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# Issue Brief

## Community Living Exchange

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## Therapeutic Foster Care

Deborah Potter
Virginia Mulkern

This document was prepared by Deborah Potter and
Virginia Mulkern of the Human Services Research Institute

Prepared for:

Rutgers Center for
State Health Policy

Susan C. Reinhard & Marlene A. Walsh

Robert Mollica

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# THERAPEUTIC FOSTER CARE

*Deborah Potter*
*Virginia Mulkern*

## The TFC Model

Therapeutic Foster Care (also known as "treatment foster care" or TFC) has been heralded as the least restrictive and lowest cost alternative to institutional, residential or group treatment settings for children and adolescents with serious emotional disturbances. These and other advantages of the model have prompted states and other funders to include such programs in their portfolios. For example, TFC programs are flexible and capable of addressing a wide range of needs among individual children. In addition, since treatment is provided in what is considered the least restrictive environment, results can be generalized more readily to community-living. Furthermore, the increased use of TFC programs has been attributed to their inclusion as a key component of systems of care for children with serious emotional disturbances as well as their ability to meet the increasing mental health needs of children in regular foster care. Today TFC programs often are funded jointly by mental health and child welfare agencies.[1] (For a brief, but detailed, history of the early days of treatment foster care, the reader can consult various sources including www.ffta.org/history.html ; Bryant and Snodgrass, 1990).

Therapeutic foster programs vary quite a bit in terms of their "treatment approach, structure, intensity, type of training and support provided and amount of payment to foster care parents" (Research and Training Center for Children's Mental Health, 1986 as cited in Kutash and Rivera, 1996). Nonetheless, there are several common features across all of them. Children are placed with foster parents who receive intensive training to work with children with special needs. In addition, to the extensive pre-service training,

[1] Some TFC programs also target youth adjudicated as delinquent or at risk for delinquency and in these cases, the juvenile justice system may contribute funding to the program.

foster parents in TFC receive support and supervision throughout their tenure as foster parents. These parents tend to receive higher stipends than foster parents with children from regular foster care. Case managers tend to supervise relatively small caseloads and have ongoing and frequent contact with the foster families.

*Some of the most well-known TFC programs are:*

*People Places,*

*Kaleidoscope,*

*Professional Parenting, and*

*Pressley Ridge Youth Development Extension (PRYDE).*

There are many widely recognized programs which offer TFC. Some of the more prominent include People Places, Inc; Kaleidoscope Inc.; Professional Parenting; and Pressley Ridge Youth Development Extension (PRYDE). These examples reflect some of the differences among TFC programs and are consistent with the programs from which they originally evolved (e.g. residential treatment, special education/partial hospitalization center, group homes). For example, PRYDE (which emerged from a residential treatment center) now provides very intensive foster care services while others, such as Professional Parenting, are less structured but offer long-term placement. People Places and Professional Parenting are moderate sized, while PRYDE is a significantly larger program. Finally, some of these programs (e.g. PRYDE) also offer technical assistance and training for those wishing to implement their program model. Together, they demonstrate that the TFC treatment approach can be incorporated into a variety of organizational structures.

Some providers and researchers have developed culturally competent models of TFC. For example, the In-Care Network Inc in Montana has developed an intervention for Indian youth in therapeutic foster care. Interventions such as this build upon the cultural and historical traditions and strengths of particular communities. For example, in building upon the Native American tradition of extended kin (e.g. uncles and aunties) foster families become part of the American Indian child's extended family. Likewise, in coordinating case management for Indian youth, the Medicine Wheel is used as a framework to focus on the child's social, physical, mental, and emotional needs as they contribute to the child's spiritual development. (Materials relevant to the In-

Care program are included in the "Materials" section and also are available through the Georgetown University Child Development Center.)

*MTFC is a manualized approach that has been extensively documented.*

One manualized approach to TFC, developed by Patricia Chamberlain and her colleagues at the Oregon Social Learning Center (OSLC), has been extensively documented and studied within the evaluation literature. Because it has met various criteria for being an evidenced-based practice (e.g. the intervention is manualized; multiple outcome studies have been conducted including randomized trials; and fidelity issues have been investigated) and its adoption has been fairly widespread, this particular program will be described in greater detail.

The work by OSLC was influenced by the parent management training program developed earlier by Gerald Patterson (1982, 1985) which demonstrated that children's behavior could be significantly affected through working with parents. Beginning in 1983, OSLC used Patterson's approach to develop a particular model of TFC known as the Oregon Multidimensional Treatment Foster Care (MTFC) model and it has been cited as a leading evidenced-based practice identified by several leading policy-makers and analysts including: the DOJ's Blueprints for Violence Prevention Project, the state of California's Caring for Foster Youth Initiative and Barbara Burns and Kimberly Hoagwood in their compendium of EBPs for community-based interventions with youth (2002). MTFC has three core principles of practice: "(a) providing a supportive environment for MTFC parents, (b) creating and maintaining a reinforcing environment for youths, and (c) having clearly defined staff roles that promote client engagement and support" (Chamberlain, 2003: 69-70)

*MTFC is most frequently used to treat youth with chronic delinquency, conduct problems, SED, and other behavioral problems.*

MTFC has been used to target three distinct populations of children/adolescents who either are within foster care or eligible for foster placement: a) children and adolescents with chronic delinquency and conduct

problems who are referred by the juvenile justice system; b) adolescents with SED who most often are referred by state mental health agencies; and c) children (latency aged and pre-school) with identified behavioral problems who are often referred by the state child welfare agency.

The goals of the MTFC program are to provide youth with close supervision; to reinforce clear and consistent limits on behavior; to impose predictable consequences for misbehavior; to develop a close mentoring relationship with at least one adult; and to reduce association with delinquent peers. To accomplish these goals, youth typically are placed in a foster treatment family for 6 to 9 months, and multidimensional interventions are implemented in the foster home, at school, in the community, and with peers.

*The Treatment Team:*

*Foster parents,*

*Program supervisor,*

*Family therapist,*

*Skill trainer/ Youth therapist, and*

*Consulting psychiatrist.*

Although the foster parents are part of a treatment team (including a program supervisor, family therapist, skills trainer/individual youth therapist, and consulting psychiatrist), the foster parents assume the role of primary interventionists. They are trained in providing treatment to their foster children and clinicians offer support and consultation to the foster parents. Foster parents place clear and consistent limits on the youth's behavior; positively reinforce desired behavior and appropriately deliver consequences for inappropriate behavior through an individualized point system. Youth earn (or loose) points throughout the day based on their behaviors and receive daily feedback from the foster parent through the three-level point system. Foster parents document the youths' behaviors on the Parent Daily Report (PDR) Checklist. Throughout the program, the foster parents act as mentors for the child/adolescent. They are paid a monthly salary and, depending on the structure of the particular program, also may receive a modest stipend for expenses. Other participants in TFC include the child's teachers. Since the children attend public school, teachers document attendance and minimal performance standards (e.g. completing homework; timely arrival to class) on the "School Card" form which foster parents use in allocating daily points.

Case management and family therapy often are also delivered to the biological parents with the goal of reuniting the children with their biological family. Aftercare support, including an aftercare curriculum and manual entitled *Success Begins at Home*, is provided when the child and biological parents are reunited.

Several essential components of the MTFC program have been identified. The Core Components for Youth include: "daily structure and support, an individualized point system, a weekly individual treatment, consistent teaching-oriented nonphysical discipline, and psychiatric consultation and medication management as needed. The Core Components for Families include weekly family treatment with a strong skills focus, instruction in behavior management methods, frequent home visits with on-call and crisis backup, an aftercare parent group, and access to 24-hour, 7-day on-call staff contact. The Components for Foster Parents include daily telephone calls, support and training, and 24-hour, 7-day on-call staff availability and crisis intervention." (www.modelprograms.samhsa.gov/print.cfm?pkProgramid=77)

*MTFC has also been adapted to serve as an early intervention for preschool-aged children.*

Although the base model of MTFC remains the same across target populations, there are some differences worth noting for the third group mentioned above (infant and pre-school aged children). The Oregon Social Learning Center adapted its initial work on TFC to meet the specific needs of maltreated pre-school aged children (Fisher, Ellis, and Chamberlain, 1999). This program first screens children for developmental delays. If such delays are found, an activity-based curriculum is implemented to address those delays so that difficulties related to regulation of emotion (e.g. temper tantrums, suicidal ideation, or behaviors that are either self- destructive or damage property) are treated. In addition, since most of these younger children are reunited with their biological parents, the birth parents receive the same skill-based training as the foster parents.

## Summary of Evidence

While advances are being made, the literature on TFC contains a host of methodological problems (cf. Bates et al 1997; Curtis et al, 2001) which limit what we know about the effectiveness of TFC programs in general. These problems include: variability in TFC treatment modalities and programs; lack of standardization in treatment protocols; small sample sizes; retrospective data collection; lack of standardized measures; and questions about the appropriateness of outcome measures. The evidence examining the effectiveness of TFC has relied largely on internal formative evaluations of a single program's operations which focus on single populations. Yet while a growing body of research has gone beyond descriptive studies to incorporate more comparative designs, only a handful of quasi-experiments with random assignment to TFC or other interventions have been conducted to date (and focus largely on OSLC's MTFC model). For example, four studies evaluating the MTFC program have used randomized trials (several others are underway). These more rigorous studies have examined particular populations within MTFC over time and in comparison to other treatment modalities. Therefore, advocates of TFC often point to results from the MTFC program since it has been studied more extensively and with more rigorous designs.

Longitudinal data indicate that there are a host of benefits both for the children and for the foster parents who participate in Therapeutic Foster Care programs.

### ➢ Benefits for Children

An early meta-analysis of 40 articles on TFC (Reddy and Pfeiffer, 1997) offered some support for TFC, although the lack of rigor and inconsistent outcomes investigated in the peer-reviewed articles limited their conclusions. Results of the meta-analysis demonstrated:

- Large positive effects (14 out of 18 articles) on placement permanency (i.e. youth remaining in the same placemen);
- Positive outcomes in improving children's social skills;

- Medium outcomes in discharge to a less restrictive setting (demonstrated in 6 out of 10 studies); and
- Moderate outcomes (i.e. in 6 out of 11 studies) investigating reduction in the children's behavior problems.

The meta-analysis, however, did not differentiate between TFC programs serving different populations of youth (e.g. juvenile justice vs. social welfare referrals). Therefore, the degree to which these results are generalizable across the full range TFC programs remains an empirical one.

In addition, there appears to be a greater body of evidence of TFC for the juvenile justice population, perhaps due to the initial use of the model with this population[2]. Yet there appear to be consistent patterns in the outcomes reported across the populations served. For example, early naturalistic evaluations of individual TFC programs generally supported consistent benefits for foster children referred from mental health settings (e.g. as reported in Hudson, Nutter, and Galaway, 1994; Reddy and Pfeiffer, 1997). Similar results have been reported in the experimental designs used by Chamberlain and colleagues at OSLC, both with juvenile justice and mental health referral sources. Benefits of TFC most often cited, include:

- More rapid improvement in children's behavior (mental health population reported in Chamberlain and Reid, 1991),
- Decreased levels of aggressive and/or delinquent behavior (juvenile justice population reported in Chamberlain and Reid, 1998), and
- Better post-discharge outcomes (Chamberlain and Reid, 1991).
- In fact, the effectiveness of TFC has largely been assessed by the degree to which the youth have been discharged to a less restrictive setting (Bates et al 1997).

[2] OSLC, for example first used TFC in 1983 as an alternative to residential and group care placement for serious and chronic juvenile offenders. A short while later, in 1986, the model was adapted to youth with serious emotional and behavioral disorders.

- In addition, there is the suggestion that TFC increases placement stability for the foster children and to increase the likelihood that a placement is a permanent one (Staff and Fein, 1995).

*The more rigorous study designs show positive effects for children in TFC programs.*

The more rigorous study designs (i.e. randomized trials) indicate that positive effects exist for children referred from among the various child-serving systems that use TFC (i.e. mental health, child welfare, and juvenile justice). The OSLC investigators have made substantial contributions using these study designs with youth involved in the mental health and in juvenile justice systems. In terms of the juvenile justice population, delinquent males (aged 14 to 17) randomly assigned either to TFC or to Group Care (Chamberlain and Reid, 1998), were found to differ along two dimensions of treatment intensity. Those youth in the TFC program spent a greater amount of time with an adult mentor and less time with delinquent peers, in comparison to youth in Group Care. Furthermore, at one year follow-up among delinquent males, TFC was shown to be more effective at reducing juvenile delinquency than was group care (Fisher and Chamberlain, 2001). Subsequent follow-ups demonstrated greater likelihood of being employed in the "legal workforce" (i.e. not participating in illegal activities for pay), and reports of more positive relationships with parents. Risky behaviors (including both unprotected sexual encounters and drug use) were less likely among youth who had been in TFC than group care.

The MTFC model also has produced demonstrated benefits for youth being released from state psychiatric hospitals (Chamberlain and Reid, 1991) when compared to a control group. Those receiving TFC were placed into care more quickly than the controls (thereby minimizing residential costs) and remained in the community slightly longer than the control group.

These studies have begun to document the range of outcomes among different populations of youth in TFC. Yet there is a recognized need to more finely tune our understanding of the populations for which and the conditions under

which TFC "works." For example, OSLC has begun reporting on outcomes for female juvenile offenders in TFC.

Meanwhile, a randomized study of an early intervention model (Fisher et al, 2000), focusing specifically on infants in TFC also has demonstrated benefits over those found among infants in regular foster care and among community-dwelling preschoolers.

**➢ Benefits for Parents**

Research has shown that Therapeutic Foster Care can increase the retention of foster parents if they gain greater competency through the training and support they receive (Jivangee, 1999b; Redding, Fried, and Britner, 2000). They also report lower levels of stress. Early intervention foster parents, for example, adopted and retained the parenting strategies presented in the program and they reported less stress than did participants in regular foster care (Risher et al, 2000).

**➢ Policy & Implementation Concerns**

Therapeutic Foster Care can be a component in a variety of publicly-sponsored programs and therefore various policy concerns exist. One over-riding concern is the level of involvement permitted and/or expected from the biological parents, especially given the pivotal role that parents and other caregivers play in systems of care and the growth of the family advocacy movement. In programs where children are removed from the home due to concerns over suspected abuse/neglect, the level of parental involvement may be limited. Likewise for parents who experience serious mental illness or substance abuse, contact with their children may be more closely monitored or may be conditional upon receiving treatment. Nonetheless, the goal of all these programs may be to eventually reunite families where feasible and appropriate.

*TFC programs need to consider what role biological parents will play.*

Therefore, public agency officials will want to consider the growing body of literature which examines the factors contributing to successful parental participation in TFC. Parental participation can involve various activities including participating in on-going communication with the treatment team (including foster parents), engaging in active decision-making about their children's care, and maintaining on-going contact with their children when they are living in foster care.

Research suggests that professional clinicians and foster parents can play a significant role in facilitating parental involvement (Jivanjee, 1999a). Providers who valued the birth parents' strengths, were empathetic, and shared information in an effort to build positive relationships were more successful in supporting family involvement. Other attitudes (e.g. fear or dislike of the parents) along with organizational barriers such as limited training, competing time demands on the providers, and conflicting program philosophy were obstacles to parental participation. From the parents' viewpoints, similar strengths and weaknesses characterize their relationship with foster parents in TFC (Jivanjee, 1999b). Parents valued information sharing and trust from the TFC providers and also identified the willingness to facilitate in-person contact with their child as important characteristics of a TFC program. Biological parents (Jivanjee, Sieverin-Held, and Siepmann, 1999) also have a need for accurate information about their children's mental health, including specific details about the diagnosis and treatment strategies presented in language that is tailored to their individual ability to understand. On the other hand, biological parents identified unique barriers which limited their ability to be involved in an ongoing way with their children, including difficulty securing transportation, inconvenient meeting times, and other constraints placed on them by the providers.

## Costs of TFC

TFC is less expensive than institutional, residential or group treatment settings. Earlier studies reported that over 90% of TFC programs had costs that were lower than those for other types of residential placement (i.e. group homes or institutions, see Bryant, Simmens and McKee, 1989). A little over a decade ago, costs for TFC programs ranged between $35 and $150 per child per day, depending upon program structure (Meadowcroft and Luster, 1990). Although considered to be typically the least expensive service among residential services for children with serious emotional disturbances, the actual costs of implementing a TFC program vary depending upon the level of payments made to the foster parents, the amount of training (especially follow-up training) provided, and the depth of reporting and subsequent monitoring conducted by the funding agency.

*TFC programs are less costly because they rely on foster parents to implement treatment.*

Costs are relatively contained because TFC relies primarily on the foster parents to implement treatment plans and minimizes the use of professional staff. In considering costs incurred by a TFC program, it also is important to note that TFC has been shown to reduce reliance on more costly treatment both as the children are receiving TFC and after. For these reasons, the TFC model is a viable one to consider as states continue to face staffing shortages in both their mental health and child welfare systems.

Costs saved will vary with the population in which a TFC program is implemented, whether it be youth with serious emotional disturbances within the mental health system, or youth with behavioral problems in the justice system. For example, TFC has the potential for moving children in residential treatment off waiting lists and into the community at a faster rate than other forms of care (Chamberlain, Ray and Moore, 1996). Other evaluations, of TFC programs serving youth within the justice system, have demonstrated that participating youth have fewer subsequent arrests and incarcerations (Chamberlain and Reid, 1998). Analysts have documented costs-saved with delinquent youth. Analysts at the Washington State Institute for Public Policy

at Evergreen State College, for example, investigated the potential cost savings for a number of interventions for youth in the juvenile justice system (Aos, Barnoski and Lieb, 1998). Although they estimated the cost of the program to be approximately $3,941 per participant, the criminal costs avoided per participant were $9,757 – a cost savings of $5,815. If the unrealized costs associated with subsequent crime victims were added to this amount, the total cost savings per participant almost tripled to $17,575. Meanwhile, Chamberlain and colleagues have estimated higher savings of $122,000 over two years due to decreases in incarceration rates (Chamberlain, 1990; Chamberlain, 2003: 51)

## Training Requirements

While individual TFC programs vary in content, all place a strong emphasis on sustained training for both foster parents and the program staff who will work with them.

Pre-service training for parents ranges from 10 to 30 hours (across several weekends) and is conducted by two or more team-based trainers. Candidates for foster care parenting are expected to attend all sessions offered and to pass the program's qualifying requirements at the end of the period. This initial contact between the program and the prospective foster parents permits the program to assess the family's relative strengths and weaknesses and thereby facilitates the program's ability to match foster parents with youth. In addition, the training can serve as a "reality check" for the parents and then provide them with the necessary tools, skills, and resources should they decide to take on the responsibility of fostering a child. Trainings typically emphasize concrete skills (the "how-to's") and cover the following topics:

- History of the Agency and program
- Description of the children and their needs
- Roles of the Foster Families
- Responsibilities of the Foster Families

- ✓ Contract with the TFC program
- ✓ Intervention: How to define a problem behavior, how to identify antecedent conditions that contribute to the behavior, how to change behavior
- ✓ Skills development: communication; negotiation, problem solving
- ✓ Recording behaviors
- ✓ Maintaining records
- ✓ Involving Birth Families (in the child's care and through home visits)

- Resources for Support
- Stress Management
- Emergency and Crisis policies (e.g. respite care; team interventions; hospitalization)
- Payment and Reimbursement policies

Once foster parents enter the program, they are expected to participate in on-going in-service training offered by the program. In-service training requirements differ across programs and range from four to 20 hours per year of training. Completion of training requirements often is tied to modest increases in per diem rates when the foster parent's performance is reviewed and their contract renewed.

Each of the program staff also receives on-going supervision and training. Depending on the particular program model of TFC, a general orientation to the program is supplemented with various forms of training including in-service training, graduate school classes, or other professional development activities. Program staff, when newly hired, first attend an orientation which, in a more condensed format, parallels topics covered in the pre-service session for parents:

- Roles of the treatment team members
- Division of responsibilities among the treatment team
  - ✓ Home Studies of prospective foster parents
  - ✓ Matching children and treatment families
  - ✓ Treatment planning
  - ✓ Integrating and coordinating treatment

- ✓ Documenting treatment
- ✓ Home Consultation/ Visits
- ✓ Aftercare (if/when the child is reunited with the biological family)
- ✓ Reporting
- ✓ Program Evaluation

- Support for the team
- Reporting requirements
- Stress Management

Program staff then are expected to attend the pre-service training for parents and may progress to teach that session. Larger programs tend to offer regularly scheduled, formal in-service workshops with printed materials while smaller programs are less formal in how they provide support to their staff. In either case, on-going training is central to maintaining the quality and involvement of TFC staff.

## Implementing TFC

In implementing a TFC program, there are issues that both the state (as a funder) and an agency (as a program site) should consider.

### ➢ Considerations at the State Level

The state should address which type of TFC program the state might sponsor. States might want to weigh the following dimensions:

- Which particular model of TFC fills an existing service gap? In terms of length of residence? Intensity and formality of the particular program? Target population?
- How will states fund the TFC program envisioned? A variety of sources have been used to fund successful TFC programs. Typically, several sources are used in a TFC program. Some sources (e.g. Medicaid) are controlled by the state while others must be funneled directly through the TFC program itself (e.g. foundation grants). The type of TFC program the state will fund will be one factor affecting the range of potential funding sources available. For example, In-Care (the TFC program serving American Indian youth) uses funding from Medicaid, state funds, federal Title IV-E funds, Bureau of Indian Affairs, Tribal funds and

foundation grants. Faith-based organizations and foundations are other potential sources of funding for TFC programs. In addition, federal funding may be appropriate for programs conducting demonstration projects or evaluation studies of interest to a sponsoring agency.

- Which program best fits with the culture of the funding authority? For example, which program has the potential for adhering to state guidelines and policies? Which program best matches the existing state requirements for credentialing or certification of foster parents?
- Which program can provide useful data for program monitoring and outcomes analysis?
- If the state is focusing on evidenced-based practices, which of several existing models best fits the state's portfolio of EBPs?

In implementing TFC, existing standards of care are available (FFTA, 1995) which can be used by the state. Other practical issues that should be addressed include the timeframe for developing the new program and necessary programmatic support (e.g. TA; and monitoring).

**➢ Considerations at the Agency Level**

There are some issues which, regardless of the content of the new program, an agency should consider when implementing a new program:

- First the agency should develop a clear plan for the new program, with a timeline for program development and implementation.
- Furthermore, in obtaining staff buy-in, agency leaders might investigate potential barriers agency staff may have due to different (and contradictory) theoretical perspectives which are at odds with the underlying basis of the TFC program to be implemented.

Other implementation issues will present particular challenges to agencies due to the unique nature of TFC programs:

- Multi-modal treatment In several models of TFC (such as in MTFC), the program itself provides (or oversees) all elements of treatment including individual, family, and substance abuse treatment. Some agencies which lack experience across the breadth of interventions may be particularly challenged in implementing such complex programs. Similarly, agencies experienced only in outpatient settings may be challenged by the multiple settings incorporated within TFC. Agencies pondering whether or not to

pursue TFC programming should address such issues at the outset.

- Strain on the agency due to intensity of the program Intensive consultation in TFC programs may also present challenges to a typical agency's operations, given the reality of high caseloads and frequent staff turnover.

- Staffing issues are highly salient in TFC programs and the successful resolution of these issues is vital to the program's success.
    - ✓ Given the team-based format of TFC, clearly defined roles are necessary for all staff. Key functions and staff roles should be well defined, differentiated, and coordinated.
    - ✓ Retention of staff is a challenge given the relatively low pay but high personal demands extracted for those in direct service positions.
    - ✓ TFC programs have found that when staff are encouraged to be creative, and act autonomously within the boundaries of their job description, then their burn out is reduced. Such autonomy is consistent with addressing the highly individualized needs presented by the youth.
    - ✓ Recognition of each staff –members' contribution (e.g. through formal awards and ceremonies) likewise minimizes burn out and fosters camaraderie.
    - ✓ In TCF, the team approach is bolstered when management (supervisors) reflects the same cooperative, on-call ethos which other staff members exhibit.

- Retention of foster-parents Even with intensive support and on-going training, turnover among foster parents in TFC programs tends to be higher than in regular foster care. Several factors can increase the likelihood of retaining valuable and trained foster parents in these demanding programs.
    - ✓ First, recruitment of foster parents should be well-timed. Foster parents who are enrolled without referrals tend to loose interest.
    - ✓ Second, retention of program staff (supervisors, especially) tends to contribute to sustained involvement of foster parents.
    - ✓ Third, opportunities for networking among foster parents should be encouraged (e.g. at in-service workshops).

➢ **Resources Needed for Implementation**

While fewer resources are required to implement TCF programs than other residential programs (due to minimal capital investment), an intensive start-up phase is needed to prepare the agency and the community. Experts (Meadowcroft and Luster, 1990) estimate that the start-up phase for a TCF program can vary between 3 and 24 months depending upon the particular barriers encountered in 5 areas: creating a receptive political climate for the program; defining which TCF model will be used; defining the client population; recruiting appropriate and dedicated foster parents; and hiring sufficient staff.

Regardless of the particular model of TCF program that is being implemented, an agency will typically follow these steps if they are consulting with trainers/developers of a particular TCF model:

1. First, interested agencies assess their "organization's readiness" to adopt a new program. During this step, both the agency's strengths and likely barriers to program implementation are identified.
2. If there are not sufficient staff in the existing agency to support the new TCF program, additional, qualified staff will be hired. Based on recent state-based RFPs, a TFC program serving 12 youth might include the following program staff:
    a. A full-time program supervisor;
    b. A full-time foster parent recruiter who also monitors reporting by the foster parents;
    c. A half-time Master's level youth therapist;
    d. A half-time family therapist;
    e. An hourly skills trainer (10-12 hours weekly per 10-12 youth); and
    f. A consulting psychiatrist
3. A core team of staff members (including at a minimum an administrator, a program supervisor, family and individual therapists, and a foster parent trainer/recruiter) are identified and participate in a multi-day training about TFC and related skills (e.g. particular methods of therapy). Obtaining "buy-in" from these key members is critical for the program's success.
4. Foster parents are recruited, trained, certified, and matched with referrals.

5. Agencies and parents access the reporting system they will be using to track the behavior of the foster child.
6. On-site support is offered to agency staff by the TFC developers.
7. TFC trainers in the agency review the data reported by parents as a way to monitor program performance (as well as to obtain outcome data).
8. Agency staff telephone foster parents daily.
9. The program's developers conduct weekly telephone conferences with agency staff to address any implementation issues.
10. The program developers may review videotapes of meetings held with foster parents and the clinical staff to provide additional feedback and to monitor fidelity to the program's design.
11. Program developers also conduct on-site training during the first year of the program's operation at the agency. As the agency gains experience in the TCF program, they may take on training responsibilities.
12. Program monitoring, evaluation, and revision are necessary activities to document program successes and challenges. If the program decides to institute CQI procedures from the outset, then these activities are viewed as central to their operations. Data generated can be used in program management as well as in seeking sustained funding for the program.

## Materials

The following training materials for TFC program staff and for foster parents are available either for purchase or free of charge, as noted. Complete mailing addresses and telephone numbers are provided in the "Other Resources" section.

**➢ Materials for Training Program Staff and Administrators**

***Standards Review Instrument*** from the Foster Family-Based Treatment Association (1995) (available for purchase from www.ffta.org/products.html)

***Materials from MTFC*** (available through TC Consultants as part of MTFC training, see www.mtfc.com )

i. Parent Daily Report (PDF) Checklist
ii. Supervision Expectations for Home Visits
iii. School Card

iv. *Success Begins at Home* Curriculum Guide (Antoine and Chamberlain, 1995)

***Materials from People's Place Inc.*** in Staughton, VA (available for purchase through www.peopleplaces.org/component.htm)

i. ABC's of In-Home Problem Solving (2 videos, A User's Workbook and a Reference Manual)
ii. Staff Manual
iii. Staff Training Outline
iv. Teaching Parent Handbook (hardcopy and diskette)

➢ **Materials for Training Foster Parents**

***Materials from MTFC*** (available through TC Consultants as part of MTFC training, see www.mtfc.com)

i. Parent Daily Report (PDF) Checklist
ii. Supervision Expectations for Home Visits
iii. School Card
iv. *Success Begins at Home* Curriculum Guide (Antoine and Chamberlain, 1995)

***Materials from other TFC Programs:***

i. AFCR (American Foster Care Resources)

- Therapeutic Foster Care: An In-Service Training Program for Foster Families (Workbook and Trainer's Guide) (available for purchase through www.afcr.com )

ii. People Places, Inc. in Staunton, VA (available for purchase through www.peopleplaces.org/products.htm)

- Teaching Parent Handbook (hardcopy and diskette)
- Parenting Skills Training (PST) curriculum (Includes trainer's manual and participant manual)

iii. PRYDE (available as part of training though Pressley Ridge www.pressleyridge.org/training/training.html)

- PRYDE Pre-Service

iv. In-Care Program (a culturally-sensitive program for American Indian youth)

- In-Care Parent Observation Form (available through the Georgetown University Child Development Center)
- Videotape and Training Manual for Social Workers and Foster Parents (available for purchase directly from In-Care in Billings, MT: www.incarenetwork.com/products.html)

➤ **Available Implementation Materials**

The remainder of this section details specific materials which states and agencies could use to implement various models of TFC:

***Standards Review Instrument*** from the Foster Family-Based Treatment Association (FFTA, 1995) (available for purchase from www.ffta.org/products.html )

***Materials from In-Care*** (available through the Georgetown University Child Development Center: www.gucchd.georgetown.edu )

- In-Care Network Initial Referral Information Form
- In-Care Network Referral Criteria Checklist
- In care- Therapist Quarterly Report Form
- In-Care Treatment Manager Monthly Progress Note form
- In-Care Network (ICN) Treatment Family Report form

***Material from People Places, Inc.*** (available for purchase through www.peopleplaces.org/products.htm)

- Program Development Manual (hardcopy and diskette)
- Staff Policy and Procedure Manual (hardcopy and diskette)

## Key Articles & Other Sources

➤ **Peer reviewed articles**

The following are key sources (peer-reviewed journal articles, books, book chapters, and policy briefs) on Therapeutic Foster Care.

Bates, Brady C, Diana J. English, and Sophia Kouidou-Giles. 1997. "Residential treatment and its alternatives: A review of the literature." Child and Youth Care Forum, vol. 26(1): 7-51.

Chamberlain, Patricia, and John B. Reid. 1991. "Using a specialized foster care community treatment model for children and adolescents leaving the

state mental hospital." Journal of Community Psychology, vol. 19: 266-276.

Chamberlain, Patricia, and John B. Reid. 1998. "Comparison of two community alternatives to incarceration for chronic juvenile offenders." Journal of Consulting and Clinical Psychology, vol. 66(4): 624-633.

Chamberlain, Patricia., J. Ray, and KM Moore. 1996. "Characteristics of residential care for adolescent offenders: A comparison of assumptions and practices in two models." Journal of Child and Family Studies, vol. 5: 259-271.

Curtis, Patrick A., Gina Alexander, and Lisa A. Lunghofer. 2001. "A literature review comparing the outcomes of residential group care and therapeutic foster care." Child and Adolescent Social Work Journal, vol. 18(5): 377-392.

Eddy, J. Mark and Patricia Chamberlain. 2000. "Family management and deviant peer association as mediators of the impact of treatment condition on youth antisocial behavior." Journal of Consulting and Clinical Psychology, vol. 68(5): 857-863.

Evans, Mary E. and Mary I. Armstrong. 1994. "Development and evaluation of treatment foster care and family-centered intensive case management." Journal of Emotional and Behavioral Disorders, vol. 2(4): 228-239.

Farmer, Elizabeth M., Barbara J. Burns, Melanie S Dubs, and Shealy Thompson. 2002. "Assessing the conformity to standards for treatment foster care." Journal of Emotional and Behavioral Disorders, vol. 10 (4): 213-222.

Fisher, Philip A., Megan R. Gunnar, Patricia Chamberlain, and John B. Reid. 2000. "Preventive intervention for maltreated preschool children: Impact on children's behavior, neuroendocrine activity, and foster parent functioning." Journal of the American Academy of Child and Adolescent Psychiatry, vol. 39(11): 1356-1364.

Fisher, Phillip A., and Patricia Chamberlain. 2001. "Multidimensional Treatment Foster Care: A program for intensive parenting, family support, and skill building." Journal of Emotional and Behavioral Disorders, vol. 8 (3): 155-164.

Fisher, Phillip A., B. Heidi Ellis and Patricia Chamberlain. 1999. "Early intervention foster care: A model for preventing risk in young children who have been maltreated." Children's Services: Social Policy, Research, and Practice, vol. 2 (3): 159-182.

Henggeler, Scott W. and Ashli J. Sheidow. 2003. "Conduct disorder and delinquency." Journal of Marital and Family Therapy, vol. 29(4): 505-522.

Hudson, Joe, Richard W. Nutter, and Burt Galaway. 1994. "Treatment foster care programs: A review of evaluation research and suggested directions." Social Work Research, vol. 18(4): 198-210.

James, Sigrid and William Meezan. 2002. "Refining the evaluation of treatment foster care." Families in Society: The Journal of Contemporary Human Services, vol. 83(3): 233- 244.

Jivanjee, Pauline. 1999a. "Professional and provider perspectives on family involvement in Therapeutic Foster Care." Journal of Child and Family Studies, vol. 8(3): 329-341.

Jivanjee, Pauline. 1999b. "Parent perspectives on family involvement in Therapeutic Foster Care." Journal of Child and Family Studies, vol. 8(4): 451-461.

Meadowcroft, Pamela, Barbara Thomlison, and Patricia Chamberlain. 1994. "Treatment foster care services: A research agenda for child welfare." Child Welfare, vol. 73(5): 565+.

Redding, R., C. Fried., and P. Britner. 2000. "Predictors of placement outcomes in treatment foster care: Implications for foster parent selection and service delivery." Journal of Child and Family Studies, vol. 9: 425-447.

Reddy, Linda A and Steven I. Pfeiffer. 1997. "Effectiveness of treatment foster care with children and adolescents: A review of outcome studies." Journal of the American Academy of Child and Adolescent Psychiatry, vol. 36(5): 581-588.

Smith, Dana K. 2004. "Risk, reinforcement, retention in treatment, and re-offending for boys and girls in Multidimensional Treatment Foster Care." Journal of Emotional and Behavioral Disorders, vol. 12 (1): 38-48.

Smith, Dana K., Elizabeth Stormshak, Patricia Chamberlain, and Rachel Bridges Whaley. 2001. "Placement disruption in treatment foster care." Journal of Emotional and Behavioral Disorders, vol. 9 (3): 200-205.

Staff, I. and E. Fein. 1995. "Stability and change: initial findings in a study of treatment foster care placements." Children and Youth Services Review, vol. 17: 379-389.

➢ **Books**

Burns, Barbara J. and Kimberly Hoagwood. 2002. "Community Treatment for Youth: Evidence-based Interventions for Severe Emotional and Behavioral Disorders. NY: Oxford University Press.

Chamberlain, Patricia. 1998. Family Connections: A Treatment Foster Care Model for Adolescents with Delinquency. Eugene Oregon: Northwest Media Inc.

Chamberlain, Patricia. 2003. Treating Chronic Juvenile Offenders: Advances Made Through the Oregon Multidimensional Foster Care Model. Washington DC: American Psychological Association.

Kutash, Krista and Vestena Robbins Rivera. 1996. What Works in Children's Mental Health Services? Uncovering Answers to Critical Questions. Baltimore: Paul H Brookes Publishing Co.

Meadowcroft, Pamela and Barbara A. Trout (Eds.). 1990. Troubled Youth in Treatment Homes: A Handbook of Therapeutic Foster Care. Washington DC: Child Welfare League of America.

Patterson, George R. 1982. Coercive Family Process. Eugene, OR: Castalia Publishing Company.

➢ **Book Chapters**

Byrant, B., F. Simmens, and M. McKee. 1989. "Doing it in public: A review of foster family treatment program development in Missouri." In J. Hudson and B. Galaway (Eds.), Specialist Foster Family Care: A Normalizing Experience. NY: Haworth Press: pp.159-175.

Bryant, Brad and Robert D. Snodgrass. 1990. "Therapeutic foster care: past and present." In Pamela Meadowcroft and Barbara A Trout (Eds.), Troubled Youth in Treatment Homes: A Handbook of Therapeutic Foster Care. Washington DC: Child Welfare League of America: pp 1-20.

Chamberlain, Patricia. 1996. "Intensified foster care: Multi-level treatment for adolescents with conduct disorders in out-of-home care." In E.D. Hibbs and O. P. Jensen (Eds.), Psychosocial Treatments for Child and Adolescent Disorders: Empirically-Based Strategies for Clinical Practice. Washington, DC: American Psychological Association: pp 475-496.

Meadowcroft, Pamela and William Clark Luster. 2003." Realizing the potential of Therapeutic Foster Care." In Pamela Meadowcroft and Barbara A. Trout (Eds.), Troubled Youth in Treatment Homes: A Handbook of Therapeutic Foster Care. Washington DC: Child Welfare League of America: pp 183-200.

Patterson, George R. 1985. "Beyond technology: The next stage in development of a parent training technology." In L'Abate (Ed.), Handbook of Family Psychology and Therapy, vol. 2. Homewood, IL: The Dorsey Press, pages 1344-1379.

➢ **Policy Briefs & Newsletters**

Aos, Steve, Robert Barnoski, and Roxanne Lieb. 1998. "Watching the bottom line: Cost-effective interventions for reducing crime in Washington." January policy brief. Washington State Institute for Public Policy, Evergreen College.

Jivanjee, Pauline, Dana Sieverin-Held, and Julie Siepmann. 1999. "Family participation in Therapeutic Foster Care: Multiple Perspectives." A Final

Report on a Study of Families and Therapeutic Foster Parents as Partners. Available on www.rtc.pdx.edu/pgPubsViewAll.php.

Research and Training Center for Children's Mental Health, Florida Mental Health Institute. 1986. "Therapeutic foster care." Update, vol. 2(1): 8-10.

## Other Resources

Those interested in obtaining further information on Therapeutic Foster Care are directed to the following sources.

**➤ General Resources**

www.ffta.org

***Foster Family-Based Treatment Association***
294 Union Street
Hackensack, NJ 07601
Office phone: 800-414-3382

www.afcr.com

***American Foster Care Resources Inc.***
PO Box 271
King George, VA 22485
Office phone: 540-775-7410

gucchd.georgetown.edu

***Georgetown University Child Development Center***
3307 M Street, NW
Suite 401
Washington, D.C. 20007
Telephone: 202-687-5000
Fax: 202-687-8899

**➤ TFC Programs & Trainers**

www.incarenetwork.com

***In Care Network***
2906 North Second Avenue
Billings, MT
Telephone: 406-259-9616
FAX: 406-259-5129
E-mail: Wsnell@incarenetwork.com

www.mtfc.com

***TFC Consultants, Inc.*** (the official Multidimensional Treatment Foster Care (MTFC) web site)

Contact: Gerard Bouwman
1163 Olive St.
Eugene, OR 97401
Office phone: 541-343-2388
Fax: 541-343-2764

www.oslc.org

***Oregon Social Learning Center Community Programs***
Patricia Chamberlain, PhD
1160 East Fourth Avenue, Eugene, OR 97401
Telephone: 541-485-2711
Fax: 541-485-7087
E-mail: pattic@oslc.org

www.peopleplaces.org

***People Places***
1215 N Augusta St.
Staunton, VA 24401
Telephone: 540- 885-8841

www.pressleyridge.org

***Pressley Ridge (PRYDE)***
Administrative Offices
530 Marshall Avenue
Pittsburgh, PA 15214
Telephone: 412-321-6995
Fax: 412-321-5313