

The characteristics of therapeutic foster parents have not been subject to specific studies but it appears that emotional stability (especially of foster mothers who frequently are the primary caretakers), as well as a sense of realism along with sensitive and authoritative (not authoritarian) responsiveness are related to successful TFC parenting. Successful TFC parents are often motivated by being childless themselves or having had related childhood experiences (Redding, Fried, & Britner, 2000, #3). In order to enhance a "goodness-of-fit" between TFC families and the child, Dore and Eisner (1993, #34) argue that a child's ability to tolerate intimacy, level of impulsivity, fear of rejection, aggression, and self-esteem, should be assessed for the matching process. The authors did not specify which qualities of TFC parents should be assessed.

### WHAT ARE THE BEST PRACTICES FOR INVOLVEMENT OF BIOLOGICAL FAMILIES?

In their survey, Hudson, Nutter and Galaway (1994b, #10) noted a discrepancy between the self-reported policies of programs regarding the involvement of biological families and actual recorded practices of such involvement. While programs frequently claim to involve families in planning and through visits, there is little evidence that these aspirations actually or sufficiently translate into practice. These findings concur with conclusions in qualitative studies (Wells & D'Angelo, 1994, #28; Jivanjee 1999a, #15, 1999b, #16).

Wells and D'Angelo (1994, #28) note that foster parents report their relationship with biological families as an important theme in the experience of providing TFC. Foster parents appeared to support or reject biological parents (usually the child's mother) based on their impression of how motivated and able the mother appeared in taking care of the child. Jivanjee (1999b, #16) conducted a qualitative study about the involvement of biological families with twelve TFC foster families and twelve professionals in an OSLC program for child welfare referred children. She, too, found that although providers and professionals shared values and attitudes that were generally supportive of family involvement, actual concrete actions toward such involvement were tempered by sympathies or antipathies toward given families, and thus highly varied from case to case. Positive attitudes expressed toward families included empathy, respect for their strengths, and respect when they complied with treatment requirements. Relations with families were enhanced when providers demonstrated honesty, trust, appreciation of strengths, sharing of information, and when they actively facilitated parent-child interactions. In negative cases, dislike or fear of families led to a strain in the relationship, and to the exclusion of biological parents or the minimizing of contacts. How much contact foster families sought with biological families was more related to their foster parents' personal backgrounds than to the training they received. In addition to personal factors, organizational barriers to family involvement included time limits, caseloads, paperwork, the intrusive nature of child protective services, lack of commitment to families and lack of specific training.

Jivanjee (1999a, #15) asked ten biological families about their perspectives on being involved in the TFC process. These families were invited by caseworkers and were at least somewhat involved in the TFC program. The sample thus does not reflect the opinions of parents who remained entirely uninvolved. Still, participants included parents with and without custody, as well as with and without reunification as an identified treatment goal. Children had been referred to TFC by child welfare systems mostly because of child abuse or neglect. In two cases, guardians had requested placement due to an inability to manage the child's behavior. Asked about the level of their *involvement in the initial placement*—a standard required by FFTA—all but two of the ten parents reported they had not at all been involved in the planning of the initial placement. Biological families reported they had mostly positive *relationships with professionals* (a finding that may be skewed due to the sample selection process). They particularly appreciated the sharing of information, being involved in decision making, support and advocacy, and when professionals took time to get to know them and build trust. In negative cases, parents felt disliked and excluded from participation. In their *relationships with foster families* biological parents appreciated providers who were willing to get to know them, discuss goals and strategies for the child, and negotiated decisions with families. An opportunity to observe interactions between the child and foster providers served as a valuable learning experience for biological parents. Some exceptional foster families took on additional teaching and co-parenting approaches, offering support and education for biological parents even beyond the time of placement. Other *barriers* to family involvement included difficulties with transportation, scheduling problems for meetings and locations thereof, and a lack of follow-through.

Redding, Fried and Britner (2000, #3) examined a number of existing studies for factors associated with higher placement stability and higher child and family satisfaction in TFC. They concluded that good relations with the provider family, and a degree of control over the frequency and type of contact children have with their biological family contributes to higher satisfaction. Biological families appeared less satisfied with TFC programs when they feared they were unable to regain custody, did not receive information about the child's progress and felt there were insufficient contacts and visitations with the child. Also, the rapport of foster parents and foster children with caseworkers, and the agency as a whole seem related to stability in placements and satisfaction of families and children.

No empirical studies were found that specifically represented the perspectives of children and youth in TFC.

### WHAT ARE THE PERSPECTIVES OF PROFESSIONALS AND FOSTER FAMILIES?

Two qualitative studies (Wells & D'Angelo, 1994, #28; Jivanjee, 1999b, #16) examined the perspectives and experiences of TFC agency practitioners and foster families. Focus groups of forty foster parents (Wells & D'Angelo, 1994, #28) who provided TFC for children with SED highlight the complex and multifaceted nature of the work. TFC parents described their experiences with children entering into the family, issues arising during their placement, and challenges when the children left the home:

The *level of information and preparation* for a child's placement varied widely between foster parents. Detailed, clear, and complete information about the child was highly valued but rarely available. At times, it appeared to parents that the child's particular difficulties were "sugar coated" by caseworkers to reduce the risk of rejection by foster families. During the course of TFC, the *complexity of foster parents' roles* emerged as a central theme. The dual role of being both a "professional" as well as a "parent" resulted in sometimes contradictory expectations or messages. How much is a foster parent expected to attach to a child? What "boundaries" are appropriate? Foster parents also expressed that they see themselves as the expert on the child rather than an often distant or overwhelmed caseworker. Subsequently, they feel disrespected and undervalued when they are not involved in meetings, or court hearings. Foster parents valued agency staff who provided *information and resources* such as respite or emotional support. Once the honeymoon period was over, foster parents often felt overwhelmed and lonely with the children in their care, a feeling that worsened when foster parents' *biological children* exhibited difficulties adjusting to the foster sibling. The *leaving* of foster children almost always involved the pain of separation and letting go, an emotional impact that was worse when the termination of placement was abrupt or unplanned.

### CONCLUSION

Although empirical evidence for the effectiveness of TFC is not unieqivocally established, available research shows that TFC can be an effective alternative to residential group home treatment for many children and youth with SED. Still, research

points to the need pay further attention to issues of gender, ethnic differences, and psychosocial characteristics of children as well as provider families, whose specific characteristics are frequently not reported in the literature. Recruitment, training and support of TFC parents need to provide a stronger emphasis and accountability for the involvement of biological families. While many children remain in their placements for at least a year, professionals and TFC families should be aware that placement disruption, including running away, is a common occurrence that requires further research to establish how it could be minimized. Ongoing training and supports are essential elements of successful TFC programs.

In summary, characteristics of best current practices in TFC suggest that a promising TFC program

(1)     defines and follows standards of care such as those provided by the FFTA;
(2)     consistently implements and monitors a specific and defined model for TFC that includes behavioral management, social learning, an eco-systemic approach and/or a strengths approach that minimizes restrictive parenting techniques;
(3)     places no more than one or two TFC children to a family;
(4)     assigns no more than 12 cases to a caseworker;
(5)     provides caseworkers with 24/7 back-up supports;
(6)     recruits foster parents through a variety of sources, including the pool of general foster care providers, word-of-mouth, and creative advertisements;
(7)     recruits foster parents who bring high levels of commitment, flexibility, and financial and emotional stability;
(8)     enhances the "fit" between foster families and foster children by attending to and matching needs, strengths, cultural, religious and other preferences;
(9)     provides a maximum of honest information about the child's strengths and needs to the TFC family prior to placement;
(10)    provides foster parents with at least 20 hours of pre-service training and at least 24 annual hours of ongoing training. At its best, training is individualized to the specific needs and strengths of the foster family;
(11)    provides supports for foster families including 24/7 crisis intervention, respite care, close (at least weekly) in-home supervision, parent support groups, and assistance in helping foster parents address their own needs and those of their own biological children;
(12)    considers and treats foster parents as full professional members of the treatment team;
(13)    trains and supports foster parents to negotiate other systems in the community (schools, MH systems, clubs, etc.) and serve as advocates for the child;
(14)    emphasizes the role of and frequently involves biological families in the TFC process
(15)     provides assistance for foster families to consistently engage with biological families;
(16)    provides for aftercare for TFC families and biological families;
(17)    allows for career opportunities for TFC parents within the program;
(18)    provides resources for independent and transitional living for older TFC youth

(19)    consistently gathers and reviews data on children, TFC families, biological families, and the various components of the TFC process and outcomes.

(20)    frequently seeks the input of  TFC families, biological families, children and professionals.

## SURVEY OF KANSAS THERAPEUTIC FOSTER CARE

In an attempt to identify local practices of Therapeutic Foster Care (TFC) in the state of Kansas, a number of key informants from all five service regions were contacted.  The picture of TFC provided in the state of Kansas in many ways resembles the one that emerged in the national literature review.  Although guided by FFTA standards, TFC services in Kansas are provided with high levels of variation. No one intervention model could be identified as predominant, little is known about the demographic and psycho-social characteristics of target populations, and even less information is available about provider families. Recruitment and retention of provider families is usually considered a problem as is the frequent disruption of placements.

### THE CONTEXT: PRIVATIZATION AND CFP CONTRACTORS

When the privatization of the Kansas Child Welfare system was undertaken in 1996, Kansas was divided into five regions, each serving various geographic areas of the state. Each region is served by Children and Family Policy (CFP) Contractors.  CFP Contractors represent "a public/private partnership providing adoption, foster care, and family preservation services through contractual arrangements with the Children and Family Policy Division of SRS which includes an assortment of services including behavior management services" (Standards for Therapeutic Foster Care Family Treatment, May, 2003).  In addition, some CFP contractors further contract service provision out to sub-contractors.

The five regions are served by the following CFP foster care contractors and sub-contractors:

- Region I: The Farm (contractor), Elm Acres (sub-contractor), Family Ties (sub-contractor), and Cowley County Mental Health (sub-contractor).
- Region II:  Kaw Valley is the contractor but does not provide TFC.  Kaw Valley does sub-contract with Associated Youth Services (AYS) to provide TFC in Region II.  AYS also contracts with KCSL, The Farm, United Methodist Youthville (UMY), and JJA.
- Region III: Kansas Children's Service League (KCSL) has this contract but does not provide TFC.  Another Chance, Inc. is a sub-contractor that does provide TFC to Region III.
- Region IV: Saint Francis Academy (SFA) provides TFC in this region.
- Region V: United Methodist Youthville (UMY) is the contractor for this region but does not provide TFC.  UMY does, however, provide  a service called Treatment Foster Care to 26 children in the state.  This nuance will be discussed on page 33. UMY sub-contracts with Salvation Army (SA), who provides TFC.

**CURRENT NUMBER OF CHILDREN IN TFC**

A total of 80 Kansas children are currently in TFC placement through 114 families. The regions breakdown as follows:

- Region I - 30 children, 21 licensed homes;
- Region II –8 children in 10 licensed homes;
- Region III –12 children, 6 licensed homes;
- Region IV – 29 children, 76 licensed homes;
- Region V – 1 child, 1 licensed home.

These numbers are reflective of the contractors and sub-contractors censuses, not where children are actually placed. For example, AYS (Region II) has children placed in Region III, but those children are counted with Region II's census.

**DEFINITIONS/GOALS/ EXPECTED OUTCOMES**

While foster care is defined as any out-of-home placement of a child, therapeutic foster care is a specific modality of care. To be eligible for therapeutic foster care, the service must be deemed medically necessary and the child must have a pre-existing medical diagnosis. TFC placement is utilized as an alternative to a more restrictive placement. A therapeutic foster home is defined by SRS as:

"A foster home licensed by the Kansas Department of Health and Environment, but which is affiliated with a Licensed Child Placing Agency which is qualified to provide behavioral management services. The program of therapeutic foster care is a coherent, integrated constellation of services specifically designed to provide treatment within a foster home setting. The Licensed Child Placing Agency provides leadership and qualified, trained staff to support and direct the therapeutic foster parents in carrying out the treatment plan goals for children placed in the therapeutic foster home.

Therapeutic foster care is family-based. The foster family is viewed as the primary treatment setting, with treatment parents trained and supported to implement the in-home portion of the treatment plan and promote the goals of permanency planning for children in their care. Foster parents are part of the professional team and serve as both care givers and active agents of planned change. Therapeutic foster care is a team function carried out under the clinical direction of qualified program staff." (Standards for Therapeutic Foster Care Family Treatment, May, 2003).

According to the Kansas Standards for Therapeutic Foster Care Family Treatment, the long term goals of the service are:

- Improved emotional, mental and functional status of individuals receiving services;
- Reduction in unplanned placement changes;
- Increased ability to live safely, attend school and be a productive member in an inclusive community environment;
- Increased likelihood of a youth's successful return to family or successful implementation of permanency planning; and
- If developmentally appropriate, increased capacity for independent living.

The same document outlines the expected outcomes of TFC as:

- Seventy-five percent (75%) of youth in this program will not be placed in a psychiatric facility.
- One hundred percent (100%) of youth will receive documented intensive (one face to face contact per week) by the case coordinator and case supervision by licensed child placing agency.
- One hundred percent (100%) of youth will receive on-call 24 hour emergency support from the licensed child placing agency as needed (documented in the foster parent's daily log).
- Fifty percent (50%) will be successfully reintegrated with their families one year after being placed into a Therapeutic Foster Care Program.

## SURVEY QUESTIONS AND RESPONSES

Each region that provides TFC was surveyed. The following organizations were contacted:

- Region I: Elm Acres;
- Region II: Associated Youth Services;
- Region III: Another Chance, Inc.;
- Region IV: Saint Francis Academy;
- Region V: Salvation Army.

Each contact was asked the following questions. See Table A. for responses to each of the questions below.

1. Does your region utilize any certain model of TFC (FFTA, Oregon Social Learning Center, etc.)?
2. How are TFC parents recruited? What is done to facilitate TFC parent retention?
3. What type of and how much pre-service training is provided to the parents?
4. What type of on-going training is provided to the parents? What and how much?
5. What type of support services do the parents receive? How often does the case manager visit? Describe crisis services available to TFC families.
6. In what ways are biological families included?
7. Do you evaluate treatment effectiveness? If so, how?
8. How do you determine level of placement?
9. Do you keep statistics on children who leave your program? For example, do the majority reach their goals and return to their biological family/family of origin? How frequently do children run-away from their TFC home?
10. What type of transition planning do you have? Aftercare?
11. How many TFC families per caseworker?
12. How many caseworkers per supervisor?
13. How is reimbursement determined for TFC families and what is your average reimbursement?

| Question | Reg. I – Elm Acres | Reg. II- Associated Youth Services | Reg. III – Another Chance, Inc. | Reg. IV- Saint Francis Academy | Reg. V- Salvation Army |
|---|---|---|---|---|---|
| 1. Does your region utilize any certain model of TFC ? | Elm Acres created the TFC program based on State and Medicaid regulations (based on FFTA - Family Foster-Based Treatment Association). | AYS utilizes state guideline (Medicaid guidelines that are based on FFTA). | ACI follows FFTA guidelines. Additionally, the program is influenced by Adlerian thought. | SFA adheres to the State Medicaid guidelines that are FFTA based. Additionally, SFA utilizes the BoysTown model and Strengths Perspective. | Salvation Army utilizes FFTA guidelines. |
| 2. How are TFC parents recruited? What is done to facilitate TFC parent retention? | Continuously recruiting foster parents for all levels of family foster care. Didn't include specific measures taken, nor was retention addressed. | No formal recruitment process – "word of mouth from other families". No formal retention policy/measures taken. | ACI struggles with recruitment and there is no formal recruitment and retention program. Recruitment occurs mainly through "word or mouth" and retention is facilitated by adequately supporting TFC families. | Retention is largely facilitated via the provision of support services for TFC families. These services include 2 days of respite care per month and weekly support services. | Recruitment and retention is one of the most difficult issues Salvation Army faces. They don't actively recruit and currently have only one active TFC family. |
| 3. What type of and how much pre-service training is provided to the parents? | TFC parents complete pre-service training, including Model Approach to Partnership Parenting (MAPP). | MAPP is completed as pre-service training. | MAPP is completed as pre-service training. | MAPP is completed as pre-service training. | MAPP is completed as pre-service training. |
| 4. What type of on-going training is provided to the parents? | TFC parents must have 40 hours of on-going training per year. Elm Acres | 40 hours of annual training. Some JJA issues emphasis because AYS | 40 hours of annual continuing education is required. Dreiker's Children to Challenge | Per state regulation, 40 hours of annual training are provided. | 40 hours of continuing education hours annually that are consistent with |

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| | has purchased training from American Foster Care Services, Inc. | contracts with JJA (in addition to Kaw Valley, UMY, KCSL, and The Farm). Trainings are held in KC, Salina, Atchison, and Larned/Pratt. | used as a framework for the continuing education offered to ACI's TFC parents. | | SRS guidelines. SRS guidelines include first aid and crisis management. |
| 5. What type of support services do the parents receive? | Elm Acres provides 24 hour crisis management and each TFC has at least one face-to-face visit weekly. This visit is typically supplemented by telephone contacts. | 2 visits per month from the case manager. 24 hour on-call crisis services. | Case manager makes a weekly visit to each family. 24 hour on-call crisis services. | TFC families are visited at least once per week by a case manager, they have access to 24 hours crisis management services, they are provided support group services twice per month, and they receive support from a Foster Parent Trainer. Foster Parent Trainers are foster parents with at least five years experience who are employed by SFA to make home visits and facilitate support groups. | A case manager visits at least once per week and 24-hour crisis services are available. A foster family support group (including TFC families as well as family foster care providers) is held three times per month. |

| 6. In what ways are biological families included? | Elm Acres involves the birth parents in treatment planning to the extent they are able. As a sub-contracting agency, working with the birth family is not the primary responsibility, working with the foster family is. | Contact with biological families depends on what the contractor is willing to facilitate. Varies from case to case and whether goals is reintegration. | Contact by ACI with biological families is limited because of nature of contractor/sub-contractor relationship. | The extent to which birth families are included is dependent upon individual circumstances and goal of reintegration. | Because Salvation Army is a sub-contractor of United Methodist Youthville (UMY), UMY is responsible for working with the birth family and contact between Salvation Army is extremely limited. |
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| 7. Do you evaluate treatment effectiveness? If so, how? | Elm Acres evaluates treatment effectiveness according to state regulated outcomes and overall number of critical incidents and disruptions. | TFC stats are kept separate from Diversion Foster Care. Keep stats on home visits, manner in which youth left program, school progress, criminal charges | ACI bases its treatment effectiveness on behavioral outcomes (i.e. school performance, acting out). | Rate of disruption and discharge from foster care is tracked, but TFC is not differentiated from all other forms of foster care. | "Disruption is a major problem and kids don't usually stay in one place long enough to look at any sort of treatment effectiveness". |
| 8. How is level of placement determined? | Level of placement is determined by the referring agency (contracting agency). | Level of placement is determined by contracting agency. | Level of placement is determined by contracting agency. | Because they are a contractor, SFA determines level of placement. | Level of placement is determined by contractor in the region of the child's origin. |
| 9. Statistics are kept on children who leave your program? | Information is kept regarding where the child goes after leaving TFC home. | See #7. | ACI no longer keeps statistics on children who leave the program. | See #7. | Some statistics kept, but TFC not sorted from other levels of family foster care. |

| 10. What type of transition planning do you have? Aftercare? | Elm Acres, along with the foster parents, assist with transition planning. As a sub-contracting agency, they do not provide aftercare services. This is the responsibility of the contracting agency. | Transition planning is the responsibility of the contracting agency. | The contracting agency develops the transition and aftercare plan. | SFA develops Transition and aftercare plan and utilizes Family Preservation services to provide aftercare, as well as traditional therapy services and respite care. | Transition planning and aftercare are very difficult because of disruption and the fact that UMY does the aftercare. |
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| 11. How many TFC families per caseworker? | Case managers can have no more than 12 therapeutic youth at one time. | At this time, AYS has only 7 TFC families, but they are in different regions. Thus, five CMs have one family and one CM has two. | ACI only has five active families and all of these are served by one case manager. | SFA usually has 10-12 families per case manager. | Salvation Army currently has only one active TFC family. |
| 12. How many caseworkers per supervisor? | Not Addressed | At this time, the most one supervisor has is five CMs. | At this time, one per supervisor. | Five workers per supervisor. | At this time, only one. |
| 13. How is reimbursement determined for TFC families and what is that? | Elm Acres bills Medicaid directly and/or the primary provider (referring Agency) according to established rates. | All families receive $35 per child/ per day. | ACI's TFC families receive $34.50 per day, per child. | $40 per day/per child. This can increase depending upon the child's needs. | TFC families receive $40 per day/per child. |

*Therapeutic vs. Treatment Foster Care*

As mentioned in the region-by-region breakdown (see pages 20-21), UMY provides treatment foster care to 26 children in Region IV and Region V. Treatment Foster Care providers are held to the same FFTA Standards as Therapeutic Foster Care providers, including parent training, continuing education requirements, minimum contact by case managers, and number of case managers per supervisor. Therapeutic Foster Care regulations require that the child's psychotherapy be provided by the Therapeutic Foster Care provider. Treatment Foster Care is defined by the fact that psychotherapy is facilitated through a provider other than the foster care provider.

*Emergency Therapeutic Foster Care in the Mental Health System*

Two years ago, Pawnee Mental Health Center at Concordia created a Mobile Crisis Program. The goal of this program is to maintain children in their current placements and prevent them from being sent to a more restrictive level of care. Any SED child is eligible and they can be currently utilizing foster care services, but this is not a requirement to access the Mobile Crisis Program. One case manager or one attendant care worker are on-call 24 hours per day to address situations in which a child is in danger of being sent to a higher level of care.

There are two physical sites where children can be taken: one apartment and one home (both in Concordia), both are licensed as emergency group homes. Duration of stay ranges from one day up to thirty days, with the average length of stay being 72 hours. Reimbursement is obtained through ICS, Respite Care, and Attendant Care.

**RECOMMEDATIONS FOR KANSAS**

The "match" between national best practices, uncovered in the national literature review, and the situation in Kansas, is not a perfect one; yet, Kansas' situation does have some positive strengths. Chief among these is that standards for therapeutic foster care in Kansas are based on those of the national Family Foster-based Treatment Association (FFTA). All therapeutic foster parents receive training in Model Approach to Partnership Parenting (MAPP) and 40 hours of ongoing training per year. Support services include case management and 24-hour on-call crisis services.

Based on the national best practices review, consideration should be given to the following potential areas of improvement in the Kansas system:

1. <u>Ensure that children who need therapeutic foster care receive it within their region.</u> There is wide variation in the number of children served by therapeutic foster care across the 5 regional contracts, ranging from 1 to 30, and not all are placed within their region.

2. <u>Improve consistency and continuity of service statewide</u>. Although all programs are based on FFTA standards, there is no uniform model of therapeutic foster care. Several national models exist, and the State should consider adopting one model for all of the State.

3. <u>Improve training for therapeutic foster parents</u>. Include new or additional content on understanding SED children, crisis management, working with biological families, understanding/navigating the system, and the strengths

perspective. Offer in-home training that allows individualized and hands-on learning.

4. <u>Improve gender-specific programming</u>. National studies indicate that girls present a very different spectrum of needs and require different programming from boys.

5. <u>Collect better data and adjust the outcome standard.</u> Data on length of stay, reasons for disruptions, and reunifications should be collected separately for children in therapeutic foster care, not aggregated with all foster children. In light of studies nationwide that report disruption rates from 28-70%, it may unrealistic to expect that 50% of children in therapeutic foster care will be reunified with families in one year. More likely, children will disrupt to other placements, move to a different planned placement, or remain in therapeutic foster care longer than one year.

6. <u>Clarify aftercare responsibilities of subcontractors.</u> When subcontractors provide therapeutic foster care, but contractors retain reunification services, too many layers of responsibility are created between SRS, the contractor, and the subcontractor, resulting in confusion at the child, family, and foster parent levels. Either the subcontractor or the contractor should be responsible for both the provision of therapeutic foster care and reunification/aftercare services.

7. <u>Enhance the role of Community Mental Health Centers in the provision of therapeutic foster care and related services.</u> 1. Explore more fully the system in North Carolina, where CMHCs are the main providers of therapeutic foster care. 2. Enhance the role of CMHCs in training foster parents about the different diagnoses and treatment of SED children, including medications.

8. <u>Initiate a pilot program with SRS' Children, Youth, and Families division to utilize Medicaid funding to pay for CMHC therapeutic "foster" homes as an alternative to foster care for SED children</u>. That is, therapeutic family homes can and should be used as one avenue to prevent state custody of children with serious emotional disorders.

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| # | Author (date) | Type of article | Key variables/ components | Main conclusions | Comments |
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| **TABLE B.** | | | **REVIEWS OF EMPIRICAL LITERATURE OR META-ANALYSES** | | |
| 1 | James & Meezan (2002) | Review and recommendation for *evaluation of treatment foster care* | Suggests more holistic evaluation of TFC. Suggests **ecosystemic domain model:**<br><br>*Intervention* domain (what is done by whom how, and how consistently)<br><br>*Explanatory* domain (factors other than intervention incl. child, foster family, biological family, peers, school, FC agency, service systems, community/ neighborhood)<br><br>*Impact* domain: outputs, outcomes (on children, bio families, TFC families) | TFC is delivered with high variability making effectiveness hard to measure; many factors in the child's environment remain unexamined, service outcomes have been defined narrowly.<br><br>*Intervention Domains*: varied and multiple interventions incl. behavioral management, problem solving, special education, counseling, independent living skills, individual, family and group services; providers insufficient information, no studies on effects; process: few studies adult supervision and foster father's emotional involvement found to be related to success; tx integrity: TFC standards available but no link between adherence and effectiveness established<br><br>*Explanatory domain*: <u>Child</u>: some studies indicate TFC more effective with younger children, gender relation to outcomes unclear, no studies examining differential for ethnicity, little known re. psychosocial characteristics; clinical status; no studies on relation to trauma history or educational achievements, pathways (placement hx) to and from TFC not examined. <u>TFC Family</u>: widely varied in characteristics, seem younger, more educated, view FC as a primary job, higher satisfaction due to higher involvement in planning, use more appropriate behavioral corrections than group care. <u>Bio families</u>: much unknown about characteristics and level of involvement. <u>Peers</u> and <u>school environment</u> virtually unexamined, <u>TFC agency</u> interaction w/ other factors largely unknown, <u>social service system</u> NC and OR currently examine factors, <u>community</u> access and involvement not studied.<br><br>*Impact Domain*: limited evidence of effectiveness, lack of broader ecosystemic evaluation, narrowly focused on outputs (official status changes like discharge status, placement stability, program completion, reinstitutionalization) which do not necessarily indicate improved client outcome, outcomes focus largely on child | Thorough summary of research findings and gaps. Strong ecosystems orientation. |

| # | Author (date) | Type of article | Key variables/ components | Main conclusions | Comments |
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| | | | | behavioral functioning, little known about outcomes for bio families or TFC families, child interaction with environment not evaluated. | |
| 2 | Curtis, Alexander, & Lunghofer, (2001)<br><br>The Odyssey Project, CWLA | *Review* of empirical studies *comparing outcomes in residential group care (RGC) with TFC* | Definitions of RGC and TFC, Characteristics of populations served in either modality, research comparing RGC and TFC, effectiveness of TFC and RGC, brief description of Odyssey Project (CWLA) | Little conclusive evidence to effectively compare RGC and TFC. Population in RGC seems often older and male, while TFC accommodates younger, female clients. Both populations show overrepresenatation of African-American children, high levels of abuse and neglect experiences. Females are more likely to have been sexually abused, TFC males more likely to be violent and have academic problems. Lack of standardized measures, comparison or control groups limits research as does absence of conceptual framework. Lack of convincing longitudinal data. So far data show that both TFC and RGC lead to improvements in behaviors while in treatment but may not persist post discharge.<br><br>*The Odyssey Project (CWLA*): a descriptive and projective study of more than 2000 children and youth in residential GC, group homes, and TFC from 24 agencies across US. Assessments at baseline, one-year intervals, discharge, and at 6 months, 1 yr and two year points post discharge. | Review comparatively limited and focused on child welfare issues. Promising for future research: CWLA Odyssey Project. |
| 3 | Redding, Fried, & Britner (2000)<br><br><br>[People Places, Inc.?] | *Review of studies, extracting predictors of Placement Outcomes in TFC* | Focus on correlates (including child, family, and agency characteristics) of placement stability, and family and child satisfaction | ***Associated with successful outcomes:***<br><br>***Child characteristics***: best outcomes for children with fewer emotional and behavioral problems, fewer prior placements and less time in institutions, fewer prior negative outcomes, good relations with FC family, degree of control over frequency and type of contact with own family.<br><br>***Biological families*** are dissatisfied when they fear they will not regain custody, do not receive information about child's progress and when they have insufficient contact and visitation. Frequency and amount of visits should be tailored ton child's needs and include child's input<br><br>***Foster parents***: limited research but emotional stability (especially of mothers), realism, hardy while sensitive, | Recommendations for FC<br><br>Recruitment, selection, initial and ongoing training and support, assessing goodness-of-fit of temperament when matching of children and foster families, models for service delivery, and empowerment of children and families |

| # | Author (date) | Type of article | Key variables/ components | Main conclusions | Comments |
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| | | | | and authoritative responsiveness are related to success as are motivation of own childlessness or own childhood experiences. *Foster parents' biological children:* often negatively affected by foster situation, need to be paid attention to before, during, and after foster experience. Agency: caseworker's rapport with foster parents, foster parents' rapport with agency as a whole, foster child-caseworker rapport. | |
| 4 | Reddy & Pfeiffer (1997) | *Meta analysis* of 40 outcome studies (1974-1996) related to TFC. Using weighted predictive value (WPV) statistic, authors coded and analyzed outcome studies on children and youth with SED | Dependent variables: placement permanency, behavior problems, restrictiveness of placement at discharge, social skills, and psychological adjustment (such as well-being, self-esteem, affect, quality of sleep etc.) | *Outcomes:* By and large, children completed TFC as planned and responded favorably. TFC had largest positive effects on *placement permanency and social skills*. Medium effects on reducing *behavior problems, decreasing level of restrictiveness at discharge, and increasing psychological adjustment* <u>However</u>, results are neither uniformly positive nor persuasively strong. *Quality of studies*: studies *lacked methodological rigor*, there was *no clear definition or consensus* on what constitutes successful *outcome* for TFC. Outcomes seem multidimensional and multidirectional and many studies adopted a too narrow focus to evaluate success (i.e. assessing one or two symptoms, only focusing on the child). Few studies reported any *follow up data*. Studies *lacked description of foster parent training and support,* or of the *interventions* rendered. Findings suggests that there was only *limited use of school psychological/ educational services and community services*, or *aftercare* pointing to the need for more attention to these areas. | *Need* for studies to include descriptions of parent characteristics, training, support services, and interventions. Need for outcome studies to address multiple dimensions and indicators, and generalization of effects across environments and time. |
| 5 | Bates, English & Kouidou-Giles (1997) | *Review of Literature on Residential Tx and its alternatives* | <u>General principles in TFC</u>: two broad categories, nine common characteristics: Professionalism, low foster parent caseload, low caseworker | **General limitations of empirical research:** Small nonrandomized samples, subjective eval methods, instruments without tested reliability/validity, unnecessarily narrow outcome criteria, no control or comparison groups, descriptive rather than statistical analysis | Good background/ context info. Programs described outdated. |

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| | | | caseload, tx oriented SV, Tx services, support, crisis intervention services, educational assessment, system of care coordination<br><br>More in-depth review of three program evals from the 1970s/80s<br>• Parent-Therapist program<br>• Special foster homes<br>• PRYDE | **Limitations of range of tx approaches**<br><br>Behavioral, social learning, systems/ecological, family therapy, reality therapy, psychodynamic. Most empirical studies behavioral in approach. But even then high level of individualization makes identification of tx methods across programs, homes, and populations virtually impossible<br><br>**Lack of theoretical grounding**, no coherent conceptualization | |
| 6 | Hudson, Nutter & Gallaway (1994a) | ***Review of evaluation research*** on TFC programs<br><br>Included: Studies (n=11) that collected data systematically and focused on TFC efforts and outcomes<br><br>Excluded: purely descriptive, legal, historical, conceptual, or articles focusing only on particular features of TFC | Programs reviewed:<br>• Parent-Therapist Program Hamilton, Ontario 1970s<br>• Alberta Parent Counsellors program 1970s<br>• Kent Family Placement Project, UK, 1970s-1980s.<br>• Children's Homes in UK 1980s<br>• PRYDE, PA. 1980s<br>• Oregon Social Learning Center, 1980s.<br>• Tennessee regular and therapeutic FC, 1980s<br>• Casey Family Program, 1980s | Wide variation in studies, need for better descriptions of programs and populations. Youth generally functioned better after TFC and mostly completed program as planned. Follow up data favored TFC over alternative programs, and seems more cost efficient<br><br><br>Need to research mature programs that have high likelihood of stable intervention fidelity, program changes during evaluation should always be justified and consistent with underlying rationale, randomize assignment after decision was made to institutionalize, need for sufficient sample numbers, more detailed client description, careful monitoring of implementation, adequate follow up intervals. | Authors provide rather general recommendations for further research.<br><br><br>Recommended outcome criteria:<br><br><br>Client condition and functioning, social environment, living situation: psychiatric, emotional, non-criminal behavior, school functioning, community involvement, JJ involvement, D/A, employment |

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| TABLE C. | | | | INDIVIDUAL EMPIRICAL STUDIES AND PROGRAM DESCRIPTIONS | |
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| 7 | Farmer, Wagner, Burns, & Richards (2003)<br><br>Willie M. Program, NC | **Study of longitudinal placement trajectories** for TFC youth<br><br>Comparing 12 months prior and 12 months after TFC placement | *Sample*: 184 youth with psych. disorders and aggressive behaviors, (74% male, mean age: 13, 56 % white)<br><br>Pre and post TFC residential placements:<br>• Group home<br>• TFC<br>• Home<br>• FC<br>• Run away<br>• Institutions (hospital, jail, residential tx) | *Pre* TFC placements:<br><br>Group home: 46 %; TFC: 18%; Home: 13.5 %; FC: 2.8 % Run away: 0.7%; Institutions: 19% (hospital: 4% , jail 2%, residential tx 13%)<br><br>64% remained in TFC for 12 months, 47% of those who left went to more restrictive, 45% to less restrictive settings. Leaving placement was correlated with age (the older the more likely) and higher externalizing behavior scores (thus not with proxies of success). No correlates with gender found.<br><br>*Post* TFC placement data for those who left within 12 months indicate: Immediate placements show increase of less restrictive settings (especially for those initially coming from institutions.) **However**, by the end of 12 month window post TFC placement, rates of group home care are similar to pre-placement (though days at home remain at an increased level, and institutionalization rates remain low).<br><br>>>*TFC in its usual practice does not appear a useful short-term (less than 12 months) transitional placement* (which is the predominant type of model programs researched to date). And initial discharge data may be insufficient and transient indicator of outcomes. | Makes important distinction between "model programs" and "usually practiced programs."<br><br>Discerns significant differences re. assumptions of function of TFC as a short-term transitional placement. |
| 8 | Farmer, Burns, Dubs, & Thompson (2002)<br><br>Willie M program, NC<br><br>FFTA | *Examination of conformity to standards* for TFC as developed by Foster family-based treatment organization (FFTA) | **Common features of TFC**<br>• Focus on youth with special needs<br>• Focused on recruitment of treatment foster parents<br>• Extended preservice training and inservice supervision/support for tx parents<br>• Placement of children in tx parents' own homes | **Overall:** 17% of programs below conformity average on all domains, 21% above.<br><br>**Program**: wide variability. Standards best met where supervisors oversee no more than 5 caseworkers (full compliance rate: 72%) who supervise no more than 8 tx parents (35% full compliance). Most agencies provide 24/7 support, 87% of SV provide such support for caseworkers, 66% on-call duty rotations (31% always on call), in 55% of programs caseworkers make contact with parents at least weekly. | *Instrument validity limited*, no link yet to outcomes for youth |

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| | related<br><br>NIMH funded<br><br><br><br>Checklist scales based on interviews with tx parents, program staff, youth and families, rated as no, partial or full conformity. | Included: all 46 TFC agencies associated with Willie M program in NC. Response rate 91% (42) (public: 21, private: 21, for profit: 11 and non-profit: 10) | • Parent stipends are substantially higher than traditional FC<br>• Planned tx combines techniques from more restrictive residential settings with emphasis on daily interactions with tx parents and others as opportunities for tx and development<br>• Individualized tx within the above parameters<br><br><u>Standards Subscales</u><br>**Program**: written program statement, Documentation of service delivery, Adequacy of evaluation, Staff training, SV, qualification and caseloads<br>**TX parent:** qualification characteristics, preservice and inservice training and support, home capacity, record keeping, roles, support services (e.g. respite)<br>**Children and their families:** preplacement activity, matching, access to staff, children's rights, tx planning, transition and perma-nency planning, involvement of family in tx planning | **Tx Parents:** 78% of agencies report difficulties recruiting and retaining parents, as few restrictions as possible are set on potential parents. 71% required 30 hrs. of preservice training, 93% some annual training but only 21% the standard 24 hours of annual in-service, monthly planned respite available in 56% (32% not), emergency respite available in 46% (28% not) [payment during respite widely varied].<br><br>**Children, youth, families:** 100% attempt to match, 75% report success in matching, overnight visit prior to placement (31%) 62% have at least a meeting, plans for transition should begin at placement (38% conformity, 17% established at least timeline, 45% no planning at beginning of placement)<br><br>Initial treatment plans in 30 days (100%) but quarterly update/review only 23% in full compliance. Also children's rights (information handbook) complied in only 24%.<br><br>**Variables associated with conformity**: Quality of tx parent training, SV, and children's standards seem largely unrelated to administrative structures.l Only: larger programs had higher conformity overall and with children's standards, for-profit programs had lower conformity overall, with tx parents and children/family domain. Program standard subscale did not account for much of variance. | |
| 9 | Galaway, Nutter & Hudson (1995) | **Study of relationship between TFC program characteristics and Discharge Outcomes**<br><br>Secondary data | <u>**Sample**</u> 210 TFC programs providing data on total 1521 clients discharged 1989 (ages 17 and younger, 43% between 15-17).<br><u>**Outcome**</u> variables:<br>Planned/unplanned discharge, restrictiveness of setting after discharge<br>Program variables:<br>1. auspices | While type of discharge and postdischarge living arrangements were highly correlated (p.< 001) (80% of planned DC to less restrictive settings, and only 37% of unplanned DC; adolescent youth being less likely than pre-ads to be discharged planned to less restrictive settings) there were <u>no significant correlations between program and outcome variables</u>. Only analysis of extreme cases (high-cost, low caseloads programs were more likely to achieve planned discharge than low-cost, highest caseloads). | Results do not support importance of FFTA standards at least within the limited frame of variables and measures used here. |

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| | | analysis of FFTA program survey | 2. size<br>3. per annual bed cost<br>4. max. SW caseload<br>5. max. no of clients per home<br>6. client density<br>7. amount of payment to FC<br>8. basis of payments<br>9. FC parent training<br>10. FC parent support group<br>11. treatment approach | | |
| 10 | Hudson, Nutter, & Galaway (1994b)<br><br>FFTA related | **Survey** of 321 TFC programs operating in fall of 1991 (associated with FFTA) as to **program and client characteristics** | **Program characteristics:**<br><br>73% private non-profit<br><br>23% public<br><br>4% private for profit<br><br><br>61% established in 1980s<br><br>budget: 50% goes directly to tx parents , 73% of programs pay per diem rates<br><br><br>**Client characteristics**<br><br>majority adolescents 15-17 (38%), 12-14 (28%), 6-11 (25%). White (65%), black (22%). Male (56%) | **Program activities**: 25 hrs (m) of preservice training, 23 hrs (m) yearly in-service, 68% mandatory support group attendance for caregivers 63% at least monthly, 38% less than monthly<br><br>98% used treatment plan<br><br>Tx modalities in order of popularity: behavior modification, social learning, systems, reality therapy, family therapy, psychodynamic<br><br>**Clients**: <u>Reasons for placement</u>: psychiatric and emotional (65%). For adolescents criminal behavior more likely as reason<br><br><u>Discrepancies between self-reported policies of parent involvement and practices</u> indicating such actual involvement in consultations and planned visits.<br><br><u>Reasons for discharge</u>: 47% goals achieved (higher rate for younger children than for older), insufficient progress (17%), breakdown-client (16%), breakdown-parental (12%), administrative (6%), client death (<1%).<br><br>54% discharged to less restrictive settings. | ***Caution:*** based on Self-reports by self-selected programs that are associated with FFTA<br><br><br>Overrepresentation of small private nonprofit programs<br><br><br>Unable to determine factors leading to more or less effective TFC |
| 11 | Chamberlain & Moore (1998) | 5-year-**study** of **male juvenile offenders** (n= 39) in TFC program in comparison with | juvenile offenders (male)<br><br><br>Baseline, 6 months intervals, for 2 years post-baseline assessment of<br>• arrests | At one year post baseline: TFC participants had significantly *fewer arrests* (p.= .003), *higher program completion* rate (p.< .001), fewer days in lock up settings (p.< .001), higher number of *days living with parents* or other relatives.<br><br>Authors hypothesize that four factors (rather than | ***Strengths:***<br><br>Experimental design, follow-up, provision of intervention details.<br><br>***Results*** underscore potential |

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| | Oregon Social Learning Center<br><br>NIMH funded | group care (GC, n=40) in Oregon.<br><br>Random assignment.<br><br>Also includes TFC case example. | • Program completion<br>• Running away<br>• Days incarcerated<br>At 3 months: assessment of key treatment components from both boys' and caretakers' perspective:<br>• Extent of supervision<br>• Consistency of discipline<br>• Association with other delinquent peers.<br>TFC model used is "parent mediated treatment model" which includes<br>• Foster parent recruitment and screening<br>• Intensive pre-service training<br>• Structured behavioral management system<br>• Ongoing consultation between parents and professional staff (daily contact, weekly supervision)<br>• Individualized youth treatment<br>• Family therapy with aftercare resources<br>• Aftercare services using wraparound approach | treatment group itself) may lead to positive outcomes:<br>• Close supervision,<br>• high contact with caregivers,<br>• highly consistent discipline,<br>• least association with delinquent peers.<br><br>(Note: GC boys had higher association rates with delinquent peers even if fellow peers in the group home were excluded from the count). | of family based care for chronic juvenile offenders (if given strong and consistent supports). The main drawback of GC vis a vis TFC appears to be the relatively lower amount of adult supervision combined with stronger association with other delinquent peers.<br><br>**Weakness**: Results do not clearly establish if same interventions could lead to same results in other than TFC settings.<br><br>No report on minority demographics |
| 12 | Chamberlain & Reid (1998)<br><br>Oregon social Learning Center<br><br>NIMH funded | Comparison **study** of **male juvenile offenders**<br><br>in Group care vs. TFC | Sample: 79 male juvenile offenders age 12-17<br><br>Random assignment to GC or TFC<br><br>(model: see above) | ANOVAs and multiple regressions found:<br><br>**One year after referral**, there was a significant difference in **run away** rates, **completion** rates and **incarceration**/lock-up favoring TFC. Rates of living with parents or relatives approached statistical significance.<br><br>**Criminal activity dropped** more sharply for TFC participants. Controlling for variations of age, age at first offense, rate of pre-referral arrests only group assignment and pre-referral arrest rates were significant predictors of postplacement criminal activities. Age at baseline or first | Note: sample mostly Caucasian boys in metropolitan area. Lack of longer-term follow-up. |

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| | | | | arrest did not appear to be a significant factor in this sample. | |
| 13 | Smith, Stormshak, Chamberlain & Whaley (2001)<br><br>Oregon Social Learning Center | **Study** examining **placement disruption** in TFC | 90 Children and Youth with SED (referred from CW)<br><br>Examining variables:<br><br>Gender (m: 51, f:39)<br><br> Age (males: <13: 36; females: <13 25)<br><br>MH diagnosis (average: 3.3 dx: most prevalent: ODD, PTSD, ADHD)<br><br>No. of previous placements: average 4.75. | ***Previous disruptions***: girls have significantly higher rate (twice the rate of boys). MH, or age did not vary regarding prior disruptions in sample.<br><br>***Rate of TFC disruption*** at 6 months: 17.8 %, at 12 months another 9.2%, totaling ***25.5 % during 12 months***.<br><br>Most disruptions (70%) occur during first 6 months.<br><br> During first six months, older girls having the highest rate of probable disruption (55% probability) followed by older boys (12.7% probability).<br><br>Thus, <u>older children have higher risk of disruption</u> (even if number of prior disruption is controlled variable), <u>and adolescent girls in particular.</u> Authors suggest that change processes differ for boys and girls, and speculate that girls exhibit different forms of aggression (namely "relational" aggression) that becomes more subtle as they age. | Provides clarification on how to define "placement disruption"<br><br>Supports previous research on older children's higher risk of disruption, raises critical issue of <u>gender as unexamined factor</u>. Authors tentatively acknowledge ***need for adjusting treatment and training to address gendered differences*** to prevent higher disruption rates (see also publications # 19 and # 21 below) |
| 14 | Staff & Fein (1995)<br><br>Casey Family Services, New England | **Descriptive Study of stability of placements for children in long-term TFC** in child welfare | Sample: 244 children (ages 5-13) not likely to be re-unified with families, placed in TFC between 1987-1991. median age at first out-of-home placement: 9.<br><br>TFC service components:<br><br>Specially trained foster parents, at least monthly contact with MSW level worker, respite for foster parents, contacts and visits with biological families, payment for therapy, tutors, camps.<br><br>Also: the program made available resources for post-unification and adoption care, services for transitional and independent living, | At the conclusion of study, 161 children were still served by agency, 83 cases had closed prior to end of study.<br><br>***Outcomes*** for those 83 and 26 additional children who were still being served but who had already been reunified, adopted etc: 35% adopted; 17% reunified with families (a surprisingly high number given the initial assumption that children in the study were unlikely to be reunified); 28% were young adults reaching age 18; and 21% returned to state welfare agencies for continued care.<br><br>***Placement disruption/re-placement***: Of the 83 whose cases had closed, 51% were placed only once, 26% twice, 12% three or four times, and 9% five or more times. Of the 161 children who still received services 49% had been placed only once, 23% twice, 16% three or four times, and 12% five or more. About 75% of children in both groups had been placed exclusively in TFC homes. | Points to high number of placements/replacement activities that TFC workers have to engage in.<br><br>Small number of children account for high number of re-placements. (TFC seems not a sufficient environment for them).<br><br>Points to need to attend to independent and transitional living services for older youth in TFC.<br><br>Even children deemed "unlikely" to be reunified or adopted turned out to need |

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| | | | connections with group care facilities, and permanency planning with state facilities. | 20% were placed in hospital or residential facilities.<br><br>Almost half of those who were placed in facilities once were placed there again on another occasion, and two-thirds remained in non-family care until reaching maturity. Many of the children who were placed more than five times or in facilities experienced both of these events. This subgroup of children (9% of total n) accounted for 30% of the total 540 placement activities that were made for all children in the study and they seemed not to benefit from this TFC program. | services in these areas. Thus TFC ought to include such services!<br><br>Shortcomings: Reasons for replacements not examined. Very little information about actual services provided. |
| 15 | Jivanjee (1999a)<br><br>Oregon Social Learning Center | **Qualitative study of biological parent perspectives about family involvement in TFC** | **Participants:** Child welfare sample, 10 parents who were at least somewhat involved in TFC,<br><br>majority of children placed for abuse, neglect, two guardians requested for placement because of inability to manage child's behavior. | Involvement in placement decision: ***although required by TFC standards only two parents reported having been involved in initial placement planning.***<br><br>Relationships with professionals: mostly positive, parents appreciated when professionals shared information, involved them in decision making, took time to get to know them and build trust, and provided support and advocacy. In negative cases parents felt excluded, disliked.<br><br>Relationships with TFC providers: parents appreciated TFC providers who were willing to get to know parents, discussed goals and strategies for tx, and negotiated w/parents. Opportunities to observe provider-child interaction often served as learning experience, some providers took on additional teaching/co-parenting approach, offering support and education to parents<br><br>Barriers: transportation issues, scheduling of location of meetings, lack of follow through.<br><br>Helpful Practices: communication, information sharing, facilitation of parent-child contact, involvement in decision making, training/education in parenting skills (formal classes and informal by TFC provider), meet parents' needs for assistance w/transportation, more convenient scheduling of visits, individual or group support to help deal w/ loss of children and other stressors. | Good effort to include ***biological parents' perspectives*** (including parents with and w/o custody, and differing goals re. reunification).<br><br>Underscores varied availability of collaborative family-centered approach by TFC providers and professionals. Need to build trusting relationships between parties.<br><br>However, small, self-selected sample, was invited by caseworkers (whose own interests and relationships w/ parents may have impacted whom they invited to participate) |

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| 16 | Jivanjee (1999b)<br><br>Oregon Social Learning Center | **Qualitative study** of **professionals' and TFC providers' perspectives on family involvement in TFC** | *Child welfare sample:* 12 interviews with professionals (caseworkers, plus two MH therapists) and 12 interviews with TFC providers matching the families who agreed to be interviewed (see study Jivanjee, 1999a, above). | While providers and professionals shared values and attitudes generally supportive of family involvement, actual concrete actions toward involvement were tempered and rather diverse. Attitudes toward families included empathy, respect for strengths, and respect for compliance with Tx requirements. Relationships were enhanced when TFC providers demonstrated honesty, trust, appreciation of strengths, sharing information, and facilitating parent-child contacts. Amount of contact with parents appeared to relate to providers' personal life background more than training. In negative cases, dislike of families or fear of families led to exclusion of parents or minimized contacts. Disapproval of parents strained relationships. Organizational barriers included: limited time, caseload, paperwork, intrusive nature of child protection, practical and emotional barriers facing parents, lack of commitment to families and lack of TFC provider training. | *Perspective of professionals and providers.*<br><br>Little focus on TFC provider-family contacts in training, and some training giving mixed messages<br><br>Implications:<br><br>Go beyond a mere claim to family involvement:<br><br>Focus on family-provider, and family-professional partnerships, make concrete strategies and assistance available |
| 17 | Fisher & Chamberlain (2000)<br><br>Oregon Social learning Center<br><br>NIMH funded | **Description** of Multidimensional treatment foster care program for Juvenile offender *and preliminary outcomes for* adaptation to pre-school *age children in Child welfare.* | MTFC approach (see Chamberlain & Moore, 1998)<br><br>Early intervention Foster care (EIFC) developed 1994 for children age 3-7 referred by child protective services (see description in Fisher, Ellis, & Chamberlain, 1999)<br><br>Sample: 30 children (10 in EIFC, 10 in regular FC, 10 in community comparison group living with own families) | Preliminary EIFC results after one-year pilot project, focused on three months after placement. Comparison groups: regular FC (RFC) and community comparison (CC). Hypotheses: children placed with EIFC parents would show greater improvements than those in RFC, and behaviors of EIFC parents would look more similar to CC parents. EIFC and CC parents showed similar levels of disciplining, monitoring, positive reinforcement. EIFC parents' stress decreased with time while RFC parents' stress increased. Symptom reports show decrease for EIFC children while increase for RFC children. Children's emotional regulation measured through weekly salivary cortisol levels (linked to stress and maltreatment). Results show: initially elevated levels for both FC groups compared to CC (consistent with links to maltreatment patterns), an atypical U-shape pattern of cortisol levels for EIFC kids (who have most severe maltreatment history) showing elevated levels during morning and bedtime hours (a typical pattern is a high morning and consistent drop pattern), a replacement of atypical pattern with the typical one over time of EIFC treatment , and | Supports usefulness of MTFC approach with young maltreated children though small non-randomized sample must be considered as cautionary factor. Interesting use of biological measure for stress in small children in addition to typical symptom report by adults.<br><br>See Fisher, Ellis, & Chamberlain (1999)<br><br>Below for more program details |

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| | | | | decreasing levels for EIFC while RFC group levels increase over time. | |
| 18 | Fisher, Ellis, & Chamberlain (1999)<br><br>Oregon Social Learning Center<br><br>NIMH funded | ***Program description*** of ***early intervention foster care model*** for preschoolers referred from child welfare | Adaptations of MTFC model<br><br>therapeutic playgroup, long-term placement planning<br><br>Lessons learned | Adaptations of MTFC approach to preschool age children focusing on three domains:<br><br>1) Behavioral problems (basic behavioral interventions, redirection, token system, pos. reinforcement for younger children), 2) Developmental delays (screening and ongoing consultation by early intervention specialist, activity based intervention (ABI) to created environment that maximizes specific learning opportunities, 3) emotion regulation (often found lacking in abused children),<br><br>Implementation has had its challenges. Cases often very complex, some children seemed tx resistant, especially those with history of prenatal drug abuse and a number of caregiver losses. Foster parents with high emotional reactivity make not a good match, some other resistance was noted from biological parents and/or other service providers. | See Fisher & Chamberlain (2000) above for preliminary results |
| 19 | Chamberlain (1996)<br><br>Oregon Social Learning Center<br><br>NIMH funded | **Book Chapter** reports on history, background and preliminary results of various OSLC projects **comparing TFC and GC for youth with conduct Disorders** | Factors associated with outcomes for youth in JJ or SED systems<br><br>**Attention to gender** | Review of gender factor study (Chamberlain & Reid, 1994, see below), leads to ***realization that "program has been designed on the basis of research that identified treatment needs of males" and poses questions as to "the appropriateness of the model for treating adolescent females"*** (p.76).<br><br>***Research is needed to determine when residential versus TFC is indicated.*** S of now, placement decisions are more often based on availability of places in an atmosphere of crisis ("place and hope") | Good summary of Gender related research and findings |
| 20 | Moore & Chamberlain (1994)<br><br>Oregon Social | **Program Description** plus case study | youth with SED | Oregon TFC model includes:<br>• Foster parent recruitment and screening (finders' fee)<br>• Intensive pre-service training 20-30 hours, role plays, (social learning parent training model point and level system, IEP like plan, developmental issues, sexual abuse, communication/problem-solving. Approaches to work with biological families, and other community | Good description of TFC program details |

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| | Learning Center | | | members) <br> • Structured behavioral management system: point and level system <br> • Ongoing consultation between parents and case consultant (daily contact, weekly group consultation, 24/7 available) <br> • School support (TFC staff consults, and helps implement interventions and plans at school) <br> • Individual therapist (ally for youth, different person than consultant, 24/7 available) <br> • Family therapy for biological family incl. teaching point-level system and individual plans implemented in TFC <br> • Aftercare services using wraparound approach | |
| 21 | Chamberlain & Reid (1994) <br><br> The Monitor Program <br><br> Oregon Social Learning Center | **Study** of *Gender Differences* in Risk factors and adjustment for male and female *delinquents* in TFC | Sample: male (n=51) and female (n=37) juvenile delinquents ages 12-18 <br><br> See above for Tx component <br><br> Average length: 6 months <br><br> Parent Daily report (PDR) of problem behaviors <br><br> Official Arrest Data <br><br> Risk Factor Rating | Significant <u>Pretreatment</u> differences: <br><br> <u>Males</u>: younger at time of first arrest, more total arrests, more felonies. <br><br> <u>Females</u>: placed outside home more often, rate of being sexually abused (over four times that of boys (!) 49%, males: 11%), more likely to have attempted suicide, and run away two or more times <br><br> <u>PDR</u>: reports indicated the perception that at six months males were doing better (or at least did not deteriorate) while <u>females seemed to do worse than at intake</u>. <br><br> Males and females <u>completed program at similar rate</u> <br><br> <u>Arrest Data</u>: <u>female continued to show higher status offense rate</u>, no gender differences re. property or personal offenses. Arrest rates dropped overall for both groups. <br><br> <u>Risk Factor Rating</u>: prior sexual abuse correlated with <u>higher number of total offenses and more status offenses in post-treatment follow-up.</u> <br><br> Girls, especially sexually abused ones, are <u>at risk to be rejected by foster parents who experience failure over time</u> | ***Gender differences in this population are clear before, during and after treatment***. Current programs fail to attend to gender differences. Authors assume girls need more time to build trusting relationships and only then begin showing problem behaviors. (High correlation of gender and sex abuse status figures into this hypothesis.) <br><br> No hypothesis by authors that treatment model itself maybe biased to favor of male behavior and development. (Chamberlain, 1996, offers insights in this direction) |

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| 22 | Chamberlain & Reid (1991)\n\nOregon Social Learning Center | **Study** assessing **effects of Specialized Foster Care** (SFC) for *children and adolescents leaving state mental hospital* | 20 (n) ***Children and youth with ED*** (8 males, 12 females) ready to leave state mental hospital were randomly assigned to SFC or control condition.\n\n***Control group (n=10)*** (3 male; 7 female): 7 went to community placements (residential, group homes, JJ, families) three remained in state hospital. Those placed in residential placements and hospital settings received milieu therapy and some level of individual therapy.\n\nExperimental ***SFC condition (n=10)*** (5 male, 5 female): FC parents recruited and trained in social learning approach, case manager, individual therapist, Family treatment, ongoing supervision and support of FC parents.\n\n**Measures**: Levels of emotional disturbance, social competency, self-reported symptoms, reported behavior problems, institutionalization rates | Significant difference in time that elapsed between referral to study and placement outside of hospital: SFC: 81 days; Control: 182 days (excluding three of control group who remained in hospital still 103 days)\n\nPlaced in family settings: SFC: all 10; Control: 4\n\nNo significant difference in days spent in community in the year following placement: SFC: 288 (rehospitalized: 3); control (n=7) 261 days (two rehospitalized)\n\nAll children showed significant clinical impairments on ED baseline measure. Reported behavior problems dropped more rapidly in SFC group for first 3 months; at 7months postbaseline control group rates dropped though not to the level of SFC. Yet, the differences did not reach statistical significance. SFC participants consistently self-reported higher distress levels (at baseline and in two intervals thereafter). Neither group showed significant improvement on social competency.\n\nAuthors conclude that results support the idea that SFC is a viable alternative to residential treatment for children and youth leaving the state hospital. | Small but randomized sample. Although power of study is limited results indicate that children and youth with significant ED can be treated in SFC after leaving hospital and fare no worse than in residential tx.\n\nHowever, study lacks longer-term follow up.\n\n[See Chamberlain & Weinrott (1990) in reference list for case description.] |
| 23 | Bryant & Snodgrass (1992)\n\nPeople Places, Inc. (VA) | **Program description**\n\nIncludes history of program evolution and brief summary of prior evaluation results | Children and youth with SED\n\nProgram in existence since 1973.\n\nComponents:\n- Social learning (ABC - behavioral theory) basis—daily behavioral chart (STEP), CBCL in intervals\n- Parenting skills training\n- Individual therapy | Program focuses on establishing continuity between providers, foster parents and biological families. Attempting to blend home-based and foster care services. Advocates for more flexible funding and coordination of both services that allows TFC team to deliver reunification services. | Good description of program context and components, staffing procedures, foster parents, population served and challenges to the program. |

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| | | | • Independent living skills group<br>• Aides (attn. care) and wraparound<br>• Home based services (fam. preservation)<br>• Information management (INFOBASE software)<br>Same services available for foster and birth parents (continuity)<br><u>Foster parents</u> complete 24 hour PST, required: 24 hours annual inservice training (individualized), weekly phone contacts, weekly/biweekly visits, 24/7 crisis response, monthly parent support groups, alternative SpEd school (run by agency), provision of summer recreation programs, <u>Small (12) caseload</u> for program managers, on-call duties shared between with colleagues. | | |
| 24 | Evans , Armstrong, & Kuppinger (1996)<br><br>Project FIRST, Demonstration project, NY | **Study of efficacy comparing TFC and Family centered intensive case management** for SED children. | *Sample*: SED children, age 5-12, rural areas, 83% white, 91% boys, 83% in parental custody, 57% SpEd, 63% disruptive behavior disorders, randomly assigned (weighted procedure), TFC n = 15; FCICM n= 27.<br><br>No CBCL, or family characteristics differences between groups, but FCICM group seemed overall more clinically impaired (CAFAS)<br><br>*Interventions*. <u>TFC</u>: family specialist provides support for five TFC families, and one respite family. <u>FCICM</u>: team of case manager and parent advocate work with max of 8 families, and 2 | No significant CBCL score change for either group during first year. Full year data available for only few families, no statistically significant differences.<br><br>Team approach in FCICM with distinct and complementary roles of parent advocate and case manager.<br><br>Lesson learned: original FCICM model was too rigid and component driven, need to adapt services to parents' individual styles and concerns<br><br>Respite care, though frequently identified as one or most desired service, was not utilized as much as anticipated. Reasons unknown. | Although a weak study, it raises the question if the same TFC-like intensity of services could prevent out-of-home care when delivered to biological parents.<br><br>>> wraparound<br><br>Preliminary data not sufficient to make statistical inferences.<br><br>TFC services comparatively ill described. |

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| | | | respite families. 24/7 in home services, provide behavior management training, parent skills training, advocacy, support groups, one-on-one support, flex money | | CBCL was completed by bio parents (not FC parents) based on child's behavior during weekend visits. |
| 25 | Morrissette (1992)<br><br>Phoenix Place, (Alberta, Canada) | ***Program description*** of Phoenix Place (step-down placement from residential group home)<br><br>including case example | Conceptual background about training, recruitment, and program processes:<br><br>Ecosystems paradigm<br><br>Elevating profile of FC<br><br>Information meetings<br><br>Breaking the ice<br><br>On going training<br><br>Launching ritual<br><br>Client assessment/selection<br><br>Limitations/ contraindications: not used for youth with severe behavioral problems (extreme violence, sexual offenders) | ***Goal***: to effectively bridge transition from institutional care to community care using eco-systems approach and emphasis on positive and collaborative involvement of biological families, reduce FC disruptions, reinstitutionalization.<br><br>After an initial orientation meeting introducing the ***ecosystems and strengths*** approach, the program uses a three-step screening procedure to select FC parents who will foster not only relation to young person but also to biological parents, and existing support systems. At least one FC parent must be home full time, attend bi-weekly support groups, frequently attend clinical review meetings, participate in all training events, and complete monthly behavioral reports. Weekly visits by worker, 24/7 support line with agency workers and residential staff.<br><br>***Transition*** from residential to FC is planned with care and at the youth's pace. Anticipating the apprehensions of youth, FC is discussed and contacts initiated while still in residential care. FC parents, families, and youth meet informally first, followed by an afternoon out for FC parents and youth. Day visits are then coordinated, also allowing FC families to discuss specific background and needs with workers. Overnight stays follow. An effort is made to ensure continuation of valuable social activities (though often impossible in rural areas).<br><br>***Training modules*** for FC families: focus on various topics and always conclude with ceremony celebrating and acknowledging FC families achievements<br><br>Youth's ***transition to TFC is celebrated in ritual*** that involves, peers, staff, FC and biological families. | Useful for recruitment, screening, training. |

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| 26 | Daly & Dowd (1992)<br><br>Father Flanagan's Boys' Town, NE | *Description of key concepts* of the Flanagan *Boys' Town* model focusing on *characteristics of effective and harm-free environments for out-of-home care* | Effective harm-free environments promote spiritual, emotional, intellectual, and physical growth using factors such as:<br>• Caregiver Support<br>• A model of Care<br>• Focus on positive behavior<br>• Consumer orientation<br>• Training<br>• Program evaluation<br>• internal program audits | *Caregiver support*: avoid burnout by keeping low child-adult ratio (no more than 4:1, less for SED children), provide training, relief time, responsive supervision, involve caregivers in all important decisions and planning, grant them professional status and career opportunities<br>*Model of care*: have a well-defined set of procedures and practices, that can be taught, and monitored via data collection<br>*Focus of positive behaviors*: attend to at least four positive behavior for each negative one, teach new skills, maintain tight administrative control over potentially aversive practices such as medication, restraint, group consequences, and time-out<br>*Consumer orientation*: seek out input from such as children, parents, teachers, coaches, neighbors, friends and employers. Adjust program based on feedback, be open to scrutiny from people outside the treatment environment<br>*Training*: provide opportunities for development, knowing what to do and what NOT to do, one year pre-service training incl. three week workshop, on-the-job supervision (24 hrs available) ongoing training that is NOT just classroom style but on-the-job, and modified according to specific needs of agency (i.e. do not rely solely on outside training providers). Feedback after training is as important as training itself!<br>*Program Evaluation:* annual evaluation of over 30 outcome and process measures ensure definition and maintenance of standards of care, certification and pay raises for caregivers are contingent upon meeting evaluation criteria. Ongoing Follow-up evaluation.<br>*Internal program audits*: Help prevent abusive or inappropriate practices by self-monitoring system. All complaints (regardless of source) are taken seriously and investigated by person not directly involved in day-to-day administration of program, all use of restraint is investigated, each child is annually and confidentially asked about incidences of inappropriate practices by caregivers (no experience of large false positive claims) | Key idea: It is necessary but not sufficient for TFC to be harm-free environment. It must also be effective in promoting growth.<br><br>Strong emphasis on training and support, active control and discourage use of restrictive responses (including time-out, quiet rooms, etc. because caregivers will gravitate toward the convenience of their short term effectiveness if such procedures are not controlled), and self-monitoring practices of program. |

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| 27 | Horner, Smith, & Ray (1990)<br><br>Washington State | ***Description*** of ***evolution and implementation*** of TFC program for children with SED (specifically sexual abuse) | ***Program Goals:*** normalization and stabilization of children's lives. While agreeable on paper, goals of different parties involved were frequently in conflict.<br><br>***Client population and treatment goals***: original target sexually abused children. Need to justify program led to no-reject policy which led to inclusion of children with many difficult and chronic problems. <u>Reunification was a goal of less than half of the children,</u> which conflicted with treatment philosophies and models of therapists.<br><br>***Case management***: underestimated intensity of time, energy and coordination efforts for this population. Lack of ability to compel providers to participate in required permanency planning. ***Community service providers***: ideologies and service structures collided with needs of foster families, and project staff. ***Crisis intervention:*** often necessary and provided by project staff because therapists did not perceive home visits as their job. While project staff sought stabilization, therapists wanted to use (and instill) crisis as catalyst for change. ***Natural parents***: Often reluctant or outright rejecting ideas of reunification.<br><br>***Foster parents*** felt not recognized, not respected, not included especially by therapists. | **Redesign of program:** Broader redefinition of target population ("hard to place kids"), project staff serve as primary therapists and secondary case managers, inclusion of foster parents in team, hot line for parents to supervisor established, therapy and re-unification efforts with natural families now voluntary, less aggressively pursued, and more flexible provided, case aides (attendant care) added to program.<br><br>Recommendations:<br><br>**Establish maximum clarity of roles** between public and voluntary service providers, negotiate specific agreements prior to beginning of project, funders should require detailed written interagency agreements. Reliance of vague general agreements is not recommended.<br><br>**Keep case management and therapy roles separate.** Case management especially with mandates for child welfare planning is a big enough task without adding on therapeutic tasks.<br><br>**Voluntary agency staff can function as therapeutic providers**<br><br>**Provide consultative (not "therapeutic") relationship to foster parents** make them an active part of the team, provide support<br><br>All providers involved should **(1) establish precise definitions of interventions and time limits, (2) agree that interventions not be changed without team meeting** of all affected providers. | Good insights into the reality of implementing a TFC program. A majority of problems encountered revolved around the different values and goals held by project staff, case managers and Mental health therapists resulting in conflicts and power struggles.<br><br>Clearly there is a need to work in the same direction (reunification or not).<br><br>***Caution:*** The exclusion of therapists (and their predominant reunification agenda) appears more a result of differing agendas than a problem inherent in MH providers.<br><br>Article points to need to address specific services for kids NOT to be reunited with biological families. However, giving up on unification may also be premature if it is no longer high on the priority list. |

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| 28 | Wells & D'Angelo (1994) | **Qualitative Focus group Study of 40 foster parents' experience** of providing treatment and care for SED children.<br><br>Agency: private, nonprofit mental health agency | Interviews focused on experiences re. *(1) children's entry* into TFC: level of information and preparation granted to FC parents varies widely. Detailed information helpful, but often either unavailable, withheld or "sugar coated" for fear of rejection of the child by TFC parents<br><br>*(2) issues during TFC:* (a) Role of TFC parents is complex and dual role as "professional" and "parent" can be contradictory for instance in re. to emotional attachment and involvement (b) relationships with bio parents: TFC parents support or reject bio parents (usually mothers) based on their evaluation of mothers' motivation and ability to care for child. (c) Relationship with caseworkers: TFC parents feel they are the authorities on matters of the child vis a vis distant, uninterested, or overwhelmed caseworkers. Find themselves resenting not being involved in JJ hearings, or being accused of abuse. (d) relation with agency workers: valued support like information re. children, provision of resources for children, provision of respite care, provision of emotional support when children complain. (e) relation with foster children: feeling lonely and in doubt due to being overwhelmed after honeymoon period. (f) relation between biological and foster children: difficulties adjusting, responsibilities via a vis own children.<br><br>*(3) leaving TFC* : Level of preparation for move: abrupt moves impact parents and children more negatively. Smooth transitions often still involve emotional pains of letting go. | Being a TFC parent is a complex multifaceted, ambiguous and emergent role for which no underlying principle or metaphor could be found. The role is often contradictory, having control over some critical features with children but lacking control over others (timing of visits, removal etc.) Parents wished for more ongoing child-specific supervision and easy access to medical and other community services.<br><br>Different contexts of TFC include family, agencies, community and judicial areas. Between context, different views about child rearing can exacerbate tensions as might different goals held within different contexts. Discontinuities between contexts makes TFC experience frustrating<br><br>Current concepts of TFC as specialized tx provided by paraprofessionals (medical model) obscures the complex relationships between TFC parents to child and other systems. What impact on attachment has a FC mother's view of herself as "mother" or as "professional"<br><br>TFC research must take more holistic context-specific view to include compatibility of expectations and related issues. | Foster Parents' perspective |

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| Table D. | | | | SPECIAL FACTORS TO BE CONSIDERED IN TFC | |
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| 29 | Ownbey, Jones, Judkins, Everidge, & Timbers (2001) | FACTORS in TFC<br><br>***Special population: sexual behavior problems***<br><br>single subject designs Study of six children (3 male, 3 female), age 8-12, in TFC | "Intensive program": intermediate term foster care, professional family support, weekly home visits, crisis consultation, 24 hr phone consult, safety planning, twice monthly parent support groups, quarterly in-service.<br><br>Outcome variables: Frequency of symptom behaviors;<br><br>Propensity to re-offend if given opportunity (internalization of tx effects) | Wide variability between clients. Frequency of behaviors reduced quickly. However, estimated propensity to re-offend does not reduce nearly as quickly, remaining quite high after 24 months. | Very small sample, Instruments of data collection not validated/ reliability tested, baseline and some outcome data sources not triangulated (relying mostly on case worker reports |
| 30 | Fasulo, Cross, Mosley, & Leavey (2002)<br><br>Communities for People, MA | FACTORS in TFC:<br><br>***Study of Predictors and characteristics of Runaway Behaviors of youth (12-18)*** *in specialized foster care **in Child Welfare*** | ***Sample***: 147 adolescents (54% girls, 46% boys, 48% African-American, 31% Latino/a)<br><br>Examines characteristics and predictors of youth who ran either temporarily (less than 2 weeks) or permanently from FC placement, specifically examining ***variables:***<br><br>***Time of runaway, No. of runaways, Age, Gender, Ethnicity, amount of Therapy, Sex abuse history, Length of stay***<br><br>For a subsample of 23 permanent runaways: where did they run to? | <u>**44% of sample ran away at least once either temporarily or permanently**</u>. ***22% ran away permanently***. Compare to other outcomes: 19% reunified, 18% placed in more restrictive settings, 12% back to general FC , 12% into permanent setting (adoption/independence), 7% to less restrictive settings.<br><br>Two thirds (66%) began runaway within first six months. First runs often during spring or summer months.<br><br>32% of those who ran temporarily, also ran permanently (p=.041). (Subsample follow up of 23 permanent run-aways: 44% to bio families, 39% to friend, 17% to friend or family member in home community.)<br><br>Most significant predictor: <u>**Gender**</u>. Girls were 3 times more likely to run away than boys. Age 14-16 year olds made up 61.9 % of runaways, 29% of them permanently with the highest rate for 16 year olds, amount of therapy was negatively correlated even if length of stay was controlled for. | Calls attention to running away as common occurrence in TFC, and points to gender and age as important factors.<br><br>TFC program ill defined making comparisons to other TFC programs difficult. |
| 31 | Schwartz (2002) | FACTORS in TFC: | Empowerment based, solution-focused approach to parent education for TFC parents: | Takes issue with one-size-fits-all and deficit-oriented approach of "parenting classes." Less than 1% of parent education material has been field-tested with children or | Useful for training, in-service. Operationalizes strengths approach with TFC families |

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| | Family resilience Project, NM | ***Conceptual article*** on ***Family resilience and pragmatic family education*** with case illustration | Professional's expertise lies in eliciting parents' expertise<br><br>Suggests six step approach:<br>1) Setting a goal<br>2) Reviewing unsuccessful attempts to meet goal<br>3) Reviewing times of success in meeting goal that have gone unrecognized<br>4) Describe the difference<br>5) Refocus on what is already working<br>6) Practicing what has already worked, agree to do more of it. | revised prior to publication. The material targets "the generic parent" rather than the unique person. Involving parents in tailoring the goals for a program increases likelihood of attendance and positive outcomes<br><br>Suggests six-step, solution-focused individualized training (part of in-service for TFC families) that includes search for specific goals, exceptions to the problem, scaling, | |
| 32 | Thomlison (1991) | FACTORS in TFC:<br><br>***Conceptual*** article about ***Stability of Care and Family Continuity*** in TFC | ***Family continuity***: extent to which tx parents support children's personal history to provide sense of family continuity<br><br>***Stability of care***: attachment family commitment to provide stable relationship for children<br><br>Based on systems and attachment theories | Argues for TFC as an ideal tx modality for SED children to enhance family continuity and stability. Recommends policies and practices should ***view TFC as (1) and extension (not a substitute) of children's family and care process, (2) recognize abilities and resiliences of children, their biological and foster families, (3) increased focus on the responsibilities of all people in the child's eco system, (4) need for all persons to focus on child's strengths***.<br><br><u>Family continuity</u>: make tx family part of child's family system, promote policies and practices toward continuous involvement, be aware of needs for sense of belonging, family identity and self-identity, impact and conflicts with natural children of foster family, need to manage family reunions and separations, maintain family and personal history, life book etc.<br><br><u>Stability of care</u>: related to attachment theory, ability to form and maintain personal relationships, develop sense of identity and belonging, maximize bio family involvement. | Advocates systems and strengths approach to enhance continuity and stability of care in TFC. |
| 33 | McFadden, E.J. (1996) | ***Conceptual*** article | Based strongly on family systems theories drawing attention to | Based mostly on family systems theory, author recommends <u>for placement</u>: | Useful for training.<br><br>Links to some issues in Wells |

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| | | addressing need to ***work with foster families from family-centered perspective*** | • Impact of TFC on biological children,<br>• marital relations,<br>• intergenerational issues,<br>• life cycle,<br>• difficult multiplicity of TFC parent roles,<br>• loyalty issues,<br>• boundary issues,<br>• differing views on discipline,<br>• loss and grief upon child leaving, suggest "crisis" as a model to understand impact on FC family. | • Don't disrupt family status or roles of own children when placing TFC children<br>• Don't place aggressive of sexually acting out foster kids in families with potential victims<br>• Provide all relevant information about types of maltreatment that has occurred<br>• Inform of dangerous propensities (fire setting, etc.)<br>• Allow time between placements to regroup<br>• For practitioners working w/ FC family:<br>• Support time and energy being allocated for marital pair<br>• Understand sexualized behavior of children as way to get needs met<br>• Make sure parents' own children get needs met<br>• Be aware of possible abuse/neglect by Foster parents<br>• Be educated about systems surrounding FC family | & D'Angelo study.<br><br>Caution: Despite its claim to a family-centered perspective the article articulates mostly risks and problems re. TFC family. A strengths perspective, and cultural competence are mentioned only in passing. |
| 34 | Dore & Eisner (1993) | FACTORS in TFC<br><br>***Conceptual*** article suggesting five psycho-social ***dimensions of child functioning associated with placement stability*** and outcome in TFC | Suggests that in order to increase goodness-of-fit between children and treatment foster care, children's psychosocial functioning should be assessed as to<br>1) ability to tolerate intimacy<br>2) impulsivity<br>3) fear of rejection<br>4) aggression<br>5) self-esteem | Authors argue for more mental health knowledge in TFC process and outline typical dimensions of children's psycho-social characteristics (based on experiences in general foster care populations) to help assess whether and how children may be a good fit for TFC. | ***Useful for Selecting, Training and Support*** of parents; solid theoretical grounding of five psycho-social dimensions. However, ***no critical appraisal*** of the assumptions inherent in theories (such as the normative stance of developmental theories, and the pathology focus of psychodynamic theories). "Goodness of fit" is here reduced to child characteristics as though these children existed in a vacuum (much focus on "psychological" little on "social" dimension.) Little integration of biological factors, complete lack of strengths and resilience perspective. |