Evidence-Based Practice in Foster Parent Training and Support: Implications for Treatment Foster Care Providers

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Executive Summary

The report on evidence-based practice in foster parent training and support is based on a comprehensive review of empirical literature conducted between May 20, 2008 and August 15, 2008 by the Center for Advanced Studies in Child Welfare (CASCW) at the University of Minnesota's School of Social Work. The report was developed under the auspices of Federal Title IV-E Funding, the Center for Advanced Studies in Child Welfare, and the Foster Family-Based Treatment Association (FFTA) as part of the Technical Assistance to FFTA Project. The executive summary of this report highlights the key findings and discusses potential practice implications for treatment foster care agencies interested in implementing research-based practices of foster parent training and support. The complete findings are presented in the full text of the report, which includes a comprehensive review of literature and annotated bibliography of pertinent research. A Quick Reference Guide, which provides key findings and empirically-based relationships among evidence-based practices in foster parent training and support, and key child welfare outcomes, accompanies this report (see Appendix I).

Foster Parent Training

The following models of foster parent training were reviewed in this report:

Model	Empirical Literature
Pre-service Training Models	
NOVA	Pasztor, 1985
Parent Resources for Information, Development, and Education (PRIDE)	Christenson & McMurty, 2007
Parenting Models	
1-2-3 Magic	Bradley et al., 2003
Behaviorally-Oriented Training	Boyd & Remy, 1978, 1979; Van Camp et al., 2008
Cognitive-Behavioral Therapy (CBT)	Macdonald & Turner, 2005
Foster Parent Skills Training Program (FPSTP)	Brown, 1980; Guerney, 1977; Guerney & Wolfgang, 1981
Incredible Years (IY)	Baydar, Reid, & Webster-Stratton, 2003; Gardner, Burton, & Klimes, 2006; Linares et al., 2006; Reid, Webster-Stratton, & Baydar, 2004; Reid, Webster-Stratton & Beauchaine, 2001; Webster-Stratton, 2000
Keeping Foster Parents Trained and Supported (KEEP)	Chamberlain, Price, & Laurent et al., 2008; Chamberlain, Price, & Reid et al., 2008; Price et al, 2008
Model Approach to Partnerships in Parenting (MAPP)	Lee & Holland, 1991; Puddy & Jackson, 2003; Rhodes, Orme, Cox, & Buehler, 2003
Multidimensional Treatment Foster Care (MTFC)	Chamberlain, Leve, & DeGarmo, 2007; Chamberlain & Moore, 1998; Chamberlain & Reid, 1998; Eddy, Bridges Whaley, & Chamberlain, 2004; Eddy & Chamberlain, 2000; Eddy, Whaley, & Chamberlain, 2004; Harmon, 2005; Kyhle, Hansson, & Vinnerljung, 2007; Leve & Chamberlain, 2005; Leve & Chamberlain, 2007; Leve et al., 2005
Multidimensional Treatment Foster Care-Preschool (MTFC-P)	Fisher, Burraston, & Pears, 2005; Fisher et al., 2000; Fisher & Kim, 2007
NTU	Gregory & Phillips, 1996
Nurturing Parenting Program NPP	Cowen, 2001; Devall, 2004
Parent-Child Interaction Therapy (PCIT)	Bagner & Eyberg, 2007; McNeil, Herschell, Gurwitch, & Clemens-Mowrer, 2005; Nixon, Sweeney, Erickson, & Touyz, 2003; Shuhman et al., 1998; Timmer et al., 2006; Thomas & Zimmer-Gembeck, 2007
Parenting Wisely (PAW)	Kacir & Gordon, 1999; O'Neil & Woodward, 2002; Segal et al., 2003

Positive Parenting Program (PPP)	Bor, Sanders, & Markie-Dadds, 2002; Leung, Sanders, Leung, Mak, & Lau, 2003; Martin & Sanders, 2003; Roberts, Mazzucchelli, Studman, & Sanders, 2006; Sanders, Bor, & Morawska, 2007; Sanders, Markie-Dadds, Tully, & Bor, 2000; Turner, Richards, & Sanders, 2007; Zubrick et al., 2005
Teaching Family Model (TFM)	Bedlington et al., 1988; Jones & Timbers, 2003; Kirgin, Braukman, Atwater, & Wolf,1982; Larzelere et al., 2004; Lee & Thompson, 2008; Lewis, 2005; Slot, Jagers, & Dangel, 1992; Thompson et al., 1996
Specialized Foster Parent Training	
Attachment and Biobehavioral Catch-Up (ABC)	Dozier et al, in press; Dozier et al., 2006
Caring for Infants with Substance Abuse	Burry, 1999
Communication & Conflict Resolution	Cobb, Leitenberg, & Burchard, 1982; Minnis, Pelosi, Knapp, & Dunn, 2001
Early Childhood Developmental and Nutritional Training	Gamache, Mirabell, & Avery, 2006
Family Resilience Project	Schwartz, 2002
Preparing Foster Parents' Own Children for the Fostering Experience	Jordan, 1994
Support and Training for Adoptive and Foster Families (STAFF)	Burry & Noble, 2001
Training Modality	
Foster Parent College	Buzhardt & Heitzman-Powell, 2006; Pacifici, Delaney, White, Cummings, & Nelson, 2005; Pacifici, Delaney, White, Nelson, & Cummings, 2006
Group vs. Individual Training	Hampson, Schulte & Ricks, 1983
On-Line Training	

The evidence base (supporting empirical literature) of each training model reviewed in this report was evaluated using the California Evidence-Based Clearinghouse's (CEBC) Rating Scales (CEBC, 2008e). The evaluation revealed that **effective training practices** currently include IY, MTFC, PCIT, and IY; **efficacious training practices** include 1-2-3 Magic and MTFC-P; **promising training practices** include ABC, Caring for Infants with Substance Abuse,

communication & Conflict Resolution, FPSTP, KEEP, NPP, PAW, and TFM; and **emerging training practices** include Behaviorally-Oriented Training, CBT, Early Childhood Developmental & Nutritional Training, Family Resilience Project, Foster Parent College, MAPP, NOVA, NTU, Preparing Foster Parents Own Children for the Fostering Experience, and PRIDE.

The review of research suggests that training programs are most able to create positive changes in parenting knowledge, attitudes, self-efficacy, behaviors, skills, and to a lesser extent, child behaviors. Training of foster parents is also linked to foster parent satisfaction, increased licensing rates, foster parent retention, placement stability, and permanency. (See the Quick Reference Guide for associations among these key child welfare outcomes and particular foster parent trainings and support services.)

Effective elements of foster parent training programs include: increasing positive parent-child interactions (in non-disciplinary situations) and emotional communication skills; teaching parents to use time out; and teaching disciplinary consistency (Kaminski, Valle, Filene, & Boyle, 2008). Training programs that incorporate many partners (teachers, foster parents, social workers, etc.) with clearly defined roles appear to be the most promising in producing long term change (i.e., MTFC, IY). Additionally, training that is comprehensive in nature and incorporates education on attachment, and training in behavior management methods appears promising at addressing the complex training needs of treatment foster parents.

Although a variety of foster parent training programs currently exist, the review of research leads us to believe that more rigorous studies are needed to evaluate the effectiveness of emerging practices for both pre-service and in-service foster parent trainings. Few of the training programs in this report have been evaluated in a Treatment Foster Care setting. Although many

studies have included youth who resemble TFC youth in their samples, most training programs have strictly been evaluated in a traditional foster care setting. Clearly, more work needs to be done to evaluate these programs for TFC youth.

Foster Parent Support

The following foster parent supports were reviewed in this report:

Model	Empirical Literature
Benefits	
Health Insurance & Managed Care	Davidoff , Hill, Courtot, & Adams, 2008; Jeffrey & Newacheck, 2006; Krauss, Gulley, Sciegaj, & Wells, 2003; Newacheck et al., 2001; Okumura, McPheeters, & Davis, 2007; Rosenbach, Lewis, & Quinn, 2000
Service Provision & Managed Care	McBeath & Meezan, 2008; Meezan & McBeath, 2008;
Stipends	Campbell & Downs, 1987; Chamberlain, Moreland, & Reid, 1992; Denby & Reindfleisch, 1996; Doyle, 2007; Duncan & Argys, 2007
Integrated Models	
Keeping Foster Parents Trained and Supported (KEEP)	Chamberlain, Price, & Laurent et al., 2008; Chamberlain, Price & Reid et al., 2008; Price et al, 2008
Multidimensional Treatment Foster Care (MTFC)	Chamberlain, Leve, & DeGarmo, 2007; Chamberlain & Moore, 1998; Chamberlain & Reid, 1998; Eddy, Bridges Whaley, & Chamberlain, 2004; Eddy & Chamberlain, 2000; Eddy, Whaley & Chamberlain, 2004; Harmon, 2005; Kyhle, Hansson, & Vinnerljung, 2007; Leve & Chamberlain, 2005; Leve & Chamberlain, 2007; Leve et al., 2005
Multidimensional Treatment Foster Care-Preschool (MTFC-P)	Fisher, Burraston, & Pears, 2005; Fisher et al., 2000; Fisher & Kim, 2007
Support and Training for Adoptive and Foster Families (STAFF)	Bury & Noble, 2001
Involvement in Program (Collaboration/Partnering)	
Co-Parenting	Linares, Monalto, & Li et al., 2006; Linares, Monolto, & Rosbruch et al., 2006
Ecosystemic Treatment Model	Lee & Lynch, 1998
Family Reunification Project	Simms & Bolden, 1991

Foster Parent Involvement in Service Planning	Denby, Rindfleisch, & Bean, 1999; Henry, Cossett, Auletta, & Egan, 1991; Rhodes, Orme, & Buehler, 2001; Sanchirico, Jablonka, Lau, & Russell, 1998
Privatized Child Welfare Services	Friesen, 2001
Shared Family Foster Care	Barth & Price, 1999
Shared Parenting	Landy & Munro, 1998
Level of Care	
Positive Peer Culture	Leeman, Gibbs & Fuller, 1993; Nas, Brugman, & Koops, 2005; Sherer, 1985
Re-ED	Fields et al., 2006; Hooper et al., 2000; Weinstein, 1969
Stop-Gap	McCurdy & McIntyre, 2004
Respite	
Respite	Brown, 1994; Cowen & Reed, 2002; Ptacek et al., 1982
Social Support	
Social Support	Denby, Rindfleisch, & Bean, 1999; Finn & Kerman, 2004; Fisher et al., 2000; Hansell et al., 1998; Kramer & Houston, 1999; Rodger, Cummings, & Leschied, 2006; Rhodes et al., 2001; Strozier, Elrod, Beiler, Smith, & Carter, 2004; Urquhart, 1989; Warde & Epstein, 2005
Support Inventories	
Casey Foster Applicant Inventory	Orme et al., 2007
Help with Fostering Inventory	Orme, Cherry, & Rhodes, 2006; Orme & Cox et al., 2006
Treatment Foster Care	
Treatment Foster Care	Galaway, Nutter, & Hudson, 1995
Wraparound	
Family-Centered Intensive Case Management (FCICM)	Evans et al., 1994; Evans, Armstrong, & Kuppinger, 1996
Fostering Individual Assistance Program (FIAP)	Clark & Prange, 1994; Clark, Lee, Prange, & McDonald, 1996
General Wraparound Services	Bickman et al., 2003; Bruns et al., 2006; Carney & Butell, 2003; Crusto et al., 2008; Hyde, Burchard, & Woodworth, 1996; Myaard et al., 2000; Pullman et al., 2006

In this report, the evidence base of each foster parent support was evaluated using the CEBC's Rating Scales (CEBC, 2008e). Although many areas of support did not include specific practice models (e.g., respite, stipends, etc.), each area of support was evaluated in light of the existing empirical literature. This evaluation revealed that **effective supports** currently include

MTFC; **efficacious supports** include FCICM, MTFC-P, and PPC; **promising supports** include Co-parenting, FIAP, KEEP, and Stop-Gap; and **emerging supports** include Ecosystemic Treatment Model, Re-ED, Shared Family Care, and Shared Parenting. Specific models of some TFC provider support services have not yet been developed, including stipends, health insurance delivery, managed care service provision, respite, and social support. However, the provision of these services to foster parents is associated with improved foster parent and child outcomes (see Appendix I).

Foster parent's primary motivation for fostering is to make a positive difference in children's lives (MacGregor, Rodger, Cummings, & Leschied, 2006; Rodger, Cummings, & Leschied, 2006). However, this cannot be successfully accomplished without a variety of supports from agencies, community and family members, and policymakers. The review of empirical literature suggests the following:

Benefits

Health care benefits for foster children are a major issue for foster parents. This includes both the continuity of coverage and coordination of care for foster children (Kerker & Dore, 2006; Leslie, Kelleher, Burns, Landsverk, & Rolls, 2003). In addition, the program funding scheme (fee-for-service versus performance based) has an impact on foster children's outcomes. Research has shown that children in performance-based programs are significantly less likely to be reunified and are more likely to be placed in kinship foster homes or adopted (Meezan & McBeath, 2008).

As stated earlier, foster parents' primary motivation for fostering is to help children, not to accumulate monthly funds. The literature suggests that supportive services and a monthly stipend can assist foster parents in paying for additional costs associated with caring for children with behavioral issues (such as TFC youth) and have a positive impact on foster parent retention (Doyle, 2007; Duncan & Argys, 2007; Meadowcroft & Trout, 1990). However, many foster parents report that the monthly stipend is inadequate to meet the costs associated with caring for foster children and youth (Barbell, 1996; Soliday, 1998), Thus, more research on the costs associated with caring for TFC youth, and the various rates of TFC provider payments is needed.

Involvement in Service Planning (Collaboration)

Foster parents express desire to be involved in the service planning for children in their care (Brown & Calder, 2002; Denby, Rindfleisch, & Bean, 1999; Hudson & Levasseur, 2002; Rhodes, Orme, & Buehler, 2001). Yet, there is a delicate intersection between professionalization of the foster parent role and providing parental care for foster children, as foster parents consider themselves parents first and foremost (Kirton, 2001). Involvement in planning and professionalization is linked to increased foster parent satisfaction and retention (Denby, Rindfleisch, & Bean, 1999; Rhodes et al., 2001; Sanchirico, Jablonka, Lau, & Russell, 1998).

Several models of foster parent involvement with biological parents have been developed and are in the early stages of evaluation (i.e., Co-parenting, Ecosystemic Treatment Model, Shared Family Care, and Shared Parenting). These models require differing amounts of collaboration between biological and foster families, ranging from planning meetings together to

foster families caring for the entire family rather than just the child. TFC agencies who wish to implement practices that involve foster parents in service planning and/or create opportunities for collaboration between foster and biological parents may find these programs helpful.

Respite Care

Respite provides a break for foster parents. The research suggests that respite care is a necessity and should be provided by programs (Cowen & Reed, 2002; Robinson, 1995). However, the format for respite will depend on the (changing) needs of parents (Meadowcroft & Grealish, 1990). Use of respite care is viewed as a deterrent to "burn out" (Meadowcroft & Grealish, 1990) and is linked to decreases in stress and satisfaction with the process (Cowen & Reed, 2002, Ptacek et al., 1982). It is therefore reasonable to assume that foster care agencies can utilize customer satisfaction surveys to evaluate their respite care services on an ongoing basis as a means of ensuring the provision of the most effective respite services for treatment foster parents. Additionally, it may be important to survey TFC providers who are not currently utilizing respite services to detect any barriers associated with using respite care.

Social Support

Support groups and social support can assist foster parents with lifestyle changes and adjustments. Foster parents stress the importance of maintaining connections with other foster parents, and many parents seek assistance from informal sources (such as other foster families, friends, and family members) before seeking formal support (Kramer & Houston, 1999). The internet may be a new area for foster parents to be supported, although current research indicates on-line sources are infrequently used (Finn & Kerman, 2004). However, one recent study found that an on-line training was effective, and could be used with kinship caregivers, to increase self-

efficacy, teach computer skills, enhance social support, and build common ground between children and caregivers (Strozier, Elrod, Beiler, Smith, & Carter, 2004). Social support of foster parents is linked to greater foster parent satisfaction and resources, as well as improved child behavior (Denby et al., 1999; Fisher, Gibbs, Sinclair, & Wilson, 2000).

Support provided by agencies and caseworkers is linked to greater foster parent satisfaction and retention (Rodger, Cummings, & Leschied, 2006; Rhodes et al., 2001; Urquhart, 1989). Support is also mitigating factor in reducing stress (Hansell et al., 1998). It is important to note that kinship and non-kinship foster parents have differing needs, and therefore may require different types or amounts of social support (Cuddeback & Orme, 2002; Oakley, Cuddeback, Buehler, & Orme, 2007).

The relationship between the social worker and foster family is also key to increasing the satisfaction and retention of foster parents (Denby et al., 1999). Foster parents indicate the need for an open, positive, supportive relationship with the worker (Brown & Calder, 2000; Fisher et al., 2000). Foster parents' satisfaction is related to their perceptions about teamwork, communication, and confidence in relation to both the child welfare agency and its professionals (Rodger et al., 2006).

Treatment foster parents may benefit from the development of support models that 1) create additional formal agency supports, and 2) help treatment foster parents identify current support needs and expand their informal support networks. Additionally, more collaboration and integration between foster parents and agencies is necessary to meet the ever changing needs of foster parents.

Evidence-Based Practice in Foster Parent Training and Support: Implications for Treatment Foster Care Providers

Introduction

The report on Evidence-Based Practice (EBP) in foster parent training and support is intended to assist Foster Family-Based Treatment Association (FFTA) foster care agencies identify the most effective practices of foster parent training and support, as determined by the state of current empirical research. This report is based on a comprehensive review of published empirical literature conducted by the Center for Advanced Studies in Child Welfare (CASCW) at the University of Minnesota's School of Social Work. The report was developed under the auspices of Federal Title IV-E Funding, the Center for Advanced Studies in Child Welfare, and the Foster Family-Based Treatment Association (FFTA) as part of the Technical Assistance to FFTA Project.

The report is organized into two main sections: 1) Evidence-Based Practice in Foster Parent Training; and 2) Evidence-Based Practice in Foster Parent Support. Included in each section are comprehensive literature reviews and annotated bibliographies. The review of literature on evidence-based practice in foster parent training outlines pre-service foster parent training models, parenting programs for foster parents, specialized foster parent trainings, and alternate training modalities. The review of literature on evidence-based practices in foster parent support describes a variety of services that may support foster parents, including benefits (health insurance, service provision, and stipends), foster parent collaboration with agency staff and biological families, level of care, respite, support from agency workers and community members, support inventories, and integrated models of support and training. The sections are then

followed by a bibliographic list of all references used in creating the report. A Quick Reference Guide, which provides key findings and empirically-based relationships among evidence-based practices in foster parent training and support, and key child welfare outcomes, accompanies this report (see Appendix I).

Search Methodology

The search for empirical research was conducted between May 20, 2008 and August 15, 2008 using the following databases:

University of Minnesota Libraries

- Child Abuse, Child Welfare, and Adoption Database (1965 to December 2007)
- Family and Society Studies Worldwide Database (1970 to July 2008)
- PsychArticles (1988 to July 2008)
- Social Sciences Citation Index (1975 to August 2008)
- Social Services Abstracts (1980 to July 2008)
- Social Work Abstracts (1977 to July 2008)[1]

World Wide Web

- Cochrane Library (1996 to August 15, 2008) at http://www.mrw.interscience.wiley.com/cochrane
- Campell Collaboration at http://www.campbellcollaboration.org
- Google Academic

[1] Includes Medline 1950 – July 2008; PsycInfo 1856 – July 2008; and Social Work Abstracts 1977 – June 2008)

In conducting these searches, the keywords “foster parent” and “foster care” were individually paired with the following:

- Train
- Support
- Respite
- Support group
- Benefit
- Profession
- Voice
- Stipend
- Pay
- Level of care
- Placement disruption
- Placement stability
- Retention
- Support system
- Involve
- Biological parent
- Relationship
- Collaboration
- Reunification
- Shared parenting
- Inclusive
- Insurance
- Managed Care

The keywords “multi-dimensional treatment foster care,” “treatment foster care,” and “wraparound service” were used to extend the search for empirical literature on foster parent training and support. In addition, bibliographies of articles produced by the search methodology outlined above were inspected for relevant articles. The Social Science Citation Index was also used to locate articles that cited articles produced by the aforementioned search methodology. Finally, all databases were searched using the name of each model included in this report as keywords.

Terminology

Empirical Research

For this report, the following terms were used to describe the empirical research on foster parent training and support (in order of rigor): randomized controlled trial (RCT), controlled study, exploratory study, and descriptive study. A *randomized controlled trial* refers to a study in which participants 1) were randomly assigned to experimental and control (and/or comparative treatment), and 2) completed both pre-tests and post-tests. A *controlled study* is one in which the outcomes of participants from treatment, control, and/or comparative treatment groups are contrasted with one another. These studies utilize a pre-test/post-test design but do not randomly assign participants to treatment groups. An *exploratory study* refers to research that utilizes both pre- and post-tests but does not include a control or comparative treatment group in its design. *Descriptive studies* examine the outcomes of treatment; however, these studies do not utilize control groups or a pre-test/post-test design. Additionally, some studies included in this report were *meta-analyses* of empirical research; a meta-analysis is a systematic statistical analysis of a set of existing evaluations of similar programs in order to draw general conclusions, develop support for hypotheses, and/or produce an estimate of overall program effects.

Evidence-Based Practice

The recent reliance on, and demand for, evidence-based practice (EBP) is a relatively new development in child welfare. According to Chaffin and Friedrich (2004, p. 1097), EBP was created due to the recognition that many common health care and social services practices are based more in "clinical lore and traditions than on scientific outcome research." Although this represents a radical view of social work practice, there has been a growing concern that social

work practices have been conducted in the absence of, or without adequate attention to, evidence of their effectiveness in decision making and client care (Gambrill, 2001). Appropriately utilizing EBP in child welfare can remedy this by bringing services more in alignment with the best-available clinical science, and promoting practices which have been demonstrated to be safe and effective.

An *evidence-based practice* is defined as an intervention, program, procedure, or tool with empirical research to support its *efficacy* and/or *effectiveness.* Efficacy refers to the capacity of an intervention to produce the desired effect when tested under carefully controlled conditions. These conditions replicate those found in a laboratory setting; the methodology utilized in this research is highly selective in terms of the sample, the training and supervision of staff, and the implementation of the practice (Chorpita, 2003). These service environments are due in part to needed constraints imposed by research design, measurement protocols on referral criteria, and concurrent interventions which serve as comparison groups. Effectiveness refers to the capacity of an intervention to produce the desired effect when utilized in a general practice setting, where the power to control confounding factors is reduced (Nathan & Gorman, 2002). Ideally, effectiveness trials follow efficacy trials and are an intermediate step between initial efficacy testing and widespread dissemination (Chaffin & Friedrich, 2004).

It is important to think of EBP as a *process* of posing a question, searching for and evaluating the evidence, and applying the evidence within a client- or policy-specific context (Regehr, Stern, & Shlonsky, 2007). EBP blends current best evidence, community values and preferences, and agency, societal, and political considerations in order to establish programs and policies that are effective and contextualized (Gambrill, 2003, 2006; Gray, 2001). In fact, the

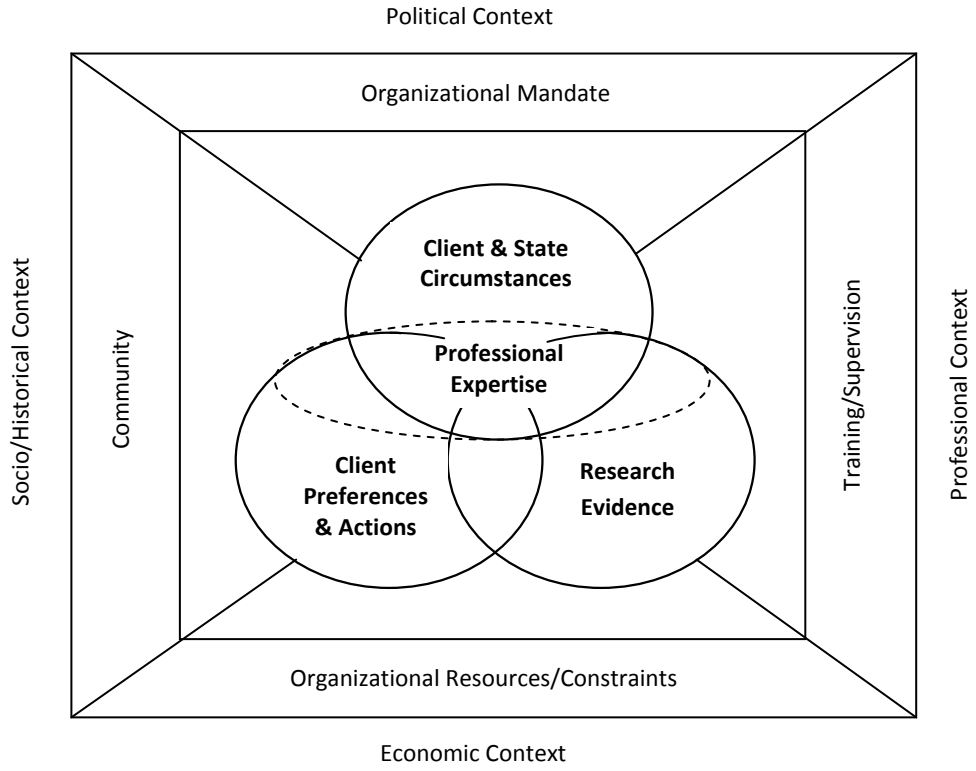
most widely cited definition of EBP emphasizes "the integration of best research evidence with clinical expertise and patient values" (Sackett, Straus, Richardson, Rosenberg, & Haynes, 2000, p.1). Thinking about EBP as a contextualized process negates the criticism that EBP is a cookbook approach that involves extracting best practices from the scientific literature and simplistically applying them to clients without regard to who the clients are, their personal motivations and goals, or other potentially complicating life situations, or without the expertise of the social worker involved (Regehr et al., 2007).

Regehr et al. (2007) proposed a model of EBP implementation that reflects the multi-faceted context of social work practice and policy (see Figure 1). This model (adapted from Haynes, Devereaux, & Guyatt, 2002) considers the emerging research on the ecological influences that may affect moving from evidence to practice, such as intraorganizational, extraorganizational, and practitioner-level factors, as well as the dynamic and reciprocal interactions between levels. For EBPs to be effectively implemented, this model suggests that clinical expertise and judgment are crucial. In practice, professionals must not only evaluate the research evidence supporting a practice, but they must also draw on their expertise to determine if a practice is appropriate for a given client and context.

The purpose of this report is to assist TFC professionals expand their knowledge of relevant EBPs in foster parent training and support. This report is intended to help TFC professionals become familiar with 1) the variety of EBPs that are currently documented in the research literature, and 2) the evidence base that supports the efficacy and/or effectiveness of these EBPs. It is important to note that because this report relies solely on practices that have

been documented in the peer-reviewed, published literature, some field practices may not be included.

Figure 1. Elements of Evidence-Based Policy and Practice



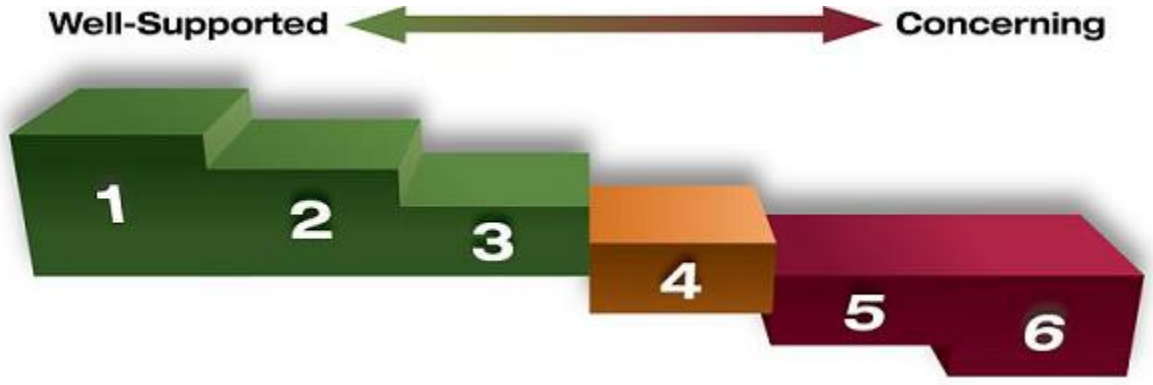
SOURCE: Regehr, Stern, & Shlonsky (2007)

Evidence-Based Practice Rating Scale

Not all models of foster parent training and support are equally supported by empirical research, and not all empirical research is equally valuable in determining whether or not a practice is considered to be evidence-based. This report utilizes the California Evidence-Based Clearinghouse for Child Welfare's Scientific Rating Scale as a classification system for rating the quality of empirical research supporting the various models of foster parent training and

support (CEBC, 2008e). This classification system uses criteria regarding a practice's clinical and/or empirical support, documentation, acceptance within the field, and potential for harm to assign a summary classification score. A lower score indicates a greater level of support for the practice (see Figure 2). Specific criteria for each classification system category are presented in Table 1.

Figure 2. California Evidence-Based Clearinghouse for Child Welfare's Scientific Rating Scale



SOURCE: CEBC (2008)

Table 1. Criteria for Evaluating Evidence-Based Practice

Rating	Evidence-Base	Safety	Documentation	Research Base	Length of Sustained Effect	Outcome Measures	Weight of Research Evidence
1	Effective Practice	No substantial risk of harm	Available	Multiple Site (RCT) Replication	1 year	Reliable and Valid	Supports practice's benefit
2	Efficacious Practice	No substantial risk of harm	Available	Single Site (RCT)	6 months	Reliable and Valid	Supports practice's benefit
3	Promising Practice	No substantial risk of harm	Available	Controlled Study			Supports practice's benefit
4	Emerging Practice		Available	Exploratory or Descriptive study			
5	Evidence Fails to Demonstrate Effect		Available	Non-efficacy in 2 RCTs			Does not support practice's benefit
6	Concerning Practice		Available	Reasonable theoretical, clinical, empirical, or legal basis suggesting that the practice constitutes a risk of harm to clients			Negative effect on clients

SOURCE: adapted from the California Evidence-Based Clearinghouse for Child Welfare's Scientific Rating Scales

Evidence-Based Practice in Foster Parent Training and Support:

Implications for Treatment Foster Care Providers

Section I: Evidence-Based Practice in Foster Parent Training

Review of Literature

Treatment foster care (TFC) is a rapidly expanding alternative child welfare and child mental health service for meeting the needs of children and adolescents with serious levels of emotional, behavioral, and medical problems, and their families. Treatment foster care programs provide intensive, foster family-based, individualized services to children, adolescents, and their families as an alternative to more restrictive residential placement options. Research on TFC indicates that it is less expensive, is able to place more children in less restrictive settings at discharge (with increased permanency), and produces greater behavioral improvements in the children served than residential treatments (Hudson, Nutter, & Galaway, 1994; Meadowcroft, Thomlison, & Chamberlain, 1994; Reddy & Pfeiffer, 1997).

The role of foster parents in TFC programs is complex. Much like traditional foster parents, TFC foster parents are responsible for providing daily care to children placed in their homes. However, unlike traditional foster parents (who have little to no responsibility for providing treatment to their foster children) TFC foster parents are viewed as the *primary* treatment agents. TFC foster parents are responsible for providing active, structured treatment for foster children and youth within their foster family homes (FFTA, 2008). Because of this significant responsibility and the high level of emotional, behavioral, and medical problems for

children and youth in their care, TFC foster parents require high levels of training tailored specifically to the population of children and youth in their care.

Providing foster care to children with increased emotional, behavioral, and/or medical needs requires not only extra time, but also greater patience, skill, and endurance in dealing with the child's demands, and the effect of the child's demands on the foster carers' personal and social life (Cliffe, 1991). This may be especially true for foster parents of adolescents (Turner, Macdonald, & Dennis, 2007). However, foster parents often voice that they are unprepared to meet the demands of children with increased behavioral and emotional needs and adolescents in their care (Henry, Cossett, Auletta, & Egan, 1991; Rhodes, Orme, & Buehler, 2001; and Sanchiricho, Lau, Jablonka, & Russell, 1998). This situation can result in placement disruption, which further strains foster care resources and has negative impacts on foster children and youth. Placement disruptions and frequent changes of foster parents can undermine children's capacity for developing meaningful attachments, disrupt friendships, and contribute to discontinuities in education and health care (Macdonald, 2004). Additionally, unplanned terminations of placements have the potential to drain the field of experienced carers, a much needed but limited resource, and compound the problems of finding and training an adequate supply of foster parents to provide children with stable care (Turner, Macdonald, & Dennis, 2007).

This section of the report is intended to assist Foster Family-Based Treatment Association (FFTA) agencies identify the most successful practices of foster parent training by providing a comprehensive literature review and annotated bibliography of evidence-based practices in foster parent training. This section focuses on studies that examine the effectiveness of interventions and models of training for foster parents. Both pre-service and in-service models

of training are included in the review. The training models are divided into four major categories: pre-service foster parent trainings, parenting models, specialized foster parent trainings, and training modalities.

Pre-Service Training Models

NOVA

The Nova model of foster parent training was developed as part of the Foster Parent Project at Nova University (Pasztor, 1985). The Foster Parent Project was based on four main principles: 1) agency language, recruitment strategies, and foster parent support need to change in order for foster parents to learn to work in ways that are more compatible with permanency planning goals, 2) foster parents should be involved as team members in permanency planning agencies, 3) the role of the foster parent should be clearly defined regarding permanency planning responsibilities, and 4) foster parent retention depends on the degree to which they are supported by others in the system. The goal of this project was to develop a model of service that could be replicated by foster care agencies of all types (i.e., large, small, urban, and rural). The model has been used in 22 states, as well as in sections of Ontario, Canada.

The training component of the Nova model includes an orientation meeting followed by six group training sessions. These sessions last approximately three hours each and include up to 30 participants. The group-based foster parent preservice training is combined with a home study process. Session content includes: 1) foster care program goals, and agency strengths and limits in achieving those goals; 2) foster parent roles and responsibilities; and 3) the impact of fostering on foster families, and on children and parents who need foster care services. The training uses

learner-centered, nondirective teaching methods to help prospective foster parents assess their own strengths and limits in working with children and parents who need foster care services. Role playing and guided imagery are heavily utilized.

The Nova model of training is rated as an ***emerging practice***. The Nova training model has been associated with increases in licensing rates and placement stability (Pasztor, 1985). Additionally, parents who report this training to be useful also report higher satisfaction with foster parent role demands (Fees, et al., 1998). This model has not been tested in a treatment foster care population; however the principals of the Foster Parent Project are conducive to working closely with treatment foster parents.

Parent Resources for Information, Development, and Education (PRIDE)

PRIDE was developed by the Child Welfare League of America (CWLA) through a collaboration of 14 state child welfare agencies, two national resource centers, and several universities and colleges. This model is used by private and public child welfare agencies in 30 states and 19 other countries to train and support foster care families. PRIDE is designed to strengthen the quality of foster care and adoption services by providing a standardized, structured process for recruiting, training, and selecting foster and adoptive parents. PRIDE covers topics including attachment, planning for permanency, loss, strengthening and maintaining family relationships, discipline, and general foster care information.

PRIDE is associated with increased foster parent knowledge about working with foster children and youth (Christenson & McMurty, 2007). Though it is widely used in pre-service training, PRIDE is rated as an ***emerging practice*** due to the dearth of empirical research to support its effectiveness.

Parenting Models

1-2-3 Magic

1-2-3 Magic is a discipline program for parents of children approximately 2-12 years of age (Bradley et al., 2003); the program can be used with a variety of children, including those with special needs. Groups of six to 25 participants meet one or two times per week for an hour and a half over a duration of four to eight weeks. A homework component is also included in the training. 1-2-3 Magic divides the parenting responsibilities into three straightforward tasks: controlling negative behavior, encouraging good behavior, and strengthening the child-parent relationship. The program seeks to encourage gentle, but firm, discipline without arguing, yelling, or spanking.

1-2-3 Magic is an ***efficacious practice*** and is linked to improved parenting and child behaviors (Bradley et al., 2003). This program was designed for parents of children with behavior problems involving compliance and oppositional issues but was not developed or tested for children with developmental delays. Most TFC parents would be greatly benefited by participating in this training.

Behaviorally-Oriented Training

Boyd and Remy (1978, 1979) were some of the first researchers to implement behaviorally-oriented training programs for foster parents. Behaviorally-oriented trainings that do not fall under any of the other parent training models in this report have been implemented as recently as this year. For example, Van Camp et al. (2008) utilized a behaviorally-oriented training consisting of 30 hours of classroom training that was taught in weekly three-hour sessions for 10 weeks, and included optional in-home visits by a behavioral analyst. This

behaviorally-oriented parenting training is linked to increased parenting skills and retention of foster parents. However, this type of training is rated as an ***emerging practice*** due to the researchers' lack of comparison groups in the studies. This training practice has not been tested in a TFC population.

Cognitive-Behavioral Therapy (CBT) – Foster Parent Training Program

The purpose of this group-based training is to promote emotional and social competence, and to prevent, reduce, and treat behavioral and emotional problems in young children (much like the Incredible Years model) using a cognitive-behavioral approach (Macdonald & Turner, 2005). The program runs four to five weeks in length with sessions lasting from three to five hours each week. The training familiarizes carers with an understanding of social learning theory, in terms of both how patterns of behavior develop and how behavior can be influenced using interventions derived from learning theory. The program places an emphasis on developing the skills to observe, describe, and analyze behavior in behavioral terms—the so-called "ABC" analysis. In the program, these skills were developed before moving on to consider specific strategies or interventions. However, some fluidity between sessions occurs.

The CBT model of foster parent training is rated as an ***emerging practice***. Parents who participate in the training report satisfaction with the program and increased confidence about dealing with difficult behavior, although no significant differences have been found between the trained and untrained group on behavior management skills, child behavioral problems, or placement stability (Macdonald & Turner, 2005). This may prove to be a promising training for TFC parents if the efficacy of this program can be demonstrated in the future.

Foster Parent Skills Training Program (FPSTP)

The Foster Parent Skills Training Program is a foster parent training curriculum that focuses on developing helping skills for foster parents of children aged five to 12 (Guerney, 1977). The program is given in a 10-session group format. Nine of the 10 sessions address helping skills, including skills of empathy, relationship development, understanding child need and development, and skills of child management. The FPSTP program is linked to sensitivity to children's needs, effective parenting skills, skills associated with promoting child and parent relationships, and attitudes of acceptance towards children (Brown, 1980; Guerney, 1977; and Guerney & Wolfgang, 1981). Although FPSTP is rated as a ***promising practice***, these findings are based on a traditional foster care population and no new studies of FPSTP have been conducted since 1981. The applicability to TFC foster parents may be limited.

Incredible Years (IY)

The Incredible Years includes three separate, multifaceted, and developmentally-based curricula for parents, teachers, and children (Webster-Stratton, 2000). IY was designed to promote emotional and social competence, and to prevent, reduce, and treat behavioral and emotional problems in young children (aged 4-8). The parent, teacher, and child programs can be used separately or in combination. IY includes treatment versions of the parent and child programs as well as prevention versions for high-risk populations, such as TFC youth.

The IY parenting component addresses parental negative affect, negative commands, poor parent bonding, and ineffective limit setting (CEBC, 2008b). Parent training groups consist of 12-16 participants who meet weekly for two hours. The Basic Parent Training Program lasts

12-14 weeks. The Advanced Parent Program is recommended as a supplemental program for the treatment version. The entire Basic plus Advance Parent Program takes 18-22 weeks to complete.

The IY child component addresses aggression, conduct problems, social competency problems, attention deficit hyperactivity disorder, internalizing problems such as fears, phobias, and somatization (conversion of anxiety into physical symptoms), and children experiencing divorce, abandonment, or abuse (CEBC, 2008b). Children's groups consist of six participants who meet weekly for two hours. The Child Training Program runs 18-22 weeks. The Child Prevention Program is 20 to 30 weeks and may be spaced over two years.

IY is rated as an ***effective practice*** and is linked to the development and maintenance of effective parenting skills and improved child behaviors (Baydar, Reid, & Webster-Stratton, 2003; Gardner, Burton, & Klimes, 2006; Linares, Montalto, Li, & Oza, 2006; Reid, Webster-Stratton, & Baydar, 2004; Reid, Webster-Stratton & Beauchaine, 2001; and Webster-Stratton, 2000). IY has not been developed or tested for children with developmental delays. The applicability of IY for TFC foster parents is noteworthy.

Keeping Foster and Kin Parents Supported and Trained (KEEP)

Keeping Foster and Kin Parents Supported and Trained is program designed to 1) give parents effective tools for dealing with their child's externalizing and other behavioral and emotional problems, and 2) support parents in the implementation of those tools (Price et al., 2008). The foster/kin parents' role is framed as that of "key agents of change" with opportunities to alter the life course trajectories of the children placed with them. Foster/kin parents are taught

methods for encouraging child cooperation, using behavioral contingencies and effective limit setting, and balancing encouragement and limits. There are also sessions on dealing with difficult problem behaviors including covert behaviors, promoting school success, encouraging positive peer relationships, and strategies for managing stress brought on by providing foster care. Sessions consist of one 90-minute group meeting per week (plus one 10-minute telephone call per week) over a course of 16 weeks; 7-10 foster parents are included in each group. There is an emphasis on active learning methods, and illustrations of primary concepts are presented via role-plays and videotapes.

KEEP is rated as a ***promising practice*** and is associated with gains in effective parenting skills, improvements in child behavior, and placement permanency (Chamberlain, Price, & Laurent et al., 2008; Chamberlain, Price, Reid, & Landsverk, 2008; and Price et al., 2008). Because of its emphasis on treating child externalizing problems, mental health problems, and problems in school and with peer groups, KEEP may be appropriate as a training mechanism for TFC foster parents.

Model Approach to Partnerships in Parenting (MAPP)

The Model Approach to Partnerships in Parenting training curriculum is based heavily upon the NOVA curriculum materials (Lee & Holland, 1991). MAPP stresses developing in participants the knowledge, attitudes, and skills deemed necessary to serve effectively as foster parents. The highly-structured MAPP curriculum occurs over a 10-week period with participant groups. Topics of the curriculum include the foster care/adoption system, placement of foster children, loss and attachment, behavior management, birth family connections, exiting foster

care, and the impacts of fostering and adopting on the foster family. All sessions utilize lectures, group discussion and sharing, role-playing exercises, and guided imagery as learning techniques. Participants are encouraged to share their own experiences and to learn from each other. Handouts and homework assignments are distributed at each session. The home-study component includes completion of an extensive family profile, examination of family strengths and needs, and assessment of abilities for foster care.

MAPP is rated as an ***emerging practice***. Although several studies have been conducted to test its effectiveness, none have found MAPP to produce the desired results (Lee & Holland, 1991; Puddy & Jackson, 2003; and Rhodes, Orme, Cox, & Buehler, 2003). Additionally, families with psychosocial problems and less resources express greater likelihood of not continuing foster care after completing this pre-service training (Rhodes et al., 2003). The benefit of this practice is questionable for TFC foster parents.

Multidimensional Treatment Foster Care (MTFC)

Multidimensional Treatment Foster Care is a model of treatment foster care for children 12-18 years old with severe emotional and behavioral challenges and/or severe delinquency (Chamberlain, 2003). MTFC aims to create opportunities for youths to successfully live in families rather than in group or institutional settings, and to simultaneously prepare their parents (or other long-term placement) to provide youth with effective parenting (CEBC, 2008c). MTFC includes four key elements of treatment: 1) providing youths with a consistent reinforcing environment where he or she is mentored and encouraged to develop academic and positive living skills, (2) providing daily structure with clear expectations and limits, with well-specified

consequences delivered in a teaching-oriented manner, (3) providing close supervision of youths' whereabouts, and (4) helping youth to avoid deviant peer associations while providing them with the support and assistance needed to establish pro-social peer relationships.

MTFC is designed to be used for training groups of foster parents (less than 10 participants per group) over a period of six to nine months (CEBC, 2008c). Foster parents typically are contacted a minimum of seven times per week. These contacts consist of five 10-minute contacts, one two-hour group contact, and additional contacts based on the amount of support or consultation required. For the youth in treatment, two contacts per week (consisting of a weekly individual one-hour therapy and weekly two-hour individual skills training) occur. Biological parents (or other long-term placement resource) experience one contact per week in the form of a one-hour family therapy session.

MTFC is rated as an ***effective practice*** and has been associated with less delinquency, run aways, violent behavior, and incarceration for TFC youth (Chamberlain, Leve, & DeGarmo, 2007; Chamberlain & Moore, 1998; Chamberlain & Reid, 1998; Eddy & Chamberlain, 2000; Eddy, Whaley, & Chamberlain, 2004, 2004b; Harmon, 2005; Leve & Chamberlain, 2005, 2007; and Leve, Chamberlain, & Reid, 2005). Additionally, components of the MTFC are highly rated by foster parents (Kyhle, Hansson, & Vinnerljung, 2007). MTFC is a highly appropriate training for TFC foster parents.

Multidimensional Treatment Foster Care for Preschoolers (MTFC-P)

MTFC-P is a treatment foster care model tailored specifically to the needs of 3 to 6-year-old foster children (Fisher & Chamberlain, 2000; Fisher, Ellis, & Chamberlain, 1999). MTFC-P is delivered through a treatment team approach in which foster parents receive training and ongoing consultation and support; children receive individual skills training and participate in a therapeutic playgroup; and birth parents (or other permanent placement caregivers) receive family therapy. MTFC-P trains parents to use of concrete encouragement for pro-social behavior; consistent, non-abusive limit-setting to address disruptive behavior; and to closely supervise the child in care. MTFC-P is oriented toward creating optimal environmental conditions to facilitate developmental progress. These conditions include a responsive and consistent caregiver and a predictable daily routine with preparation for transitions between activities.

Foster parents typically receive a minimum of seven contacts per week, which consist of five 10-minute contacts, one two-hour group session, and additional contacts based on the amount of support or consultation required (CEBC, 2008d). Children in treatment are typically contacted twice a week; these contacts consist of a two-hour therapeutic playgroup and a two-hour skills training session. For the biological family or other long-term placement resource, one contact per week in the form of a one-hour skill-building session occurs.

Two of the main components of MTFC-P are conducted in a group environment: Foster Parent Support Meetings and Therapeutic Playgroups. The Foster Parent Support Meetings are comprised of 10 caregivers from foster homes. The Therapeutic Playgroup is conducted with approximately 10 children. All sessions occur in a six to nine month timeframe.

MTFC-P is rated as an ***efficacious practice*** and is associated with reduced foster parent stress, improved parenting skills and child behavior, and placement permanency (Fisher, Burraston, & Pears, 2005; Fisher, Gunnar, Chamberlain, & Reid, 2000; Fisher & Kim, 2007). Children in MTFC-P are treated for disruptive, maladaptive behaviors. These include a wide range of diagnoses and developmental delays. MTFC-P is appropriate for dealing with behaviors of aggression, anxiety, depression, hyperactivity, autism spectrum, attachment, enuresis, encopresis, defiance, tantrums and general anti-social behavior (CEBC, 2008). Because of this, TFC foster families may benefit greatly from participation in the MTFC-P program.

NTU

NTU is a treatment foster care program implemented via an African-centered approach (Gregory & Phillips, 1996). The NTU psychotherapy approach is based on the principles of mental health and healing: harmony, balance, interconnectedness, and authenticity. The model provides a comprehensive cultural/spiritual, biopsychosocial approach to intervention for TFC. Interventions are based on the needs of the foster child and can include 1) weekly in-home family and/or individual therapy; 2) group therapy or play therapy; 3) small client to therapist rations (5:1); 4) multifamily therapy retreats (for child, foster and biological families); 5) case management; 6) monthly psychological-psychiatric services; and 7) HELP (How Empowerment Liberates Parents) training program for foster parents. Cultural services, including a therapeutic rites of passage program and a cultural hour group, are included. Other individualized supportive services are also provided (e.g., respite, tutorial services, academic incentives, etc.).

NTU is rated as an ***emerging practice***. It is associated with improvements in child behavior, educational outcomes, and mental health, and foster parent satisfaction (Gregory & Phillips, 1996). The NTU program may be appropriate for TFC foster parents who are working with African-American foster children as it provides cultural support in addition to traditional TFC services.

Nurturing Parenting Program (NPP)

The Nurturing Parenting Program is a family-based program utilized for the treatment and prevention of child abuse and neglect (Cowen, 2001). At-risk biological families and families caring for abused or neglected children are included in the target population. Programs are designed for parents with young children (birth to 5 years old), school-aged children (5 to 11 years old), and teens (12 to 18 years old). Developed from the known behaviors that contribute to the maltreatment of children, the goals of the curriculum are: 1) to teach age-appropriate expectations and neurological development of children; 2) to develop empathy and self worth in parents and children; 3) to utilize nurturing, non-violent strategies and techniques in establishing family discipline; 4) to empower parents and children to utilize their personal power to make healthy choices; and 5) to increase awareness of self and others in developing positive patterns of communication while establishing healthy, caring relationships.

NPP is delivered in a group and home-based format. Parent groups consist of 12-15 participants; child groups consist of 8-12 participants, depending on the children's ages and abilities. Groups meet weekly for two and a half to three hours over a period of 12 to 48 weeks. The home-based sessions typically last 90 minutes.

NPP is rated as a ***promising practice*** and is linked to increases in positive parent attitudes and parenting skills (Cowen, 2001; Devall, 2004). This training may be applicable to TFC parents, but will most likely need to be supplemented by more detailed training on emotional, behavioral, and medical issues.

Parent-Child Interaction Therapy (PCIT)

PCIT was developed for families with young children (aged 3-6) experiencing behavioral and emotional problems (Urquiza & McNeil, 1996). In PCIT therapists coach parents during interactions with their child to teach new parenting skills. These skills are designed to strengthen the parent-child bond; decrease harsh and ineffective discipline control tactics; improve child social skills and cooperation; and reduce child negative or maladaptive behaviors.

PCIT is conducted in two phases: child-directed interaction (CDI; also described as the Relationship Enhancement phase; 7-10 sessions) and parent-directed interaction (PDI; also described as the Behavior Management phase; 7-10 sessions). Both phases of the treatment are preceded by a didactic treatment session in which the parent and child are instructed in basic PCIT Relationship Enhancement and Behavior Management concepts. The objective of these sessions is to introduce both parent and child to the concepts and provide a rationale for each concept. Six to eight treatment sessions then follow, in which the parent and child acquire and develop skills. These sessions are referred to as "coaching" sessions because the parent wears a small remote hearing device, while the therapist talks to him or her from an adjoining observation room, watching through a two-way mirror.

PCIT is rated as an ***effective practice***. Participants of PCIT programs report less stress, and develop and maintain effective parenting skills and improved child behaviors (Bagner & Eyberg, 2007; McNeil, Herschell, Gurwitch, & Clems-Mowrer, 2005; Nixon, Sweeney, Erickson, & Touyz, 2003; Shuhman, Foote, Eyberg, Boggs, & Algina, 1998; Timmer et al., 2006; Timmer, Urquiza, & Zebell, 2006; Thomas & Zimmer-Gembeck, 2007). PCIT treats noncompliance, aggression, rule breaking, disruptive behavior, dysfunctional attachment with parent(s), and internalizing symptoms. PCIT may be helpful for TFC foster parents who are working with emotionally and behaviorally challenged children.

Parenting Wisely (PAW)

Parenting Wisely is a self-administered, highly interactive computer-based program that teaches parents and children (aged 9-18) skills to improve their relationships and decrease conflict through support and behavior management (Kacir & Gordon, 1997). PAW utilizes an interactive CD-ROM to present parents with video scenarios depicting common challenges with adolescents. Parents are to choose one of three solutions to these challenges. They are then able to view the scenarios enacted and receive feedback about each choice. The program tutors parents by pointing out typical errors parents make and highlighting new skills that will help them resolve problems. Parents and children can use the program together as a family intervention. The Parenting Wisely program uses a risk-focused approach to reduce family conflict and child behavior problems.

PAW is rated as a ***promising practice*** and is associated with the development and maintenance of effective foster parent knowledge and skills as well as improved child behavior

(Kacir & Gordon, 1999; O'Neil & Woodward, 2002; and Segal, Chen, Gordon, Kacir & Glys, 2003). PAW was developed to assist parents deal with child behavior problems (i.e., acting out, disruptive behavior, internalizing problems, hyperactivity, peer relationship problems), parent or child substance abuse, child abuse and neglect, and parental depression as well as conduct disorder, oppositional-defiant disorder, substance abuse, and child depression. PAW is a relatively quick training tool that can be administered in the home. Thus, TFC foster parents may benefit greatly by participating in this training.

Triple P-Positive Parenting Program (PPP)

The Triple P-Positive Parenting Program aims to prevent severe behavioral, emotional, and developmental problems in children by enhancing the knowledge, skills, and confidence of parents (CEBC, 2008f). It incorporates five levels of intervention on a tiered continuum of increasing strength for parents of children and adolescents (from birth to age 16). The multi-disciplinary nature of the program allows utilization of the existing professional workforce in the task of promoting competent parenting. The program targets five different developmental periods from infancy to adolescence. Within each developmental period, the reach of the intervention can vary from being very broad (targeting an entire population) to quite narrow (targeting only high-risk children). Triple P-Positive Parenting Program enables practitioners to determine the scope of the intervention given their own service priorities and funding.

PPP can be provided individually, in a group, or a self-directed format. Group sessions last up to one hour. The number of sessions varies according to the level of the intervention required by the family: Level 2 requires approximately one to two weekly sessions delivered via

individual brief consultations (or in large-group parenting seminars); Level 3 requires up to four brief 20-minute weekly consultation sessions; Level 4 requires eight to 10 weekly sessions; and Level 5 requires on average an additional 3 weekly sessions per family.

PPP is rated as an ***effective practice*** and has been associated with reduced foster parent stress, and improvements in foster parent confidence and parenting skills (Bor, Sanders, & Markie-Dadds, 2002; Leung, Sanders, Leung, Mak, & Lau, 2003; Martin & Sanders, 2003; Roberts, Mazzucchelli, Studman, & Sanders, 2006; Turner, Richards, & Sanders, 2007; and Zubrick et al., 2005). PPP is also associated with improvements in foster child behavior (Bor et al., 2002; Leung et al., 2003; Martin & Sanders, 2003; Roberts et al., 2006; Sanders, Bor, & Morawska, 2007; Sanders, Markie-Dadds, Tully, & Bor, 2000; Turner et al., 2007; and Zubrick et al., 2005). PPP addresses conduct problems, ADHD, oppositional defiant disorders, feeding problems, and pain syndromes; this training may be beneficial for TFC foster parents.

Teaching Family Model

TFM uses "teaching parents" to offer a family-like environment in the residence and is characterized by clearly defined goals, integrated support systems, and a set of essential elements (Kirgin, 1996). The teaching parents help with learning living skills and positive interpersonal interaction skills. They are also involved with children's parents, teachers, and other support network to help maintain progress. TFM has been applied in residential group homes, home-based services, foster care and treatment foster care, schools, and psychiatric institutions. Approximately 40 hours of training is required to teach foster parents how to implement this

model in their homes. TFM uses ongoing consultation after placement, with individual certification typically occurring after one year of practice (CEBC, 2008).

The Teaching Family Model is rated as a ***promising practice***. It has been linked to improvements in communication and relationships between parents and youth (Bedlington, Braukman, Ramp, & Wolfe, 1988; Slot, Jagers, & Dangel, 1992), improved child behavior and mental health (Jones & Timbers, 2003; Larzelere, Daly, Davis, Chmelka, & Handwerk, 2004; Lewis, 2005; Slot et al., 1992), fewer criminal offenses (Kirgin, Braukman, Atwater, & Wolf, 1982; Slot et al., 1992), improved educational outcomes (Thompson et al., 1996), less restrictive placements (Larzelere et al., 2004), and favorable discharges, such as reunification with biological parents (Lee & Thompson, 2008). The TFM may be extremely useful for treatment foster parents who require additional training in parenting techniques.

Specialized Foster Parent Training

Attachment and Biobehavioral Catch-up (ABC)

Attachment and Biobehavioral Catch-up targets several key issues that have been identified as problematic among children who have experienced early maltreatment and/or disruptions in care (Dozier, Dozier, & Manni, 2002). These young children often behave in ways that push caregivers away. ABC was developed to assist foster parents of infants develop skills that will promote nurturing parent-child relationships. Parents attend weekly hour-long sessions over the course of 10 weeks.

The first intervention component helps caregivers to re-interpret children's behavioral signals so that they provide nurturance even when it is not elicited (Dozier et al., 2002). Nurturance does not come naturally to many caregivers, but children who have experienced early adversity especially need nurturing care. Thus, the second intervention component helps caregivers provide nurturing care even if it does not come naturally. Third, many children who have experienced early adversity are dysregulated behaviorally and biologically. The third intervention component helps caregivers provide a responsive, predictable environment that enhances young children's behavioral and regulatory capabilities.

ABC is rated as a ***promising practice*** and is associated with improvements in child behaviors, including less avoidant behaviors and behavior problems (Dozier, Brohawn, Lindheim, Perekins, & Peloso, in press; Dozier et al., 2006). Because developing a nurturing relationship with neglected infants can be difficult, ABC may be beneficial to TFC foster parents who find themselves in this situation.

Caring for Infants with Substance Abuse

Caring for Infants with Substance Abuse is an in-service training program designed to enhance the competency of foster parents who are caring for infants with prenatal substance effects, and to promote the intent to foster such infants (Burry, 1999). The training curriculum is delivered in four weekly sessions lasting two and a half hours each. Training goals include: 1) preparedness in providing foster care to infants with prenatal substance effects, 2) knowledge of community resources specific to infants with prenatal substance effects, 3) ability to perform and describe appropriate care for infants with prenatal substance effects, and 4) knowledge of future

decisions regarding future fostering of infants with prenatal substance effects. The training program has been rated as a ***promising practice*** that has positive effects on foster parents' knowledge and skills. TFC foster parents who are caring for infants who suffer the effects of substance abuse may find this training useful.

Communication & Conflict Resolution Training

Communication and Conflict Resolution Training is a model designed to teach specific therapeutic parenting skills (communication and conflict resolution) to foster parents (Cobb, Leitenberg & Burchard, 1982). The training program consists of 16 weekly, two-hour sessions in which staff and foster parents meet as a group. These sessions are supplemented with bi-weekly home visits in which a staff member visits each foster parent's home and provides more concentrated assistance and review. The curriculum is structured around three skill segments: communication skills (five weeks), behavior management skills (five weeks), and conflict resolution skills (four weeks). Training includes active listening, expression of feelings, and problem definition skills. Training may be led by mental health professional staff or by foster parents who have already successfully completed the program. The Communication and Conflict Resolution Training is rated as a ***promising practice*** and is associated with improvements in communication and conflict resolution skills for foster parents. TFC foster parents may be benefited by participating in this training, especially if they care for adolescents.

Early Childhood Developmental and Nutritional Training

Early Childhood Developmental and Nutritional Training was developed out of the recognition that there was a lack of in-service training opportunities for traditional and treatment

foster care providers regarding the nutritional and emotional needs of young children and infants (Gamache, Mirabell, & Avery, 2006). The training was created and approved in conjunction with Women, Infants & Children (WIC), the local Child Protection Services licensing office, and researchers at Eastern Washington University's School of Social Work. This training 1) provides information on the relationship between brain development and diet or nutrition, 2) demonstrates inexpensive ways to offer enrichment activities to infants and young children, 3) provides a resource packet which includes information on developmental stages, enrichment activities, brain development of a typical and neglected children, contacts for registered nurses and WIC staff, SIDS, and feeding and nutrition, and 4) provides information on the dietary and nutritional needs of infants and young children. Although this was a pilot study, the results are promising. Foster care providers who participated in this training reported significant improvements in their knowledge and understanding of infant nutritional needs. Because control groups were not utilized, this training is rated as an ***emerging practice***. Once efficacy can more fully be demonstrated, TFC providers may benefit greatly from this training.

Family Resilience Project (FRP)

The Family Resilience Project is an in-service training opportunity developed specifically for Treatment Foster Care (TFC) families (Schwartz, 2002). The purpose of FRP is to offer TFC parents individualized training that is directly related to the parenting of those treatment foster care children residing with them. Based on the fundamental concepts of family resilience, an "Individual Review and Refocus" approach is developed and implemented with each family. This approach consists of a six-step process:

1. Setting a goal.
2. Reviewing one or more times that have not led to success in attaining the goal.
3. Reviewing one or more times that have already been successful but have gone unrecognized as such in attaining the goal.
4. Describing the difference.
5. Refocusing on what has worked already, highlighting the differences described above and their consequences.
6. Practicing what has already worked; agree to do it more.

The Family Resilience Project is rated as an ***emerging practice***. Preliminary findings indicate that this project may be associated with positive parenting behaviors. Once efficacy of the project is established, FRP may become an indispensable resource for TFC parents.

Preparing Foster Parents' Own Children for the Fostering Experience

Preparing Foster Parents Own Children for the Fostering Experience is designed to promote the stability of the fostering experience for the foster family by decreasing the opportunities for conflicts between the child in care and the foster family's children (Jordan, 1994). The curriculum is organized in a three session format with each session scheduled for approximately one and one-half hours. Designed and presented in a loose leaf format, the curriculum also provides the trainer with numerous vignettes, role plays, suggestions for discussions, and game and interaction ideas for reinforcing the concepts of each training session.

The first session promotes skills to: 1) identify the members of the foster care system; 2) understand the basic roles of each member of the system; 3) identify reasons youth come into the foster care system; 4) understand necessity for confidentiality; and 5)identify potential changes in family relationships with a new child in the household. The goals of the second session are to:

1) identify a variety of feelings, behaviors, and problems brought into the home by foster children; 2) identify why certain feelings can cause these certain behaviors; 3) suggest methods of coping with these behaviors; 4) plan ways to discuss various behaviors with parents; and 5) clarify the difference between being a "snitch" and telling parents when something is wrong. The final session helps children to: 1) identify activities and situations that will be new for the new child; 2) describe ways to help the new child be comfortable in the home and community; 3) discuss reasons that parents will have less time to spend with "own" children, but recognize that the love is still the same; 4) identify stages of separation and loss; 5) describe the grieving process in age appropriate terms; and, 5) clearly define the goals of family foster care.

This training is rated as an ***emerging practice*** and has not yet been formally evaluated. The lack of research in this area indicates that training on preparing foster parents' own children for the fostering experience is often overlooked. Additionally, children in TFC have high levels of emotional, behavioral, and medical issues that require substantial time commitments from foster parents (FFTA, 2008). Therefore, if the efficacy of the Preparing Foster Parents' Own Children for the Fostering Experience can be demonstrated, TFC foster parents (and their children) will benefit greatly from this training.

Support and Training for Adoptive and Foster Families (STAFF)

The Support and Training for Adoptive and Foster Families project was developed as a response to concerns about large members of infants with prenatal substance exposure being placed in foster care or for adoption with families who were not prepared for their special needs (Bury & Noble, 2001). The STAFF project focuses on meeting its goals of permanency for

infants with prenatal substance effects through both training and support services. The STAFF curriculum was designed specifically as an in-service training program, so that participants had previously completed either pre-services foster parent training, adoption preparation training, or both. The curriculum includes both didactic and interactive activities, and includes five modules. The six-hour curriculum was designed to be delivered in a number of formats including, one six-hour session, two three-hour sessions, or as three two-hour sessions of training.

The STAFF project is rated as an ***emerging practice***. If the efficacy of this project can be demonstrated, TFC foster parents may be benefited from attending the training.

Training Modalities

Foster Parent College

The Foster Parent College (developed through Northwest Media, Inc.) is an interactive multimedia training venue for foster parents. Users can take brief parenting training courses either online (http://FosterParentCollege.com) or on DVD on behavior management, parenting strategies, and advanced parenting workshops. A variety of topics including dealing with serious child behavior problems, strengthening family relationships, and behavior management for children diagnosed with mental illnesses is covered.

Foster Parent College is rated as an ***emerging practice***. A preliminary study of the *Anger Outburst* course suggests that foster parents who completed this training developed increased knowledge of and confidence in dealing with foster children's temper tantrums, assaultive behavior toward other children, rage toward the mother, and erratic or unpredictable anger

(Pacifici, Delaney, White, Cummings, & Nelson, 2005). Other research suggests that parents feel satisfied with the courses and develop knowledge of challenging behavior and legal issues as a result of participating in the on-line program (Buzhardt & Heitzman-Powell, 2006; Pacifici, Delaney, White, Nelson, & Cummings, 2006). TFC foster parents may find this training beneficial, especially given the flexibility of the on-line training format and the variety of courses offered.

Group vs. Individual Training

A recent study compared foster parents who received parent training in child rearing skills (utilizing a combination of behavioral and reflective approaches) through a traditional group training format versus individually-based training in foster parents' homes (Hampson, Schulte & Ricks, 1983). Both modalities used two basic books: *Parents Are Teachers* and *Between Parent and Child*. The trainings lasted for 11 weeks. The in-home training sessions met weekly for one hour; group training sessions met weekly for 1.5 hours. On average, the in-home parents each received approximately 6.1 hours of training, while each family received 11 hours of training. For the group trained families, each parent received approximately 6.2 hours of training and each family received approximately 13.2 hours of training, on average.

When the two groups were compared in terms of differential gains, relatively few differences were noted. As a general rule, group trained parents demonstrated slightly greater increases in parent attitude scores. Virtually all parents improved over the course of training, but parents with higher initial levels of attitude and knowledge remained in the higher rank orders following the training. Parents in the home trained group rated the overall improvements they

perceived in their children's behavior as greater than group trained parents. There was a more durable pattern of satisfaction and perceived improvements for parents who were trained in home. Both training modalities seem to offer equivalent gains for foster parents, but the results may be misleading due to the small sample utilized in the study. More research is needed before a determination as to this practice's efficacy can be made. However, flexibility in training modalities may be important to TFC foster parents and agencies alike.

Summary

A variety of pre-service and in-service foster training programs exist, including general pre-service trainings, foster parent trainings in parenting, and specialized foster parent training programs, such as those for foster parents of infants with substance abuse effects, nutritional training, etc. Most training programs have research supporting their utility in general foster care populations. However, a few (i.e., MTFC, MTFC-P, Family Resilience Project) have been specifically developed for TFC providers, while the applicability of others (e.g., 1-2-3 Magic, IY, PCIT, etc.) to a TFC population seems high.

The review of research suggests that training programs are most able to create positive changes in parenting knowledge, attitudes, self-efficacy, behaviors, skills, and to a lesser extent, child behaviors. Training of foster parents is also linked to foster parent satisfaction, increased licensing rates, foster parent retention, placement stability, and permanency (see Table 2).

Effective elements of general foster parent training programs include: increasing positive parent-child interactions (in non-disciplinary situations) and emotional communication skills;

teaching parents to use time out; and teaching disciplinary consistency (Kaminski et al., 2008). Training programs that incorporate many partners (teachers, foster parents, social workers, etc.) with clearly defined roles appear to be the most promising in producing long term change (i.e., MTFC, IY). Additionally, training that is comprehensive in nature and incorporates education on attachment, and training in behavior management methods appears promising at addressing the complex training needs of treatment foster parents.

Evidence-Based Practice in Foster Parent Training and Support: Implications for Treatment Foster Care Providers

Section I: Evidence-Based Practice in Foster Parent Training

Annotated Bibliography

Citation	Study
Pre-Service Training Models	
General Foster Care Provider Training	
Crase, S. J., Lekies, K. S., Stockdale, D. F., Moorman, D. C., Buam, A. C., & Yates, A. M. et al. (2000). The effects of foster parent preservice training on parenting attitudes, foster parenting attitudes, and foster care knowledge. In Mercier, J.M, Garasky, S.B., & Shelley, M.C. II (Eds.), *Redefining Family Policy: Implications for the 21st Century.* Ames, Iowa: Iowa State University Press. **Population:** Family-based foster parents	**Method:** This study used a pre-test/post-test design to evaluate the Foster Parent Preservice Training. The study focused on the effects of the foster parent training on trainees' attitudes toward parenting, attitudes toward foster parenting, and knowledge. 184 participants of the preservice training were included in this study. **Findings**: Findings suggest that preservice training provided participants with insight and understanding into the roles and responsibilities of foster parenting. Following training, trainees expressed more positive attitudes toward foster parenting as well as increased levels of knowledge about the foster care system. **Limitations:** The model of preservice training was not fully disclosed.

Henry, D., Cossett, D., Auletta, T., & Egan, E. (1991). Needed services for foster parents of sexually abused children. *Child and Adolescent Social Work*, *8,* 127-140. **Population:** Family-based foster care	**Method:** This article reports on a descriptive study of the service provided to foster parents who care for sexually abused children. Agency directors, social workers and foster parents were asked to respond to mailed questionnaires, which focused on the foster parents' knowledge of the abusive events, their responses to the children's most problematic symptoms, and available and needed services. Subjects were selected from the first 100 cases of children referred over a two year period to The Child Sexual Abuse Diagnostic and Treatment Center. Thirty of these children were identified as foster children. Telephone contact was initiated with 21 foster families. Eight foster agencies, 12 social workers (for 16 sexually abused children) and 8 agency directors were identified. Participants also completed telephone interviews. **Findings:** All directors reported that the agency informed foster parents of previous sexual abuse prior to placement, but only half of foster parents in the sample admitted knowledge of the children's abusive experiences prior to placement. All respondents agreed that foster parents of sexually abused children needed specialized training and education. Agency staff indicated that they provided adequate parent training and education to foster parents; foster parents noted the services were not adequate for their needs. More than half of the foster parents in the sample indicated the need for more training. Foster parents expressed need for ongoing support and training throughout the entire placement period. **Limitations:** The manner in which the questionnaires were written allowed the possibility of multiple interpretations of questions.
Rhodes, K. W., Orme, J. G., & Buehler, C. (2001). A comparison of family foster parents who quit, consider quitting, and plan to continue fostering. *Social Service Review, 75*, 84-114.	**Method:** This descriptive study examined why some foster families continue to foster whereas others do not. Data for the analysis were from the National Survey of Current and Former Foster Parents (NSC&FFP), which was conducted in 1991. Only current foster homes started by 1985 are examined in the study. Of the total sample of 1,048 current foster homes, 336 were approved in 1985 or after. Of these 317 completed the long interview form (94%). Of the sample of 267 current foster families was further divided into parents who planned to continue fostering families was further divided into

Population: Family-based foster care	parents who planned to continue fostering and parents who planned to quit. Of the sample of 265 former foster homes, 144 completed the long interview form (54%). **Findings:** Most foster parents cited more than one reason for discontinuing foster care. Common reasons included lack of agency support, poor communication with workers, and children's behaviors. The findings from comparing former foster parents with those who planned to quit soon suggest that several variables are more critical to current parents who are planning to quit than to foster parents who already quit. Frequent reasons included, health problems, full time employment, inadequate reimbursement, lack of day care, not having a say in child's future, seeing children leave, and problems with child's biological families. Less than one third of foster parents reported having enough information about the legal aspects of foster care, or about working with children who were of a different race, handicapped, or sexually abused. Findings suggest that after quitting, foster parents might perceive they lacked information about the unique parenting demands of foster children, whereas agency relationships might be a deciding factor that results in qualified homes planning to quit. Training appeared to positively impact a foster parents continued fostering, that is if a foster parent received additional training, they were more likely to continue fostering. Many of the foster parents who intend to quit fostering believed that their families and foster children are not receiving adequate services and that they have no say in the children's futures. Limitations: Use of a point-in-time sample might have led to overrepresentation of current foster families with longer services. Study focused only on nonkinship foster family retention. Relatively few of the comparisons made indicated statistically significant differences between continuing, planning to quit, and former foster parents. NSC&FPP used a retrospective rather than prospective research design.

Runyan, A., & Fullerton, S. (1981). Foster care provider training: A preventive program. *Children and Youth Services Review, 3,* 127-141. **Population:** Family-based foster care	**Method:** 127 foster parents participated in a 10-week training program designed to assist foster parents in understanding of problems in child development and behavior and in the use of effective methods for promotion of the child's emotional and social adjustment. **Findings:** Evaluative data suggest that parental attitudes improved, problem behavior of the foster children decreased, and parent-agency relationships were enhanced following training. **Limitations:** No control was used in this study; the findings should be considered tentative.
Sanchiricho, A., Lau, W. J., Jablonka, K., & Russell, S. J. (1998). Foster parent involvement in services planning: Does it increase job satisfaction? *Children and Youth Services Review, 20,* 325-346. **Population:** Family-based foster care	**Method:** This descriptive study examined the impact of foster parent involvement in service planning on foster parent job satisfaction. In addition, this study examined the effects of foster parent training and the role of caseworkers in the relationship between involvement and satisfaction. Data was drawn from a survey of 1500 current New York State foster parents. 616 foster parents completed the mailed questionnaire. **Findings:** 84% of foster parents reported that they have cared for foster children who exhibited special needs. Less than half (48.5%) of parents received pre-service training in service planning. More than one third of parents (37.0%) received in-service training in service planning. Forty percent of respondents did not receive any training on how to carry out service plans or how to be an active partner in the service planning process. Parents who had in-person contact with the child's caseworker reported a higher quality of involvement in service planning than those who lacked such contact. While both pre-service training and in-service training were both related to quality of involvement, only pre-service training produced a statistically significant effect in the multivariate analysis. Educational attainment had a negative effect on both the quality of involvement in service planning and job satisfaction. Respondents who cared for special needs children reported a lower quality of involvement in service planning than those who had not cared for such children.

	Limitations: The low response rate threatens internal validity of the study due to the possibility that respondents differed from non-respondents in ways that may have been influenced in the findings. The data were obtained from a survey conducted in a single state.
Urquhart, L. R. (1989). Separation and Loss: Assessing the impacts on foster parent retention. *Child and Adolescent Social Work, 6*, 193-209. **Population:** Family-based foster care	**Method**: A comparative census survey of statewide foster parent population was conducted. Currently licensed homes were compared with those previously licensed on factors pertaining to the separation and loss experience. A total of 376 foster parents participated in the study, 275 (43% response rate) from open homes and 101 (15% response rate) from closed homes. All foster parents are or were licensed in the state of New Mexico. **Findings:** Significant differences were found in two major dimensions: 1) training and 2) agency services and supports. Both dimensions were indicated to be valuable factors of foster parent retention. **Limitations:** There was a low response rate of closed homes, and reliance on self-reported survey measures in this study. Additionally, the survey was constructed in an "always" or "never format.
Meta-Analytic Review of Parent-Training Programs	
Kaminski, J., Valle, L. A., Filene, J. H., & Boyle, C. L. (2008). A meta-analytic review of components associated with parent training program effectiveness. *Journal of Abnormal Child Psychology, 36*, 567-589. **Population:** Parents and caretakers, including foster and adoptive parents	**Method:** This study used meta-analytic techniques to synthesize the results of 77 published evaluations (from 1990 to September 2002) of parent training programs that intended to enhance behavior and adjustment in children aged 0-7. The objective was to determine which program components of parent training programs were reliably associated with more successful outcomes for parents and children. (All articles included in the analysis utilized appropriate, relevant comparison groups.) **Findings:** The use of parent training programs for changing parenting behavior and preventing or ameliorating child behaviors was supported. However, parent training programs were more effective at changing parenting outcomes than child outcomes. Training programs were most able to create changes in parenting knowledge, attitudes, and self-efficacy, but positive effects were also found for parenting behaviors and skills. Effective elements of training programs included: increasing positive parent-child

	interactions (in non-disciplinary situations) and emotional communication skills; teaching parents to use time out; and teaching disciplinary consistency. **Limitations:** Many studies had missing data, which limited the researcher's ability to conduct moderator analysis on the impact of intervention dosage, participant demographic characteristics, intervention location, and facilitator/provider qualifications on behavioral changes. The results are correlational and thus do not imply cause and effect.
Nova Model of Foster Care Education	**Emerging Practice**
Fees, B. S., Stockdale, D. F., Crase, S. J. Riggins-Caspers, K., Yates, A., & Lekies, K. S. (1998) Satisfaction with foster parenting: assessment one year after training. *Children and Youth Services Review*, *20*, 347-363. **Population:** Family-based foster care	**Method:** This descriptive study examined whether demographic characteristics, preservice training, and prior experience with children and families impacted satisfaction among foster parents one year after completion of pre-service training. Participants were recruited from a one year longitudinal study of individuals enrolled in family foster parent preservice training in 10 of 13 sites in Iowa in 1994. Participants needed to have: 1) completed a 12-hour preservice training (NOVA Foster Parent Preservice Training Curriculum) and returned follow-up surveys, 2) achieved licensure; and 3) had placements within 12 months after training. **Findings:** Participants reported higher satisfaction with role demands of foster parenting if they felt preservice training was useful and/or if they had more experience with children or families. Social service support and personal needs satisfaction had no significant relationship with any predictor variable. **Limitations:** Participants were recruited from 13 different sites where they received preservice trainings. No method was present to ensure that the curriculum was presented in similar fashions or in its entirety.

Pasztor, E. M. (1985). Permanency planning and foster parenting: Implications for recruitment, selection, training and retention. *Children and Youth Service Review,* 7, 191-205. **Population** Family-based foster care	**Method**: This article discusses the changing role of foster parents in regards to permanency planning. It describes the Foster Parent Project from Nova University; specifically recruitment, selection, training and retention of foster parents. The project goal was to develop a model that could be replicated by large, small, urban and rural agencies. The model has been used either statewide or in parts of 22 states, as well as sections of Ontario, Canada. This article gives an overview of exploratory research that has been conducted in these areas. The model has four main premises: 1) agency language, recruitment strategies and foster parent support need to change in order for foster parents to learn to work in ways that are more compatible with permanency planning goals, 2) involve foster parents as team members in permanency planning agencies, 3) the role of the foster parent should be clearly defined regarding permanency planning responsibilities, and 4) foster parent retention depends on the degree to which they are supported by others in the system. The training component of the Nova model includes an orientation meeting, followed by six sessions (approximately three hours each and including up to 30 participants) to combine foster parent preservice training with the home study process. Session content includes: 1) foster care program goals and agency strengths and limits in achieving those goals; 2) foster parent roles and responsibilities; and 3) the impact of fostering on foster families and on children and parents who need foster care services. Learner-centered, nondirective teaching methods are used to help prospective foster parents assess their own strengths and limits in working with children and parent who need foster care services. Role playing and guided imagery are heavily utilized. **Findings:** A study of this model in Florida found: 1) licensing rates increased by 21%, 2) placement disruptions decreased by almost 50% in Nova-training foster homes. A study of this model in Texas found that placement disruptions statewide fell to 169 from 280. **Limitations:** Data provided for the studies are not published in peer-reviewed journals; their design is exploratory in nature.

Parent Resources for Information, Development, and Education (PRIDE)	**Emerging Practice**
Christenson, B. & McMurty, J. (2007). A comparative evaluation of preservice training of kinship and nonkinship foster/adoptive families. Child Welfare League of America. **Population:** Family-based kinship and nonkinship foster and adoptive care	**Method:** This article examines (using a pre-test/post-test design) the PRIDE training competencies in kinship and nonkinship families to evaluate if the preservice training and resource family development program meets the curriculum competency goals to prepare foster and adoptive parents to provide service. 228 prospective foster/adoptive parents age 21 and older (69 kinship and 159 nonkinship) who enrolled in the Foster PRIDE/ Adopt PRIDE preservice training throughout the seven regions of Idaho participated in this study. All families participated in 27 hours of PRIDE training. PRIDE is a model for the development and support of foster care families that is used by private and public child welfare agencies in 30 states and 19 other countries. ***PRIDE*** is designed to strengthen the quality of foster care and adoption services by providing a standardized, structured process for recruiting, training, and selecting foster parents and adoptive parents. **Findings:** Kinship providers showed a larger lack of medical, spiritual, and mental health services and support than non-kinship providers. Non-kinship providers significantly increased their competencies regarding foster care. In other words, the program met the curriculum competency goals to prepare non kinship foster and adoptive parents. However, training may not meet all needs of kinship care providers. **Limitations:** Lack of replication, the study was conducted in Idaho which has less diversity, and there is no long-term longitudinal evaluation of PRIDE.
Parenting Models	
1-2-3 Magic	**Efficacious Practice**
Bradley, S. J., Jadaa, D., Broudy, J., Landy, S., Tallett, S. E., & Watson, W. et al, (2003). Brief psychoeducational parenting program: An evaluation and 1-year follow-up. *Journal of the American Academy of Child and Adolescent Psychiatry, 42*, 1171-1178.	**Method:** This study used an RCT to evaluate the effect of 1-2-3 Magic on child behavioral outcomes. 222 families with children aged 3-4 years were randomly assigned to 1-2-3 Magic or a wait-list control group. *1-2-3 Magic* is a group format discipline program for parents of children 2-12 years of age. Parenting responsibilities are divided into three tasks: controlling negative behavior, encouraging good behavior, and strengthening the child-parent relationship.

Population: Family-based foster care	**Findings:** Parents' parenting behavior improved on over-reactivity, laxness, and verbosity. Children were less hostile/aggressive, anxious, andhyperactive/distractable, and had less difficult behavior as a result of participating in 1-2-3 Magic. At the one-year follow-up, a subgroup of the original 1-2-3 Magic group showed maintained improved results on parenting behavior and child behavior, although difficult behavior improvements were not maintained. **Limitations:** The sample was predominately white, middle-class and educated; the results might not generalize to other groups.
Behaviorally-Oriented Training	**Emerging Practice**
Boyd, L. H. & Remy, L. L. (1978). Is foster-parent training worthwhile? *Social Service Review, 52*, 275-29. **Population:** Family-based foster care	**Method**: This study was a two year follow-up evaluation on a behaviorally-oriented training program for foster parents. The original training consisted of an intensive behaviorally-oriented sixteen week program. Classes were complemented with in-home visits from the private agency staff. The 267 placements were divided according to whether the foster parents were trained or not trained, whether placements were short or long term, and whether training preceded or followed the placement, resulting in five groups of placements. The first group consisted of children who were in placement two years or less and whose parents were trained prior to placement (N = 55); the second group, a comparable (control) group, consisted of children who were in placement two years or less and whose parents had no training (N = 113); the third group consisted of children who were in placement longer than two years and whose parents were trained during or after placement (N=27); the fourth (control) group consisted of children who were in placements longer than two years and whose parents were not trained (N=40); a fifth residual group consisted of 32 child placements which did not meet the other conditions. **Findings:** Altogether, 87.5% of a total of 120 foster families were examined. Of these 46.7% were no longer licensed. Of those examined, only 34.4% had one or both parents trained. Altogether 267 placements were studied. Foster parent training had a decisive impact on all placement outcomes. **Limitations:** The sample and measures which were used to obtain the data were not fully described.

Boyd, L. H., & Remy, L. L. (1979). Foster parents who stay licensed and the role of training. *Journal of Social Service Research, 2,* 373-87. **Population:** Family-based foster care	**Method**: This study was a two-year (exploratory) follow-up evaluation on a behaviorally-oriented training program for foster parents. The original training consisted of an intensive behaviorally-oriented sixteen week program. Classes were complemented with in-home visits from the private agency staff. A total of 267 placements (from 105 foster family homes) participated in the study. **Findings:** Trained parents were significantly more likely than untrained parents to relicense. Training appears to have been profitable for every combination of foster parent types and foster child characteristics. However, training most helped *home centered* foster parents (less assertive parents who have little involvement in the community) who had high risk children. The second most helped category also involved home centered parents but, in this case, with low risk children. The third most helped category consisted of community oriented parents (parents who tended to be assertive and high on community activism) with low risk children, and the least helped category consisted of these parents with high risk children. **Implications:** Although training is helpful to all foster parents, it seems to be more beneficial to particular types of foster parents, such as those who are home centered.
Van Camp, C. M., Vollmer, T. R., Goh, H., Whitehouse, C. M., Reyes, J., & Montgomery, J. L. et al. (2008). Behavioral parent training in child welfare: Evaluations of skills acquisition. *Social Work Practice, 18*, 377-391. **Population:** Family-based foster care.	**Method:** This article examines the extent to which behavioral parent training was effective in increasing skills of caregivers. Two groups were compared: a group of caregivers trained with a 30-hour training series and a group of four foster parents who were trained with an abbreviated version. *Study 1:* caregivers of children in child welfare completed behavioral parent training via 30 hours of classroom training and optional in-home visits by a behavior analyst. Of the 247 caregivers, 163 completed the course and the average attrition level was 34%. The consisted of a total of 30 hours of training and was taught in 3-hour sessions once per week for 10 weeks. Assessments were done through role-play situations and the participants were asked to respond how they normally would in such a situation. During the assessments participants' behavior was observed by a behavior analyst, who scored their accuracy.

	Study 2: Participants included four foster parents who completed training similar to that described in study 1. The training was abbreviated. For two of the participants, parts of the training were omitted. **Findings:** Parents in all of the non-abbreviated courses demonstrated improvements in parenting skills following training, as assessed during in-class role plays. Results indicated that in each of the courses, the average level of skill accuracy nearly doubled following training. All four participants in study 2 developed better accuracy following training; these increases occurred only after training for each specific skill. Thus, increases in parenting skills were found in both studies as a function of curriculum training. **Limitations:** Analysis of in-home parent and child behavior is limited as participants volunteered themselves. There was no analysis of the effects of parent training on child behavior. The behavioral observer was not blind to the parents' condition, and therefore may have expected more from parents.
Cognitive Behavioral Training	**Emerging Practice**
Macdonald, G., & Turner, W. (2005). An experiment in helping foster carers manage challenging behavior. *British Journal of Social Work, 35*, 1265-1282. **Population:** Family-based foster care	**Method:** This study utilized an RCT to test the effectiveness of cognitive-behavioral methods in the management of difficult behavior for foster carers. 117 foster carers were randomly assigned to either a cognitive-behavioral training group (n=67) or a waiting list control (n=50). Those in the control group continued to receive standard services. **Findings:** Contrary to expectations, no statistically significant differences were found between the groups with regard to behavior management skills, the frequency and/or severity of behavioral problems, and placement stability. However, foster carers expressed satisfaction with the overall training program and increased confidence in dealing with difficult behavior. **Limitations:** A small sample size, drop out of participants from the control group, and the preference by therapists and parents for the treatment group limit the results of this study.

Foster Parent Skills Training Program (FPSTP)	**Promising Practice**
Brown, D. (1980). A comparative study of the effects of two foster parent training methods on attitudes of parental acceptance, sensitivity to children, and general foster parent attitudes. Doctoral Dissertation, Michigan State University, East Lansing. Retrieved August 1, 2008 from ProQuest Digital Dissertations database. (Publication no. AAT NQ46809). **Population:** Family-based foster care	**Method:** This study utilized an RCT to compare the effects of two formalized training programs (FPSTP and ISSUES) on foster parents' attitudes of parental acceptance, sensitivity to children, and general foster parent attitudes. Fifty-nine foster parents were randomly assigned to one of five treatment groups. Two groups received the Issues in Fostering (Issues) curriculum; two groups received the Foster Parent Skills Training Program (FPSTP) curriculum; and one group (the control group) did not receive any training. Trainers were also randomly assigned to a training program, and trained and supervised by representatives of those programs. Participants made a 10 -12 week commitment to their assigned training program. The FPSTP curriculum focused on children between ages five and 12. Nine of the ten program sessions addressed developing helping skills including 1) skills of empathy, relationship development, understanding child need, and development; and 2) skills of child management. The last session involved skill integration. **Findings:** No differences were found between the groups on parental acceptance or general foster parent attitudes. No differences were found between combined training group scores and the control group on sensitivity to children. However, parents in the FPSTP group were more sensitive to children following the training than were parents in the ISSUES group, as indicated by the higher use of "effective" responses in the FPSTP group. Additionally, parents in the FPSTP group increased their usage of "effective" responses over time. Results suggested that the FPSTP training offered more help with a larger percentage of the foster parents' self-reported problems than did the ISSUES training. The ISSUES training had its greatest impact in helping foster parents deal with problems with agency representatives. **Implications:** Training curriculum may be developed in a way that combines the strengths of both programs. It was suggested that information from the ISSUES training that deals with separation trauma, and information that defined the foster parents' role in relationship to other professionals should be added to the FPSTP curriculum. **Limitations:** All participants expressed desire for training; there could be high levels of

	motivation, openness to instruction, and the desire to change. There was high attrition for the control group. The instruments used required a specific level of reading and comprehension skills.
Guerney, L. (1977). A description and evaluation of a skills training program for foster parents. *American Journal of Community Psychology, 5,* 361-371. **Population:** Family-based foster care	**Method:** This study utilized a controlled design to assess a skills-training program (FPSTP) for foster parents of children aged 5 to 12 years. Participants in the FPSTP group were recruited through child welfare agencies in Pennsylvania. The no-contact control group was comprised of individuals who expressed interest but were unable to participate in the training. Pre- and post-test scores on accepting attitudes towards foster children, the ability to employ parenting responses defined as desirable, and the ability to refrain from using parenting responses defined as undesirable were compared. **Findings:** The FPSTP group demonstrated higher acceptance scores, an increased use of desirable parent responses, and a decrease in the use of undesirable parent responses compared with the control group. Undesirable parent responses increased in the control group. Gains were maintained for approximately nine months following program completion. **Limitations:** Significant subject loss from both FPSTP and control groups occurred. Follow-up measures were difficult to obtain due to participants not returning completed measures.
Guerney, L. F., & Wolfgang, G. (1981). Long-range evaluation of effects of foster parents of a foster parent skills training program. *Journal of Clinical Child Psychology. 10,* 33-37. **Population:** Family-based foster care	**Method:** This study is a long-range evaluation of the Foster Parent Skills Training Program (FPSTP) as the program advanced from a university research and demonstration project to a program used in child welfare agencies. Control groups were utilized in several of the outcome studies. The evaluation measured the program's impact on: 1) skill acquisition, 2) parent attitudes, 3) foster children as perceived by agency personnel and foster parents, 4) agencies, 5) relationship between agencies and foster parents, and 6) the ability of agency-based trainers to train foster parents effectively. **Findings:** The study results confirmed the FPSTP's ability to increase foster parents' 1) attitudes of acceptance towards children, 2) development of skills associated with promoting child and parent relationships, and 3) ability to reduce the use of undesirable parent-child responses. These results were maintained at follow-up, approximately nine

	months after program completion. Mixed results were found for increasing foster parents' perceived competence. **Implications:** Researchers purport that the studies effects are positive even for parents of children outside of the age range that the program was originally designed for, and among children with exceptional needs. **Limitations:** This article does not indicate how many subjects were in each study or how participants were assigned to control and treatment groups. Additionally, approximately half of the participants in the follow-up studies attended a "refresher course;" participants who attended the "refresher course" did better than those who did not attend. The maintained results may be inflated due to this fact.
Incredible Years (IY)	**Effective Practice**
Baydar, N., Reid, M.J., & Webster-Stratton, C. (2003). The role of mental health factors and program engagement in the effectiveness of a preventive parenting program for Head Start mothers. *Child Development, 74*, 1433-1453. **Population:** Children enrolled in Head Start and their families	**Method:** This study utilized an RCT to test the effectiveness of the Incredible Years (IY) program. A total of 882 children who attended Head Start (mean age = 4.7 years) were randomly assigned to either the IY intervention group (n=607) or the control group which received the standard Head Start curriculum (n=275). The IY program has components which focus on parent training, teacher training, and child training. The parent training is broken down into different programs; Early Years (ages 2-7), School-Age (5-12), ADVANCE (4-10), and EDUCATON (supplements earlier programs). All programs include videotapes, extensive group leader manuals, books for parents, home activities, and refrigerator notes. The programs are offered as parent group discussions facilitated by 1-2 trained leaders; each group includes 12 to 14 parents. In addition, videotape modeling, role-playing and rehearsal, weekly homework activities, weekly evaluations, phone calls, makeup sessions, and buddy calls are included in the program. Teacher training is designed to train teachers in classroom management skills and motivate students. It is offered to groups of teachers and may be delivered in six, monthly day-long workshops or in weekly 2-hour sessions for 24 weeks. The child training program, *Dina Dinosaur's Social Skills and Problem-solving Curriculum*, is designed to teach groups of children friendship skills, appropriate conflict management strategies, successful classroom behaviors, and empathy skills.

	Programming includes videotape modeling, fantasy play and instruction, role playing, activities, feedback and reinforcement, and fostering skills maintenance and generalization. **Findings:** Mothers with mental health risk factors (depression, anger, history of abuse as a child, and substance abuse) exhibited poorer parenting skills than those without risk factors. However, mothers with risk factors engaged with and benefited from the parenting training program at a level comparable to mothers without these risk factors. Program engagement was assessed by number of sessions attended, percentage of homework assignments completed, and the group leader's rating of engagement. IY mothers had lower scores on both harsh/negative parenting and ineffective parenting and higher scores on supportive parenting.
Gardner, F., Burton, J., & Klimes, I. (2006). Randomised controlled trial of a parenting intervention in the voluntary sector for reducing child conduct problems: Outcomes and mechanisms of change. *Journal of Child Psychology and Psychiatry, 47*, 1123-1132. **Population:** Children aged 2-9 with clinical levels of conduct problems	***Method:*** *This study utilized an RCT to examine the effectiveness of IY for reducing child conduct problems. A total of 76 children (aged 2-9 years) who had clinical levels of conduct problems were randomly assigned to an IY group or waitlist control.* ***Findings:*** Results indicated that parents in the IY group increased their positive and decreased their negative parenting behaviors. Children improved on negative behaviors and independent play. These levels were maintained at 18 months, although the comparison was with treatment baseline only. Control families were not analyzed at 18 months, because the chosen design required them to be offered the intervention at 6 months.
Linares, L. O., Montalto, D., Li, M. & Oza, V. S. (2006). A promising parenting intervention in foster care. *Journal of Consulting and Clinical psychology, 74*, 32-41.	**Method:** This study utilized an RCT to examine the effects of the Incredible Years (IY) program intervention in an effort to improve parenting practices (positive discipline, setting clear expectations), co-parenting (the extent to which parents function as partners or adversaries in their parenting roles), and child externalizing problems. One hundred twenty-eight parents (biological and foster) were recruited from one child welfare agency in New York City. Children were between the ages of three and 10 years and had been placed in foster care for an average of 8.4 months. Biological and foster parents were randomly assigned to an intervention (Incredible Years) or control (usual care) conditions.

Population: Family-based foster care	The IY group participated in a two-component intervention consisting of parenting courses and a co-parenting program. The parenting component used the *Parents and Children Basic Series Program*; covering topics such as play, praise and rewards, effective limit setting, and handling behavior. During the co-parenting component, parents were encouraged to practice open communication and negotiate conflict. **Findings:** The study found that biological and foster parents in the IY group reported significant gains in use of positive parenting and co-parenting. At follow-up (approximately 3 months after training), IY parents sustained greater improvement in positive parenting, showed gains in clear expectations, and reported a trend for fewer child externalizing problems than parents in the control group. **Implications:** The study claims that "manualized" interventions used by foster care staff are superior to standard care interventions with regarding to co-parenting. The study also shows the feasibility and cost-effectiveness of a joint formant for parent education among biological and foster parents. The study has strong support of the use of co-parenting between parents. **Limitations:** Study results were based on self reports. Sample was somewhat selective as it screened out kinship foster parents, biological parents with histories of sexual abuse, and families in which the goal was not reunification with biological parents. Replication is warranted.
Reid, M.J., Webster-Stratton, C., & Baydar, N. (2004). Halting the development of conduct problems in Head Start children: The effect of parent training. *Journal of Clinical Child and Adolescent Psychology, 33*(2), 279-291. **Population:** Children enrolled in Head Start and their families	***Method:*** *This study utilized an RCT to investigate the effect of IY on child behavior. 882 children (aged 5 or younger) who were enrolled in Head Start were randomly assigned to either the IY intervention or to the standard Head Start curriculum.* ***Findings:*** *F*amilies who had children with behavioral problems at baseline benefited most from the IY program. Changes in conduct problems were related to maternal engagement in the program and to mothers' success in implementing the positive parenting strategies taught in the program.
Reid, M.J., Webster-Stratton, & Beauchaine, T.P. (2001). Parent training in	***Method:*** *This study used an RCT to compare outcomes of children (mean age=5.7 years) whose parents participated in the IY program to those enrolled in a traditional*

Head Start: A comparison of program response among African American, Asian American, Caucasian, and Hispanic mothers. *Prevention Science, 2*, 209-227. **Population:** Children enrolled in Head Start and their families	*Head Start curriculum. A total of 634 families were randomly assigned to either the IY or control group; 474 families provided data at a one-year follow-up.* ***Findings:*** Following treatment, mothers were observed to be more positive, less critical, more consistent, and more competent than were control mothers. Differences across ethnic groups did not exceed chance levels.
Webster-Stratton, C. (2000). The Incredible Years Training Series. *Juvenile Justice Bulletin.* Office of Juvenile Justice and Delinquency Prevention. **Population:** Parents of children ages 2 to 10 without conduct problems, parents of children ages 3-10 who have conduct problems (includes biological and foster families).	**Method:** This study used a series of four RCTs to investigate the outcomes of children and youth who participated in the Incredible Years (IY) training program. **Findings:** All four studies found that IY parents reported significantly fewer child behavior problems, reduced stress levels, and more prosocial behaviors than parents in control groups. Home observations of families (from a sample of Headstart participants) indicated that IY mothers were significantly less harsh and critical in their discipline approaches and significantly more positive and nurturing than a group of control mothers. At the one-year follow-up most improvements were maintained. The BASIC program appears highly effective in reducing child conduct problems by promoting social competence, reducing parents' violent methods of discipline, and improving their child management skills. The ADVANCE program has been shown to be highly productive treatment for promoting parents' use of effective problem solving and communication skills, reducing maternal depression, and increasing children's social and problem solving skills.
Keeping Foster and Kin Parents Supported and Trained (KEEP)	**Promising Practice**
Chamberlain, P., Price, J., Leve, L. D., Laurent, H., Landsverk, J. A., & Reid, J. B. (2008). Prevention of behavior problems	**Method:** This study utilized an RCT to examine the efficacy of the Keeping Foster and Kin Parents Supported and Trained (KEEP) model in increasing foster parents' use of positive reinforcement and decreasing child behavior problems. Study participants

for children in foster care: outcomes and mediation effects. *Society for Prevention Research, 9*, 17-27. **Population:** Family-based foster care	included all parents receiving a new foster child (aged 5-12) from the San Diego County DHHS. Families were randomly assigned to the KEEP intervention or to a control (services as usual) condition. The sample consisted of 700 foster families (34% kinship, 66% non-relative). The objectives of KEEP are to give parents effective tools for dealing with their child's externalizing and other behavioral and emotional problems, and to support them in the implementation of those tools. The intervention lasted 16 weeks during which parents received training, supervision, and support in behavior management methods. The group meetings lasted 90 minutes with approximately 15 minutes devoted to didactic presentations by facilitators. Each week home practice assignments were given. **Findings:** Compared to the control condition, participation in the KEEP group increased parental effectiveness in behavioral management skills, which related to decreased child behavior problems, especially for families who reported higher levels of initial problems (more than six problem behaviors per day). **Limitations:** The study did not test the sustainability of changes in parenting over time. Of the eligible foster parents 38% declined to participate in the study. Data collected were based on parent reports of the child behaviors.
Chamberlain, P., Price, J., Reid, J., & Landsverk, J. (2008). Cascading implementation of a foster and kinship parent intervention. Manuscript in preparation. **Population:** Family-based foster care	**Method:** This study utilized an RCT to investigate the efficacy of a cascading implementation of the KEEP model with 463 foster and 237 kinship parents in San Diego County. Participants that were randomly assigned to the KEEP group received 16 weeks of foster/kinship support and training as well as supervision in behavior management methods. Intervention groups consisted of 3 to 10 foster parents. Each session lasted 90 minutes and was curriculum structured. Curriculum topics included: framing the foster/kin parents as a central role in altering the life course trajectories of children, methods for encouraging child cooperation and reinforcing normative behavior, using behavioral contingencies including effective limit setting, and balancing encouragement and limits with an emphasis on increasing rates of positive reinforcement of the child.

	Findings: At treatment termination, foster/kin parents in the KEEP condition reported significantly fewer child behavior problems than those in the control condition. These changes were found to be due to changes in parenting behavior. Foster parents in the KEEP groups showed an increase in the proportion of positive reinforcements relative to discipline parenting practiced; this increase predicted a decrease in child problem behaviors. Additionally, given proper training and supervision, the intervention can be transported to third generation interventionists who were not directly trained or supervised by the original developers of the intervention. **Limitations:** Location of meetings may have been an issue for random assignment. It is unclear if these results will sustain over time and repeated trainings using a cascading implementation.
Price, J. M., Chamberlain, P., Landsverk, J., Reid, J. B., Leve, L. D., & Laurent, H. (2008). Effects of a foster parent training intervention on placement changes of children in foster care. *Child Maltreatment*, *13,* 64-75. **Population:** Family-based foster care	**Method**: This study examined the impact of the KEEP model on child placement and disruptions utilizing an RCT. The study recruited foster and kinship parents receiving a new placement (aged 5-12) from the San Diego County DHHS. The sample included 700 foster families; 34% kinship placements and 66% non-relative placements. Participants were assigned to either the intervention (KEEP model) or control (standard child welfare casework services) condition. The intervention group received 16 weeks of training, supervision and support in behavior management methods. Curriculum topics included positive reinforcement, non-harsh discipline methods, close monitoring of the child's whereabouts, managing peer relationships, avoidance of power struggles and improving school success. **Findings:** The study found that participants in the KEEP group were twice as likely to achieve a positive exit (exits from current placement for positive reason such as reunification with biological parent or relative or adoption) by the end of the study period. The study also found that participation in the intervention group lessoned the effect of a history of multiple placements. The study suggests that building the capacities of foster parents to manage a child's behavior problems can lead to reductions in that child's disruptive behaviors to a level that can be managed by "most" foster and kinship caregivers. **Limitations**: The study focused only on the fist six and one half months following baseline assessment. Thus, the long-term effects of the KEEP model on placement changes or continuance in current placement were not examined.

Model Approach to Partnerships in Parenting (MAPP)	**Emerging Practice**
Lee, J. H. & Holland, T. P. (1991). Evaluating the effectiveness of foster parent training. *Research on Social Work Practice, 1*, 162-174. **Population:** Family-based foster care	**Method:** This study examined the efficacy of the Model Approach to Partnerships in Parenting (MAPP) model. A small pilot study of the project was conducted in two sites, making use of pretest/posttest comparison-group design to evaluate the impacts on parents. The two training groups were composed of 17 subjects. The comparison group consisted of 12 members. Training sessions were conducted in county offices by foster care and adoption staff of the Division of Family and Children's Services (Georgia). The study implemented the MAPP training program (staff was trained by MAPP developers and certified). The MAPP training curriculum is a highly structured program completed over 10-weeks. All sessions utilize lectures, group discussion and sharing, role playing exercises, and guided imagery as learning techniques. Handouts and homework assignments are distributed each session. **Findings:** There were no significant differences in trainees' scores on appropriate developmental expectations, value on physical punishment, understanding of appropriate parent-child roles, or empathy toward chldren's needs 1) after completion of the program when compared with scores prior to entry or 2) between trainees and comparison-group members either before or following intervention. **Implications:** The MAPP program was not effective in producing the desired results for this study. These findings raise questions regarding the efficacy of this popular program. **Limitations:** The authors provide several items to consider. The authors question the effectiveness of the AAPI in distinguishing important differences and question it's appropriateness for use with foster parent training programs. There was no quality assurance in the study design regarding the implementation of the MAPP program. Limited descriptive information about the sample was provided.
Puddy, R. W. & Jackson, Y. (2003). The development of parenting skills in foster parent training. *Children and Youth Services Review, 12),* 987-1013.	**Method:** This study evaluated the efficacy of the MAPP/GPS model. A total of 82 foster parents who had never been licensed as foster parents participated in the study. Participants were assigned (non-randomly) to two groups, the MAPP/GPS group (n= 62) and the control group (n=20).

Population: Family-based foster care	**Findings:** The study found that the MAPP/GPS program did not adequately prepare foster parents according to its program goals, nor did it prepare parents to manage the behavior problems of their foster children. Foster parents in the MAPP/GPS program presented change in only four of the twelve skills or criteria identified by the program for successful foster and adoptive families. **Implications:** The MAPP/GPS program is popular; the program's lack of success means many children may be underserved. **Limitations:** The sample size of the control group was small (n=20). Also, variables influencing the interventions' implementation were not controlled (i.e., there was no way to determine if trainers were doing the same thing). Third, variations in participant demographics may have affected the acquisition of parenting skills.
Rhodes, K. W., Orme, J. G., Cox, M. E., & Buehler, C. (2003). Foster family resources, psychosocial functioning, and retention. *Social Work Research, 27,* 137-150. **Population:** Family-based foster and adoptive families	**Method:** This longitudinal study examined the effect of family resources and psychosocial problems on foster parent retention. Data was collected as part of a larger study of successive cohorts of foster family applicants recruited during preservice MAPP trainings in three large counties in a southeastern US state. All families in this study completed MAPP. Only applicants to adopt and foster were recruited; kinship foster families (who are not required to take training) and therapeutic foster families (where training is given by contract agencies) were excluded from the sample. A subsample of 131 families was selected from the sample of the larger study (n = 161). Foster family resources, psychosocial problems, and retention were examined. **Findings:** Forty-six percent of the 131 families who did complete training either had already discontinued or planned to discontinue six months after training. Families with more resources, epically income, were more likely to continue. Families with more psychosocial problems and few resources expressed greater uncertainty about continuing. **Implications:** The large number of families that complete training and then discontinue services after six months suggests the need for more screening at the front end. Additional supports to those who have less income resources may be needed.

	Limitations: The sample size may have been insufficient to detect small effect sizes. Additionally, the sample was from a public agency in only one state. Only data from families who completed training was obtained.
Multidimensional Treatment Foster Care (MTFC)	**Effective Practice**
Chamberlain, P., Leve, L. D., & DeGarmo, D. S. (2007). Multidimensional Treatment Foster Care for girls in the juvenile justice system: 2-year follow-up of a randomized clinical trial. *Journal of Consulting and Clinical Psychology, 75,* 187-193. **Population:** Adolescent girls with criminal, antisocial, and delinquent behaviors (Family-based Treatment Foster Care)	**Method:** This study examines the 2-year follow-up study to determine the efficacy of Multidimensional Treatment Foster Care (MTFC) on incarceration and delinquency rates in juvenile justice girls (aged 13-17) who were referred to out-of-home care (N=81). The girls were randomly assigned into the experimental condition (MTFC; n=37) or the control condition (GC; n=44). The control condition was the standard intervention service provided for delinquent girls who were referred for out of home care. MTFC is a model of treatment foster care for children 12-18 years old with severe emotional and behavioral disorders and/or severe delinquency. MTFC aims to create opportunities for youths to successfully live in families rather than in group or institutional settings, and to simultaneously prepare their parents (or other long-term placement) to provide youth with effective parenting. MTFC parents receive 12 -14 hours of pre-service training, participate in group support and assistance meetings weekly, and have access to program staff back-up and support 24 hours a day/7 days a week. In addition, MTFC parents are contacted daily (Monday through Friday) by telephone to provide the Parent Daily Report (PDR) information, which is used to relay information about the child's behavior over the last 24 hours to the treatment team and to provide quality assurance on program implementation. **Findings:** Participation in MTFC resulted in better outcomes than placement in GC at 12- and 24 month follow-ups. Findings show that effects found at 1 year (see Leve, Chamberlain & Reid, 2005), were maintained at the 2 year assessment with a slightly larger impact and that trajectories of reductions across the course of the study were significantly larger for MTFC girls. **Limitations:** A small, predominantly Caucasian sample size limits the generalizability of these findings. Additionally, the results suggested some inconsistency in the self-reports of delinquent activity; a number of girls underreported their delinquent activity. These findings are first of their kind and need to be replicated.

Chamberlain, P., & Moore, K. J. (1998). A clinical model of parenting juvenile offenders: A comparison of group versus family care. *Clinical Child Psychology and Psychiatry, 3*, 375-386. **Population:** Adolescent boys with criminal, antisocial, and delinquent behaviors (Family-based Treatment Foster Care)	**Method:** This study utilized an RCT to compared outcomes for 39 boys (aged 12-17) who participated in MTFC and 40 in group care (GC) placements. Community families were recruited and trained to provide placements for study boys. One boy was placed per home. GC boys were placed with 6-15 others with similar delinquency problems. **Results:** Boys who participated in MTFC had significantly fewer criminal referrals and returned to live with relatives more often.
Chamberlain, P., & Reid, J. (1998). Comparison of two community alternatives to incarceration for chronic juvenile offenders. *Journal of Consulting and Clinical Psychology, 6*, 624-633. **Population:** Adolescent boys with criminal, antisocial, and delinquent behaviors (Family-based Treatment Foster Care)	**Method:** This study utilized an RCT to examine the efficacy of the Multidimensional Treatment Foster Care (MTFC) program. 79 boys (aged 12-17) years were randomly assigned to either the *MTFC* program or Group Care (GC). MTFC boys lived with foster parents trained in the use of the program. **Findings:** Participation in MTFC produced more favorable outcomes than participation in GC. Boys ran away less frequently from MTFC than from GC, completed their programs more often, and were locked up in detention or training schools less frequently. MTFC boys had fewer criminal referrals than boys in GC from the time they were placed through the year after discharge from the programs. They also reported that they committed fewer delinquent acts and fewer violent or serious crimes. Finally, boys in the MTFC group spent more days living with their families in follow up. These differences held even among older youths and those who began exhibiting delinquent behaviors at a younger age (groups which have been shown to be less likely to show benefits).
Eddy, M. J., Whaley, R. B., & Chamberlain, P. (2004). The prevention of violent behavior by chronic and serious male juvenile offenders: A 2-year follow-up of a randomized clinical trial. *Journal of Family Psychology, 12*, 2-8. **Population:** Adolescent boys with criminal, antisocial, and delinquent	**Method:** This study is a 2-year follow-up of a randomized trial which assessed the efficacy of the MTFC model in preventing violent behavior. A sample of 39 boys (aged 12-17) who participated in MTFC and 40 in group care (GC) placements was utilized in this study. Community families were recruited and trained to provide placements for study boys. One boy was placed per home. GC boys were placed with 6-15 others with similar delinquency problems. **Results:** Boys in the MTFC group had fewer violent offenses and fewer self-reported overall criminal activities in follow-up than did boys in the GC control condition.

behaviors (Family-based Treatment Foster Care)	
Eddy, J. M., & Chamberlain, P. (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, 5*, 857-863. **Population:** Adolescent boys with criminal, antisocial, and delinquent behaviors (Family-based Treatment Foster Care)	**Method:** This study explored mediators for the effectiveness of MTFC in a sample of 39 boys (aged 12-17) who participated in MTFC and 40 in group care (GC) placements. Community families were recruited and trained to provide placements for study boys. One boy was placed per home. GC boys were placed with 6-15 others with similar delinquency problems. **Results:** Parenting practices (supervision, discipline, positive reinforcement and positive interactions with parents) and limiting association with delinquent peers mediated the effects of program type on outcomes.
Eddy, J. M., Whaley, R. B., & Chamberlain, P. (2004). The prevention of violent behavior by chronic and serious male juvenile offenders: A 2-year follow-up of a randomized clinical trial. *Journal of Emotional and Behavioral Disorders, 12,* 2-8. **Population:** Adolescent girls with criminal, antisocial, and delinquent behaviors (Family-based Treatment Foster Care)	**Method:** This study utilized an RCT to test the 2-year follow-up efficacy of the MTFC program. 79 adolescent males who were involved with the juvenile justice system were randomly assigned to MTFC or usual group home care (GC). **Findings:** MTFC youth were significantly less likely to commit violent offenses than GC youth. 25% of the GC youth had two or more criminal referrals for violent offenses in the two year period vs. only 5% for the MTFC youth. The rates of self-reported violent offending for MTFC youth were in the normative range in the two year period whereas rates for GC youth were four to nine times higher. MTFC youth were also significantly less likely to report incidents of common violence, such as hitting.
Harmon, K. (2005). A qualitative exploration of foster parents' experiences: Preparation and placement in a multidimensional treatment foster care program. Doctoral Dissertation, Alliant International University, San Diego, California. Retrieved August 1, 2008 from ProQuest Digital Dissertations database.	**Method:** This study used a qualitative design to investigate the experience of foster parents as they progressed through various stages of training and child placement in an MTFC program. Participants included 11 foster parents ranging in age from 20 to 56- years-old who were participating in an MTFC program through an established foster family service agency in Southern California. **Findings:** Parents expressed positive feelings about the following three program features: 1) effective communication between the parents and the agency;

(Publication no. AAT 3164907) **Population:** Family-based Treatment Foster Care	2) components of the required Parent Daily Report (PDR) phone calls; and 3) the implementation of the point and level system. Results indicate that particular training components were seen as essential in foster care programs to promote effective foster parenting and positive responses from foster children. Foster Parents indicated that training needed provide skills on using consistent, flexible, positive parenting. This included a point and level system for behavioral stabilization, positive parenting (recognizing emotional needs of the child and understanding the communication behind behaviors), and continued support in the implementation of creative discipline **Limitations:** Qualitative method of the study does not allow generalizability outside of specific population. Some participants were not as fluent in English as first thought. Difficulty of the parents expressing themselves emotionally was found, even with a structured interview.
Kyhle, P. W., Hansson, K., & Vinnerljung, B. (2007). Foster parents in Multidimensional Treatment Foster Care: How do they deal with implementing standardized treatment components? Children and Youth Services Review, 29, 442-459. **Population:** Adolescent girls with criminal, antisocial, and delinquent behaviors (Family-based Treatment Foster Care)	**Method:** This exploratory study focused on the experiences of foster parents who worked in an MTFC program in Sweden. A total of 28 foster parents who worked or had worked with the MTFC program participated in the study; this included 16 foster parents who had ongoing placement in the MTFC program, and 12 foster parents had concluded at least one MTFC placement. **Findings:** Of the total 28 foster parents, 17 (60%) had previous experience working as traditional foster parents before they started the MTFC program. The vast majority of foster parents were generally very positive about working with the manual. This was shown in both the quantitative and qualitative analysis. Analysis of the foster parents as a group rated approximately 80% of the highest possible positive values on all components of the program. Among the instruments, the Parent Daily Report checklist had the lowest rating. The interviews revealed three different groups: Group 1 considered involvement with the youth to be a professional job; group A had a professional attitude toward foster parenthood but did not wish to be governed by the program; and group 3 viewed foster parenthood as a “way of life” and had a positive but also more relaxed attitude toward the program. The results show that foster parents

	positively perceive the manual-based program although it involved restrictions and limitations to their autonomy within their family's daily life. **Limitations:** Standardized instruments were not used. A small, Swedish sample limits the generalizability of the findings. No information about attitude change over time, or follow-up period was mentioned.
Leve, L. D., & Chamberlain, P. (2005). Association with delinquent peers: Intervention effects for youth in out-of-home care. *Journal of Abnormal Child Psychology, 33*, 339-347. **Population:** Adolescents with criminal, antisocial, and delinquent behaviors (Family-based Treatment Foster Care)	**Method:** This study utilized data from two RCTs (one male sample and one female sample) with delinquent adolescents randomly assigned to either MTFC or group care (GC) as a control. The randomized sample consisted of 73 MTFC youth (36 boys and 37 girls) and 80 GC youth (36 boys and 44 girls) aged 12-17. **Findings:** MTFC youth had fewer associations with delinquent peers at 12 months than did the GC youth. Further, associating with delinquent peers during the course of the intervention mediated the relationship between group condition and 12-month delinquent peer association.
Leve, L. D. & Chamberlain, P. (2007). A randomized evaluation of Multidimensional Treatment Foster Care: Effects on school attendance and homework completion in Juvenile Justice girls. *Social Work Practice, 17,* 657-663. **Population:** Adolescent girls with criminal, antisocial, and delinquent behaviors (Family-based Treatment Foster Care)	**Method:** This study examines the efficacy of MFTC on school attendance and homework completion in juvenile justice girls (aged 13-17) who were referred to out-of-home care (N=81). The girls were randomly assigned into the experimental condition (MTFC; n=37) or the control condition (GC; n=44). The control condition was the standard intervention service provided for delinquent girls who were referred for out of home care. **Findings:** MTFC girls had higher levels of homework completion and school attendance than did GC girls after program participation. Results suggest that MTFC effectively reduced girls' delinquency outcomes and effectively increased girls' educational engagement due to girls in MTFC spending more time than GC girls on homework while in treatment (regardless of treatment setting). Also, homework completion while in treatment reduced girls days in locked settings at the 1-year follow-up. **Limitations:** A small sample size limits the generalizability of the findings.

Leve, L. D., Chamberlain, P., & Reid, J. B. (2005). Intervention outcomes for girls referred from juvenile justice: Effects on delinquency. *Journal of Counseling and Clinical Psychology, 73,* 1181-1158. **Population:** Adolescent girls with criminal, antisocial, and delinquent behaviors (Family-based Treatment Foster Care)	**Method:** This study examines the 12 month efficacy of MFTC on incarceration and delinquency rates in juvenile justice girls (aged 13-17) who were referred to out-of-home care (N=81). The girls were randomly assigned into the experimental condition (MTFC; n=37) or the control condition (GC; n=44). The control condition was the standard intervention service provided for delinquent girls who were referred for out of home care. **Findings:** MTFC was more effective than the control condition in reducing incarceration and delinquency rates. The MTFC girls had spent 52 fewer days in locked settings at follow-up than they had in the 12 months preceding treatment. Results suggest that MTFC is more effective than group care in reducing delinquency in girls referred for out of home care. **Limitations**: A small, predominantly Caucasian sample size limits the generalizability of these findings. Additionally, the results suggested some inconsistency in the self-reports of delinquent activity; a number of girls underreported their delinquent activity. These findings are first of their kind and need to be replicated.
Multidimensional Treatment Foster Care – Preschool (MTFC-P)/Early Intervention Foster Care Program (EIFC) **Efficacious Practice**	
Fisher, P. A., Burraston, B., & Pears, K. (2005). The Early Intervention Foster Care Program: Permanent placement outcomes from a randomized trial. *Child Maltreatment 10,* 61-71. **Population:** Family-based foster care for children aged 3-6 who have behavioral problems or developmental delays	**Method:** This study utilized an RCT to test the efficacy of the Early Intervention Foster Care (EIFC) program on children's permanent placement outcomes. 90 children (aged 3-6) in need of a new foster placement (including children who were new to the foster care system, those reentering foster care, and those moving between placements) were randomly assigned to either the EIFC (n=47) or regular foster care comparison condition (n=43). Parents of the EIFC group received training, supervision, and support and children received behavioral therapy as needed. The Early Intervention Foster Care (EIFC) project is an efficacy trial of the Oregon Social Learning Center Multidimensional Treatment Foster Care Program, a preventive intervention that targets 3 commonly co-occurring variables among young foster children: (1) behavioral problems, (2) physiological dysregulation within the neuroendocrine system, and (3) developmental delays. EIFC parents participate in a

	minimum of 12 hours of training. During training, parents are provided an overview of the model, taught about identifying and giving information about behaviors, and taught procedures for implementing an individualized daily program. The training methods used are didactic and experiential. During the training, emphasis is on methods and techniques for reinforcing and encouraging children. **Findings:** Children in EIFC had significantly fewer failed permanent placements than children in the regular foster care comparison condition. The number of prior placements was positively associated with the risk of failed permanent placements for children in the comparison condition but not for children in EIFC. Type of prior maltreatment did not predict permanent placement outcomes. **Limitations:** The efficacy of this program by maltreatment type could not be assessed due to low rates of physical and sexual abuse among children in EIFC with failed placements.
Fisher, P. A., Gunnar, M. R., Chamberlain, P., & Reid, J. B. (2000). Preventive intervention for maltreated preschoolers: Impact on children's behavior, neuroendocrine activity, and foster parent functioning. *Journal of the American Academy of Child and Adolescent Psychiatry, 39,* 1356-1364. **Population:** Family-based foster care for children aged 3-6 who have behavioral problems or developmental delays	**Method:** This study used a controlled study to test the effectiveness of the EIFC program in the period immediately following a child's placement in a new foster home. Data were collected from three groups of youths (mean age 4.7 years): 1) youths referred for placement in an EIFC foster home by the state child welfare system because of one or more placement disruptions and/or because of highly disruptive and aggressive behavior; 2) nonreferred youths who were about to be placed in a regular foster care home (RFC) via the state; and 3) a community comparison group (CC) of nonmaltreated, same-age youths living with their biological families. **Findings:** EIFC parents adopted and maintained positive parenting strategies (including monitoring, consistent discipline, and positive reinforcement) similar to rates in the CC group. Parents in the RFC group exhibited significantly lower rates of these parenting practices. The intervention also appeared to reduce parents' stress levels and bring them more in line with the CC group whereas the RFC group experienced a steady increase in stress levels. Though EIFC children exhibited the poorest behavioral adjustment at the beginning of the intervention, they showed the greatest improvement over time; children's behavior in the RFC group deteriorated over time. The levels of cortisol approached a more normal pattern for the EIFC children.

	Limitations: The lack of random assignment and racial and ethnic diversity limits the generalizability of these findings. Some effects did not reach statistical significance; this could be due to the small sample size utilized in the study.
Fisher, P. A. & Kim, H. K. (2007). Intervention effects on foster preschoolers attachment-related behaviors from a randomized trial. *Prevention Science, 8, 161-170.* **Population:** Family-based foster care for children aged 3-6 who have behavioral problems or developmental delays	**Method:** This study utilized an RCT to test the efficacy of the Multidimensional Treatment Foster Care for Preschoolers (MTFC-P) program on children's attachment-related behaviors. 117 children (aged 3-5) in need of a new foster placement (including children who were new to the foster care system, those reentering foster care, and those moving between placements) were randomly assigned to either the MTFC-P (n=57) or regular foster care comparison condition (n=60). Parents of the MTFC-P group received training, supervision, and support and children received behavioral therapy as needed. **Findings:** Children randomly assigned to the MTFC-P condition showed significant increases in secure behavior and significant decreases in avoidant behavior relative to children assigned to a regular foster care condition. Both groups showed significant decreases in resistant behavior over time. Analyses also revealed a significant interaction between treatment condition and age at first foster placement on change in secure behavior. Older age at first placement was related to greater increases in secure behaviors for MTFC-P children, whereas the opposite was true for RFC children, suggesting that MTFC-P is particularly effective for children placed later and might mitigate the negative effects of early adversity in the family of origin. **Limitations:** Most of the attrition cases involved children who moved out of area to be with biological relatives. Although those who dropped out of the study did not differ in terms of problem behaviors when assessed at baseline, the possibility exists that changes in attachment-related behaviors for those children might have been different than those observed for the children who were retained.
NTU	**Emerging Practice**
Gregory, S. D. P., & Phillips, F. B. (1996). "NTU": Progressive Life Center's Afrocentric Approach to Therapeutic Foster Care (p. 333-350). In M. Roberts (Ed.) *Model Programs in Child and Family Mental Health.* Mahwah, NJ: Lawrence	**Method:** This book chapter reports on a treatment foster care program implementation using an African-centered approach. The NTU psychotherapy approach is based on the principles of ancient African world view, including four principals of mental health and healing: harmony, balance, interconnectedness, and authenticity. The model provides a comprehensive cultural/spiritual, biopsychosocial approach to intervention for TFC. Interventions are based on the needs of the foster child and can include 1) weekly in-

Erlbaum Associates. **Population:** Family-based treatment foster care	home family and/or individual therapy, 2) group therapy or play therapy 3) small client/therapist ratios (5:1), 4) multifamily therapy retreats (for child, foster and bio families) 5) case management, 6) monthly psychological-psychiatric services, and 7) HELP (How Empowerment Liberates Parents) training program for foster parents. In addition cultural services are provided; a therapeutic rites of passage program and cultural hour group. Additional supportive services are individualized for the client including: transition home placements, respite services, tutorial services, academic incentives, recruitment-training services, support groups, and step-down programs. The population served included 35 African-American foster children between the ages of 4 and 16, who were labeled as seriously emotionally disturbed (SED) and had a DSM-IV diagnosis. The researchers describe the population as "severely culturally deprived, spiritually disconnected, unaware of their personal biography, disconnected with their community and family, and lacking a sense of belonging." Of the foster children in the program, approximately 70% were admitted with a pharmaceutical regime intact. A pre-test/post-test design was used to test the efficacy of the NTU program. **Findings:** Of the 19 children in the emotional category, 14 (74%) improved significantly in this area, 21% remained stable, and 5 % continued to experience significant problems. School problems: 37% showed progress with school related problems, 47% remained stable, and 16% continued to experience severe problems. Behavior problems: 53% improved significantly, 42% remained stable, and 16% continued to have severe to moderate behavioral problems. In 1991-1992 sixty percent of the programmatic areas of NTU were ranked 5 (on a 1-5 scale with a score of 5 defined as "exceeds expectations"). Recruitment and training was ranked as the strongest area. IN 1992-1993 the average rating was a 4. Five out of the eight (63%) of the clinical areas were ranked 5. In 1993 the majority of therapists (54%) felt that the treatment parents were exceeding their requirements. 83% of the treatment parents indicated that they receive direct clinical services frequently and consistently, and 90% indicated that the clinical intervention is effective and could see the healing occurring.

	Limitations: This study relied on exploratory analyses. Randomized clinical trials are needed to determine program efficacy. Also the program indicated difficulty in working with adolescents who were transitioning from more institutionalized care and re-integrating into more family-based care.
Nurturing Parenting Program (NPP)	**Promising Practice**
Cowen, P.S. (2001). Effectiveness of a parent education intervention for at-risk families. *Journal of the Society of Pediatric Nursing, 6*, 73-82. **Population:** At-risk families, or families caring for abused or neglected children	**Method:** This study used a pre-test/post-test design to test the efficacy of the Nurturing Parenting Program (NPP). A total of 154 families participated in the study. The NPP are family-based programs utilized for the treatment and prevention of child abuse and neglect. Program sessions are offered in group-based and home-based formats ranging from 12 to 48 sessions. Programs are designed for parents with varying ages of youth from birth to adulthood. Parents and their children meet in separate groups that meet concurrently. ***Findings:*** *Post-test scores show significant improvements in* parents' inappropriate expectations, empathy, belief in corporal punishment, and role reversal. **Limitations:** The study lacked a control group and had a substantial percentage of available families who did not fully participate or provided incomplete data. The sample was predominately white so generalizations should be made with caution.
Devall, E.L. (2004). Positive parenting for high-risk families. *Journal of Family and Consumer Sciences, 96*, 22-28. **Population:** At-risk families, including teen parents, unmarried parents, single or divorced parents, foster parents, parents	**Method:** This study utilized a pre-test/post-test design to test the efficacy of the Nurturing Parenting Program (NPP). A total of 323 parents of at-risk families, including teen parents, unmarried parents, single or divorced parents, foster parents, parents referred by social services, families with substance abuse issues, and incarcerated parents participated in the study. **Findings:** Parents' post-test scores showed improvement on inappropriate expectations, empathy, belief in corporal punishment, and role-reversal. Parents' nurturing also improved.

referred by social services, families with substance abuse issues, and incarcerated parents	**Limitations:** This study lacked a control group. Also, because of missing data, just over half of the sample is represented in the results.
Parent-Child Interaction Therapy (PCIT)	**Effective Practice**
Bagner, D. M., & Eyberg, S. M. (2007). Parent-Child Interaction Therapy for disruptive behavior in children with mental retardation: A randomized controlled trial. *Journal of Clinical Child and Adolescent Psychology, 36*, 418-429 **Population:** Children (aged 3-6) with oppositional defiant disorder and mental retardation	**Method:** This study utilized an RCT to investigate the efficacy of the Parent-Child Interaction Therapy (PCIT) model on parent and child behavior, and parent stress. 30 mothers and their children (aged 3-6) who were referred by pediatric healthcare professionals, teachers, or self-referred participated in the study. Mothers with children who had been diagnosed with oppositional defiant disorder (ODD) and mental retardation (MR) were randomly assigned to either the PCIT treatment condition or to a wait-list control group. **Findings:** PCIT parents improved significantly on parenting skills taught by the program; the percentage of compliant behaviors shown by the children also increased significantly in comparison to the control group. In addition, PCIT children's externalizing behaviors decreased. However groups did not differ on maternal distress, although PCIT mothers reported fewer child problem behaviors.
McNeil, C. B., Herschell, A. D., Gurwitch, R. H., & Clemens-Mowrer, L. (2005). Training foster parents in Parent-Child Interaction Therapy. *Education and Treatment of Children, 28*, 182-196. **Population:** Family-based foster care for children with behavioral problems	**Method:** This exploratory study examines the effectiveness of an abbreviated version of PCIT for foster parents who have children with behavioral problems placed in their home. 30 children (aged 2-8 years) who exhibited behavior problems along with one of their foster parents participated in the study. The majority of foster parents were mothers (one father participated). Six, two day early intervention workshops were conducted. These workshops included one full day of didactic sessions in which parents were instructed in the use of specific play therapy skills that are the focus of the first seven sessions in a traditional model of PCIT. For the second day of training parents were asked to bring their foster child, and instructed in the use of specific discipline skills and were then coached in the use of these skills by a therapist. Observation could occur through a one-way mirror for other foster parents. **Findings:** Of the 30 families who participated in the training, 27 were available one month after the training to provide information. Only 8 families were available to

	participate five-months after training completion. Prior to training, children were displaying problem behaviors within the clinically significant range. One month after training, parents reported their same child's behavior to be improved to the point that it was no longer in range of clinical concern. Five months after training, parents report continued behavioral improvements below clinical cutoffs. In addition parents reported a decline in how problematic they viewed the child's behavior to be over the five month time period, suggesting parents were adjusting to or better managing the child's behavior. **Limitations:** Three limitations are apparent in this study which contribute to a lessened ability to generalize the findings: 1) the lack of comparison conditions with randomization to groups, 2) heavy reliance on parent-report data, and 3) a small sample size.
Nixon, R. D. V., Sweeney, L., Erickson, D. B., & Touyz, S. W. (2003). Parent-Child Interaction Therapy: A comparison of standard and abbreviated treatments for oppositional defiant preschoolers. *Journal of Community and Clinical Psychology, 71*, 251-260. **Population:** Children (aged 3-5) who met criteria for oppositional defiant disorder, had clinical levels of behavior problems, and had displayed defiant behaviors for 6 montsh	**Method:** The study compared families receiving standard PCIT with an abbreviated version using a combination of videotapes, telephone consultations and face-to-face sessions and with a wait-list control group. 54 families with children (aged 3-5) who measured in the clinical range on *Eyberg Child Behavior Inventory (ECBI)*, met criteria for oppositional defiant disorder (ODD) according to the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)* and had displayed disruptive behaviors for 6 months were randomly assigned to either the standard PCIT, abbreviated PCIT, or wait-list control group. **Findings:** At the end of treatment, mothers in both PCIT conditions reported less oppositional and conduct problem behavior than did control group participants. Mothers in the standard PCIT condition reported less severe problems than those in the other two groups. Fathers in the abbreviated PCIT group reported less oppositional behavior. **Length of post-intervention follow-up:** 6 months
Shuhman, E. M., Foote, R. C., Eyberg, S. M., Boggs, S., & Algina, J. (1998). Efficacy of Parent Child Interaction Therapy: Interim report of a randomized trial with short term	**Method:** This study utilized an RCT to examine the efficacy of the PCIT program using a sample of 64 families with children (aged 3-6) who were referred to a clinic for conduct disorder. Families were randomly assigned either to receive PCITor to a wait-list control.

maintenance. *Journal of Clinical Child Psychology, 27*, 34-45. **Population:** Children (aged 3-6) with conduct disorder	**Findings:** Following the intervention, the PCIT parents showed higher levels of praise and lower levels of criticism in interactions with children than the control group. Children's compliance also increased in the observed interaction and their *ECBI* scores improved significantly. Parental stress scores and *Locus of Control* scores shifted to normal levels in the PCIT group, while those for the control group remained at clinical levels. Although comparisons could not be made with the control group at 4-month follow-up, all gains made by PCIT treatment families were maintained. **Limitations:** This sample of families had no significant levels of marital distress or depression at baseline. They were recruited from a group that actively sought treatment for their children, thus limiting the generalizability of the findings.
Timmer, S. G., Urquiza, A. J. , Herschell, J. M., McGrath, N. M., Zebell, A. L., & Vargas, E. C. (2006). Parent-Child Interaction Therapy: Application of an empirically supported treatment to maltreated in foster care. **Population:** One family-based foster family	**Method:** A 41-year-old married foster-adoptive mother and her 4-year-old foster son entered into PCIT due to the child's extreme physical and verbal aggression toward his parents, his impulsivity, and the parents' inability to soothe their foster son when he threw temper tantrums. 36 sessions of PCIT were completed. **Findings:** Two separate, standardized measures (ECBI and CBCL) showed significant reduction of child behavior problems, moving from the clinical to normative range during the course of treatment. Parental stress was decreased. The foster mother's use of praise and description increased over time – indicating high involvement in the chlid's activities – and infrequent use of questions and commands – indicating low levels of intrusiveness.
Timmer, S. G., Urquiza, A. J., & Zebell. N. (2006). Challenging foster caregiver-maltreated child relationships: The effectiveness of parent-child interaction therapy. *Children and Youth Services Review, 28,* 1-19.	**Method:** The primary goal of this study was to determine the effectiveness of PCIT in reducing the parenting stress and behavior problems of children placed with foster parents (as compared to a biological parent-child sample). A total of 98 biological parent-child dyads and 75 foster parent-child dyads participated in the study. **Findings:** Caregivers' ethnicity significantly predicted early treatment termination. Compared to Caucasians, African American caregivers were twice as likely to drop out of treatment early. Children with a history of maltreatment were nearly 50% LESS likely to drop out. As symptom severity increased, so did the likelihood of dropping out of treatment. Strong treatment effects on measures of parent and child functioning were found for foster parents and biological parents, suggesting that PCIT has beneficial effects. On the whole, significant variations in treatment gains by parent groups were

	not observed. Completion of PCIT predicted decreased child behavior problems and parent distress for foster and biological parent-child dyads. **Limitations:** No random assignment of caregiver-child dyads to treatment was utilized. Also, this study did not report follow-up data to demonstrate the maintenance of treatment effects over time. Selection effects for sample, no control group, and a heavy reliance on caregiver reports of children's behavior may have skewed the results. The authors indicate that it is possible that parent's reports of improvements in children's behavior are a reflection of a shift in their own attitudes towards their children, rather than a change in children's behavior.
Thomas, R. & Zimmer-Gembeck, M. J. (2007). Behavioral outcomes of Parent-Child Interaction Therapy and Triple P – Positive Parenting Program: A review and Meta-Analysis. *Journal of Abnormal Child Psychology, 35,* 475-495.	**Method:** The aim of this study was to provide a comprehensive assessment of the state of the evidence (via meta-analysis) to guide decisions about the implementation and continued dissemination of Positive Parenting Program and PCIT programs. The authors identified all randomized controlled trials and single group-follow up studies dated between 1980 and 2004. A total of 24 studies were included in the analysis. **Findings:** Results revealed that these interventions improve parenting, such as improving parental warmth, decreasing parental hostility, increasing parental self-efficacy, and reducing parental stress. Participation in PCIT and Triple P results in improvements in child behavior and parenting from pre- to post-treatment. Conclusions, about which intervention may result in greater improvements in parenting and family functioning, depended on the measures used to assess outcomes and the subtype of each intervention. Standard PCIT tended to have larger effects than Triple P when compared to waitlist, and when outcomes were based on parent report of child negative behaviors and observed parent negative behaviors. Standard PCIT did not have a larger effect than Enhanced Triple P, except when comparing observed parent negative behavior. Significant treatment effects on children's behaviors were found for both Triple P and PCIT interventions when outcomes were assessed via female caregiver. Effects were generally medium for Triple P and large for PCIT. **Limitations:** Demographic information in many studies was limited making comparisons of participants difficult. Methods of recruiting participants were different for studies. Parent-reported child behavior problems were assessed with either the Eyberg Child Behavior Inventory or the Child Behavior Checklist in all but one study in the review.

Parenting Wisely (PAW)	**Promising Practice**
Kacir, C., & Gordon, D.A. (1999). Parenting adolescents wisely: The effectiveness of an interactive videodisk parent training program in Appalachia. *Child and Family Behavior Therapy, 21*, 1-22. **Population:** Mothers of youth aged 12-18	***Method:*** *This study used an RCT to evaluate the efficacy of the Parenting Wisely (PAW) program. A total of 38 mothers were randomly assigned to either a PAW or control group (in which no intervention was given).* ***Parenting Wisely*** is a self-administered, highly interactive computer-based program that teaches parents and children, ages 9-18, skills to improve their relationships and decrease conflict through support and behavior management. The program utilizes an interactive CD-ROM with nine video scenarios depicting common challenges with adolescents. Parents are provided the choice of three solutions to these challenges and are able to view the scenarios enacted, while receiving feedback about each choice. Parents are quizzed periodically throughout the program and receive feedback. The program operates as a supportive tutor pointing out typical errors parents make and highlighting new skills that will help them resolve problems. **Findings:** At approximately one and four months following the training, children's problem behavior improved in PAW families as compared to control families. PAW group parents scored higher than control group parents on parenting knowledge at one month. **Limitations:** This study relied on a small sample size and subjective measures to assess improvements in child and parenting behaviors. Additionally, the authors suggest that misinterpretation of the *Parent Behavior Questionnaire* might have occurred prior to the intervention.
O'Neill, H. & Woodward, R. (2002). Evaluation of the Parenting Wisely CD-ROM parent training programme: An Irish replication. *Irish Journal of Psychology, 23*, 62-72. **Population:** Youth aged 9-18 with behavior problems	**Method:** This study used a pre-test/post-test design to assess the efficacy of the PAW model. Fifteen families with children aged 9-18 who were referred to a psychology service for child behavior problems in Ireland participated in this study. Families were randomly assigned to intervention or control group conditions. In most cases, only the mother completed the intervention. **Findings:** Results showed positive treatment effects on reported child behavior problems. Parents' behavior and knowledge scores also improved significantly.

	Limitations: This study was limited by the small sample size and lack of reported comparison with the control group; only pretest/posttest scores are reported.
Segal, D., Chen, P.Y., Gordon, D.A., Kacir, C.D., & Gylys, J. (2003). Development and evaluation of a parenting intervention program: Integration of scientific and practical approaches. *International Journal of Human-Computer Interaction, 15*, 453-467. **Population:** Youth (aged 11-18) recruited through mental health clinics	**Method:** This study utilized an RCT to compare the efficacy of two different versions of the PAW model. Forty-two parents of youth (aged 11-18) who were recruited through community and outpatient mental health clinics participated in the study. Parents were randomly assigned to receive either a non-interactive video (NV) or an interactive multimedia (IM) version of the PAW program. **Findings:** There was no significant difference on overall outcomes between intervention groups. Both groups showed improved scores on child adjustment, parent behavior, and parent responses to negative behaviors. **Limitations:** This study utilized a small sample which may contribute to the non-significant findings. Additionally, a non-intervention control group was not present.
Positive Parenting Program (PPP)	**Effective Practice**
Bor, W., Sanders, M. R., & Markie-Dadds, C. (2002). The effects of the Triple P-Positive Parenting Program on preschool children with co-occurring disruptive behavior and attentional/hyperactive difficulties. *Journal of Abnormal Child Psychology, 30*, 571-587. **Population:** Families with risk factors	**Method:** This study utilized an RCT to examine the impact of the Positive Parenting Program (PPP) on the disruptive behavior of children and the knowledge, skills, and confidence of parents. 87 families who had a least one risk factor (i.e., maternal depression, relationship conflict, single parent household, low family income, or low occupational prestige for the major income earner) and whose child demonstrated ADHD criteria were randomly assigned to a standard PPP, enhanced PPP, or wait list group. The PPP is a multi-level system of parenting and family support. It aims to prevent severe behavioral, emotional and developmental problems in children by enhancing the knowledge, skills, and confidence of parents. Enhanced PPP employs the same materials as the standard program, but includes interventions tailored to the needs of each family, including instruction on coping skills and strategies for partner or social support. **Findings:** At post-intervention, both PPP conditions were associated with lower levels of parent-reported child behavior problems, lower levels of dysfunctional parenting, and greater parental sense of competence than the wait-list conditions. Enhanced PPP was

	also associated with less observed negative child behavior. These effects were maintained at the one-year follow-up.
Leung, C., Sanders, M. R., Leung, S., Mak, R., & Lau, J. (2003). An outcome evaluation of the implementation of the Triple P-Positive Parenting Program in Hong Kong. *Family Process, 42*, 531-544. **Population:** Families of children (aged 3-7) with developmental problems	**Method:** 69 parents and their children (aged 3-7) who were attending maternal and child health centers or child assessment centers for child developmental problems participated in an RCT to determine the efficacy of the PPP. Families were randomly assigned to PPP or a wait-list control group. **Findings:** Post-intervention scores indicated lower levels of child behavior problems, lower dysfunctional parenting styles and a higher sense of competence for the PPP group in comparison with controls. **Limitations:** This study relied on a small sample and self-report data only.
Martin, A. J., & Sanders, M. R. (2003). Balancing work and family: A controlled evaluation of the Triple-P Positive Parenting Program as a work-site intervention. *Child and Adolescent Mental Health, 8*, 161-169. **Population:** Families of children (aged 3-9) with behavioral problems	**Method:** This study utilized an RCT to determine the efficacy of the PPP as a work-site intervention. 42 families who were staff at the University of Queensland participated in the study. To be included, families were required to have a child (aged 3-9) with behavioral problems in the clinical range on the difficulties scales on the *Strengths and Difficulties Questionnaire*. Participants were randomly assigned to either a group version of the PPP program or a waitlist control. **Findings:** At the end of the intervention, parents reported lower levels of disruptive child behavior and dysfunctional parenting practices and higher levels of self-efficacy in managing home and work responsibilities. These improvements were maintained at the 4-month follow-up**.**
Roberts, C., Mazzucchelli, T., Studman, L., & Sanders, M. (2006). Behavioral family intervention for children with developmental disabilities and behavioral problems. *Journal of Clinical Child and Adolescent Psychology, 35*, 180-193.	**Method:** This study utilized an RCT to assess the efficacy of the PPP for children with developmental disabilities and behavioral problems. Participant children (aged 2-7, n=47) had levels of intellectual or adaptive functions below age norms, due to genetic causes, cerebral palsy, accident, disease, or unknown causes. Families were receiving services including speech and occupational therapy, physiotherapy and pre-educational skills. Families were randomly assigned to the intervention group or a wait list. Intervention participants received instruction in the Stepping Stones PPP program, which was adapted for use with parents of children with developmental disabilities.

Population: Families of children (aged 2-7) with developmental disabilities and behavioral problems	**Findings:** The intervention was associated with fewer child behavior problems reported by mothers and independent observers, improved maternal and paternal parenting style, and decreased maternal stress. These effects were maintained at the 6-month follow-up. **Limitations:** Attrition limited this study: 29 of the 47 original families participated at post-intervention and only 15 intervention children remained at 6 months.
Sanders, M. R., Markie-Dadds, C., Tully, L. A., & Bor, W. (2000). The Triple P-Positive Parent Program: A comparison of enhanced, standard and, behavioral family intervention for parents of children with early onset conduct problems. *Journal of Consulting and Clinical Psychology, 68*, 624-640. **Population:** Families exhibiting risk factors	**Method:** This study utilized an RCT to evaluate the efficacy of the Positive Parenting Program (PPP) to improve the disruptive behavior of children. 305 Australian families, who exhibited at least one risk factor (i.e., maternal depression, relationship conflict, single parent household, low family income, or low occupational prestige for the major income earner), were randomly assigned to a standard PPP, enhanced PPP, self-directed PPP, or wait list group. Standard PPP employs the same materials as the self-directed program, but adds active skills training and support from a trained practitioner. Enhanced PPP includes interventions tailored to the needs of each family, including instruction on coping skills and strategies for partner or social support. **Findings:** At post-test, the two practitioner-assisted interventions were associated with lower levels of parent-reported disruptive child behavior, lower levels of dysfunctional parenting, and sense of competence. Children in the Enhanced PPP condition showed more reliable improvement, although by the end of the 1 year follow-up all PPP conditions had achieved similar levels of improvement in disruptive behavior. The practitioner-assisted programs were also associated with greater improvement in parent-reported disruptive behavior. However, 1-year outcomes were compared to pretest levels only, not to the wait-list controls.
Turner, K. M. T., Richards, M., & Sanders, M. R. (2007). Randomized clinical trial of a group parent education programme for Australian indigenous families. *Journal of Paediatrics and Child Health, 43,* 429-437.	**Method:** 51 families that requested help for child behavioral or development issues at community health sites in Australia participated in an RCT to determine the efficacy of the PPP. Families were recruited if they had a preadolescent child (aged 1-13), the primary caregiver had concerns about the child's behavior and their own parenting skills. Children were excluded if they had developmental delays, major disabilities, were autistic, or were currently on medication or receiving other treatment for behavior problems. Participants were randomly assigned to the intervention group or a wait list. The intervention was a culturally sensitive adaptation of the PPP group program.

Population: Families of preadolescents who had concerns about their child's behavior and their parenting skills	**Findings:** Parents attending group PPP reported a decrease in rates of problem child behavior and less reliance on some dysfunctional verbal parenting practices such as overly long reprimands and talking rather than taking action. No difference was seen on parental over-reactivity (e.g., authoritarian discipline, displays of anger) or permissiveness. Effects were primarily maintained over 6 months.
Zubrick, S. R., Ward, K. A., Silburn, S. R., Lawrence, D., Williams, A. A., Blair, E., Robertson, D., & Sanders, M. R. (2005). Prevention of child behavior problems through universal implementation of a group behavioral family intervention. *Prevention Science, 6*, 287-304. **Population:** Families with children aged 3-4	**Method:** This study utilized a controlled design to assess the efficacy of the PPP. 1610 participants were recruited through media and professional referral. The intervention group received training through a group version of the PPP, followed by telephone support sessions once a week for four weeks. Children were aged 3-4 years. **Findings:** Treatment was associated with significant reductions in parent-reported levels of child behavior problems and self-reported levels of dysfunctional parenting over the 2-year follow-up. Positive effects were also found on parent mental health, marital adjustment, and levels of child-rearing conflict. **Limitations:** There were significant differences between groups in this study. The comparison group children were somewhat older, more likely to come from blended families, and more likely to have mothers with no higher education. However, comparison group children entered the study with lower average levels of behavior problems.
Teaching Family Model (TFM)	**Promising Practice**
Bedlington, M. M., Braukman, C. J., Ramp, K. A., & Wolfe, M. M. (1988). A comparison of treatment environments in community-based group homes for adolescent offenders. *Criminal Justice and Behavior, 15*, 349-363. **Population:** Court-adjudicated youth (aged 11-18) who were assigned to group homes.	**Method:** This study utilized a controlled design to assess the efficacy of the Teaching Family Model. 185 youth (aged 11-17) who were court-adjudicated to a group home were randomly assigned to either the TFM or control group. The Teaching Family Model is characterized by clearly defined goals, integrated support systems, and a set of essential elements. The model uses a married couple or other "teaching parents" to offer a family-like environment in the residence. The teaching parents help with learning living skills and positive interpersonal interaction skills. **Findings:** Teaching-Family homes were rated as having significantly higher levels of adult/youth communication and instances of adults teaching youth.

Jones, R. J., & Timbers, G. D. (2003). Minimizing the need for physical restraint and seclusion in residential youth care through skill-based treatment programming. *Families in Society, 84*, 21-29. **Population:** Youth (aged 8-18) in residential programs for behavioral and emotional problems	**Method:** This study utilized a pre-test/post-test design to assess the efficacy of the Teaching Family Model (TFM) for youth with behavioral and emotional problems in two residential programs. **Findings:** For the Barium Springs program, restraints were reduced by 40% and significant negative incident reports were reduced by 80% after the introduction of the TFP. At the Bridgehouse program, there was a 75% reduction in restraints, a similar decline in secluding clients in a locked, quiet room, and close to elimination of the use of the time out room. With the exception of the Barium Springs restraint level, all of these reductions reached statistical significance.
Kirigin, K. A., Braukman, C. J., Atwater, J. D., & Wolf, M. M. (1982). An evaluation of Teaching-Family (Achievement Place) group homes for juvenile offenders. *Journal of Applied Behavior Analysis, 15,* 1-16. **Population:** Youth (aged 14-15 at entry) who were assigned to residential programs by the court.	**Method:** This study utilized a controlled design to assess the efficacy of the TFM model for reducing criminal offenses for youth (aged 14-15 at entry) who were assigned to residential programs by the court. Youths in group homes using the TFM were compared to youths in group homes chosen by state agencies to be representative residential programs. **Findings:** For girls, a higher percentage of TFM participants had offenses pre-treatment, but a significantly lower percentage had offenses during treatment. During the post-treatment year, a lower percentage of both boys and girls in the program had offenses, but this was not statistically significant. Looking at rate of offences, TFM boys significantly decreased their number of offences during treatment, while the rate for non-Teaching-Family boys increased. For girls, the number of offenses was significantly reduced during treatment, but they did not differ significantly from the comparison group during that time. For both boys and girls, groups did not differ in rate of offenses during the follow-up period.
Larzelere, R.E., Daly, D.L., Davis, J.L., Chmelka, M.B. & Handwerk, M.L. (2004). Outcome evaluation of Girls and Boys Town's Family Home Program. *Education and Treatment of Children, 27*, 130-149	**Method:** A pre-test/post-test design was used to study the restrictiveness of living, child behavior, and mental health of 440 youth (aged 8-19) who were referred to the Family Home Program by juvenile justice, social or mental health services, family, or self. **Findings:** Both boys and girls were found to have improved on all outcome variables. They were discharged to less restrictive environments than they were in before the

Population: Youth (aged 8-19) who were referred to the Family Home Program by juvenile justice, social or mental health services, family, or self.	program. 84% of girls and 78% of boys went to their own home or to independent living following discharge. Boys and girls' behavioral problems also improved, except for boys' social problems (as measured by the CBCL). Finally, boys and girls had significantly fewer mental health diagnoses at 12 months than at intake. On the non-standardized measures, departure success averaged at "somewhat successful" on the scale, and 87% of presenting problems were rated as improved. Results also showed that youth who completed the program were functioning better at follow-up than those who did not and the percentage of youth who had been arrested was significantly lower at follow-up than it had been prior to intake.
Lee, B. R., & Thompson, R. (2008). Comparing outcomes for youth in treatment foster care and family-style group care. *Children and Youth Services Review, 30,* 746-757. **Population:** Family-based treatment foster care	**Method:** This study utilized a controlled design to test the effectiveness of the Teaching Family Model (TFM) in a family-style group care setting. Data from Girls and Boys Town were used to make comparisons between the TFM (n=716) and Treatment Foster Care (TFC, n=112) conditions. Groups were propensity-matched to help ensure similarity. **Findings:** TFM youth were more likely to be favorably discharged, more likely to return home, and less likely to experience subsequent placement in the first 6 months after discharge than standard TFC youth. Legal involvement and residing in a home-like environment at follow-up did not differ. **Limitations:** Even though groups were matched, random assignment did not occur. Also, youth in the TFC condition were enrolled in programs at Girls and Boys Town only.
Lewis, R. E. (2005). The effectiveness of Families First services: An experimental study. *Children and Youth Services Review, 27*, 499-509. **Population:** Families referred by school	**Method:** 150 families with a child (aged 4-17) who was referred by school or juvenile court for problems in functioning participated in an RCT to assess a version of the TFM which had been adapted for use in the family's home. Families were randomly assigned to treatment or control groups. Control groups families had access to services normally available to schools, courts and the community. **Findings:** Youth in the TFM group showed a significant improvement in concrete services/physical care, resources, and child behavior problems. There was no

or juvenile court due to a child with serious problems in functioning	significant difference across groups for parent effectiveness/parent-child relationships, due to improvement in the control group's score over time. All group differences narrowed over time, largely due to the control group having received some traditional services.
Slot, N.W., Jagers, H.D., & Dangel, R.F. (1992). Cross-cultural replication and evaluation of the Teaching Family Model of community-based residential treatment. *Behavioral Residential Treatment, 7*(5), 341-354. **Population:** Youth (aged 14-19) who lived in a residential facility	**Method:** Three studies were designed to test the efficacy of the TFM across cultures. The first study utilized 58 youth (aged 14-19) and a pre-test/post-test design; the second study included 50 treatment youth and 470 comparison youth; and the third study included 57 treatment and 57 comparison youth (aged 14-18, matched by age). All youth were living in a Dutch residential facility. **Findings:** Study 1: Youth experienced significant improvements in overall adjustment, family adjustment, relationship with parents, number of offences, social competence, and number of problems at home. Youth also demonstrated significant improvement in their ability for relationships outside the family. However, their abilities for community participation, and academic and vocational factors did not improve. There was also a significant increase in drinking post-treatment, but not to levels considered problematic in the Netherlands. Study 2: This study measured levels of juvenile delinquency in youth experiencing the Teaching Family Program (TFP) to a cohort of Canadian youth. The number of youth staying at the same offending level was lower for the TFP group than the comparison group (24% vs. 48%). The number moving toward a less serious offending level was higher for the TFP group (73% versus 20%). The number of youth moving toward a more serious offending level was lower for the TFP group (3% versus 24%). Study 3: This study compared TFP participants with youth in the traditional Dutch state institute. There were no differences between groups on scores for overall problems and abilities for relationships outside the family: both groups improved. However, state institute youth improved on abilities for community participation, while TFP youth did not. The authors attributed this to greater access to and use of alcohol for TFP youth. In a final analysis, the authors also report that length of stay for TFP youth was an average of 240 days versus 573 days for state institute youth.
Thompson, R. W., Smith, G. L., Osgood, D. W., Dowd, T. P., Friman, P. C., & Daly, D. L. (1996). Residential care: A study of short- and long-term educational effects.	**Method:** A controlled design was used to study educational outcomes for youth who participated in the Teaching Family Model. Youth admitted to the residential treatment program on referral by social services served as the treatment group (n=497; mean age 14.7 years). The comparison group was comprised of youth who applied but were not

Children and Youth Services Review, 18, 221-242. **Population:** Youth admitted to a residential treatment program on referral by social services	admitted to the residential treatment program (n=84; mean age 14.4 years); virtually all of the comparison group youth received counseling or other treatment **Findings:** TFM youth reported an increase in GPA while they were in residence. It decreased after leaving the program, but remained significantly higher than the comparison group's GPA. TFM youth completed years of school at a faster rate than comparison students, but this rate decreased significantly after leaving treatment. Ratings on importance of education increased for the TFM group, but decreased for the comparison group. This difference remained after departure. Treatment youth had more help with homework both during and after the program than did comparison youth. **Limitations:** Youth in the current study attended special schools, which has not been the case in other evaluations of the TFM. Thus generalizations should be made with caution.
Specialized Foster Parent Training Programs	
Attachment and Biobehavioral Catch-Up (ABC)	**Promising Practice**
Dozier, M., Brohawn, D., Lindheim, O., Perkins, E., & Peloso, E. (in press). Effects of a foster parent training program on young children's attachment behaviors: Preliminary evidence from a randomized clinical trial. *Child and Adolescent Social Work Journal*. **Population:** Family-based foster care	**Method:** This study utilized an RCT to examine the attachment outcomes of 46 children (aged 4 months – 3 years) who were randomly assigned to either a group which received the Attachment and Biobehavioral Catchup (ABC) intervention or to a comparison group which received the Developmental Education for Families (DEF) program. Parents kept diaries of attachment related behavior (e.g., help-seeking behaviors) by children, their own behavioral response, and infants' response to foster parents' behavior for a period of 3 days. Diaries were coded for child security (proximity seeking, contact maintenance, and successful calming) and avoidance (child anger and inability to be soothed). The Attachment and Biobehavioral Catch-Up intervention was designed to help children develop regulatory capabilities. It targeted three specific issues: helping caregivers learn to reinterpret children's alienating behaviors, helping caregivers override their own issues which interfered with providing nurturing care, and providing an environment that helps children develop regulatory capabilities. The control intervention (DEF) was designed to enhance cognitive and linguistic development.

	Findings: Children in the ABC intervention condition had lower levels of avoidance than children in the DEF group. The two groups did not differ on security scores.
Dozier, M., Peloso, E., Lindheim, O., Gordon, M. K., Manni, M., Sepulveda, S. et al. (2006). Developing evidence-based interventions for foster children: An example of a randomized clinical trial with infants and toddlers. *Journal of Social Issues, 62*, 767-785. **Population:** Family-based foster care	**Method:** This study used an RCT[2] of 60 children (aged 20-60 months) to compare the outcomes of children who participated in the Attachment and Biobehavioral Catch-Up (ABC) intervention to those who participated in the Developmental Education for Families (DEF) program. Both interventions consisted of 10 individually administered sessions carried out at approximately weekly intervals. An additional 104 children were included in secondary analyses to allow comparisons with children who were not in the foster care system. **Findings:** Children whose caregivers received the Attachment and Biobehavioral Catch-Up intervention showed more typical production of cortisol than children whose caregivers received the control intervention, suggesting less risk of developing mental disorders later on in life. Parents in the attachment intervention also reported relatively fewer problem behaviors for older versus younger children. **Limitations:** Small sample sizes and a brief time frame support the need for replication. Findings are not generalizable to children of different ages.
Caring for Infants with Substance Abuse	**Promising Practice**
Burry, C. L. (1999). Evaluation of a training program for foster parents of infants with prenatal substance effects. *Child Welfare*, *78*, 197-214. **Population:** Family-based foster care	**Method:** Researchers examined the impact of an in-service training program designed to enhance the competency of foster parents who were caring for infants with prenatal substance effects, and to promote the intent to foster such infants. Samples of foster parents self selected to either the treatment group (n=28) or the comparison group (n=60). Participants in the treatment group received specialized training on caring for infants with prenatal substance effects while participants in the control group attended televised foster parent training programs on other topics. Both groups represent typical foster parents who attend foster parent training.

[2] Randomized Controlled Trial (RCT) – participants are randomly assigned to treatment and control groups.

	The training curriculum was delivered in 10 hours (four weekly sessions, 2.5 hours per session). Training goals regarding parenting infants with prenatal substance abuse effects included: 1) preparedness in providing foster care to infants with prenatal substance, 2) knowledge of community resources specific to infants with prenatal substance, 3) ability to perform and describe appropriate care for infants with prenatal substance, and 4) knowledge of future decisions regarding future fostering of infants with prenatal substance. **Findings:** The study found that parents in the treatment group did not report greater feelings of efficacy in caring for infants with prenatal substance effects even though they were able to demonstrate specific skills and knowledge for caregiving of infants with prenatal substance effects. Parents in the treatment group did not report greater feelings of social support and were no more likely to intend to foster infants with prenatal substance effects than parents in the control group. **Implications:** Topic specific training has the ability to increase the knowledge, skills, and abilities of foster parents. Trainings wishing to increase social supports for foster parents should include specific components to address such issues into the curriculum. **Limitations:** Similar to other studies, the comparison group was small. It was also not possible to control for participants' exposure to information on infants with prenatal exposure to substance effects outside of the training.
Communication & Conflict Resolution Training	**Promising Practice**
Cobb, E. J., Leitenberg, H., & Burchard, J. D. (1982). Foster parents teaching foster parents: Communication and conflict resolution skills training. *Journal of Community Psychology, 10*, 240-249.	**Method:** The study examined a model of foster parent training in which specific therapeutic parenting skills (communication and conflict resolution) were taught to foster parents by other previously trained foster parents. Two training classes were carried out over the same period of time, one taught by "mental health" professional staff and one taught by a select group of foster parents who had completed the program the previous year. Foster parents in the community who expressed an interest in participation were randomly assigned into the two classes (n=34). Foster parents who expressed some interest but were unable to take part served as the untrained comparison group (n=18).

Population: Family-based foster care	The training program consisted of 16 weekly, two-hour sessions in which staff and foster parents met as a group. These sessions were supplemented with bi-weekly home visits in which a staff member went to each foster parent's home and provided more concentrated assistance and review. The curriculum was structured around three skill segments: communication skills (five weeks), behavior management skills (five weeks), and conflict resolution skills (four weeks). Training included active listening, expression of feelings, and problem definition skills. **Findings:** Pre-to post-test measures revealed that foster parents who received training from either the professional or non-professional staff (trained foster parent) showed greater acquisition of communication and conflict resolution skills than did the comparison group of untrained foster parents. Trained foster parents and professional staff did not differ substantially in their ability to transmit these skills.
Minnis, H., Pelosi, A. J., Knapp, M., & Dunn, J. (2001). Mental health and foster carer training. *Archives of Disease in Childhood,* 84, 302-306. **Population:** Family-based foster care	**Method:** This study utilized an RCT to examine the impact of foster parents' training on children's emotional and behavioral functioning. Participants were recruited from 17 Scottish council areas if they were caring for children (aged 5 to 16) who were deemed likely to be in placement for a further year. The sample included 121 families with 182 children. Participants were randomly assigned to either the standard services or a treatment group that was based on the Save the Child manual *Communicating with Children: Helping Children in Distress*. Training sessions ran six hours per day for two days with a follow-up day-long session one week later. Participants were surveyed before training and 9 months following training completion. **Findings:** Over 60% of the children in the sample had measurable psychopathology before the training (baseline). Results of the study showed that the training had measurable, and possibly even clinically significant, effects but *no statistically significant impact* on child psychopathology or on costs. Study participants found the extra training to be beneficial. Scores for parent-reported psychopathology and attachment disorders decreased by about 5%, self esteem increased by 2%, and costs by 22%, though these effects were not statistically significant.

	Implications: Although this study did not provide statistically significant results, more extensive programs have. The study suggests that the increasing number of children with mental health needs in the foster care system warrants further investigation. **Limitations:** The lack of statistically significant results could be due to high attrition rates (of well adjusted participants) in the intervention group and a small sample size.
Early Childhood Developmental and Nutritional Training (WIC)	**Emerging Practice**
Gamache, S., Mirabell, D., & Avery, L. (2006). Early childhood developmental and nutritional training for foster parents. *Child and Adolescent Social Work Journal, 23,* 501-511. **Population:** Family-based foster care	**Method:** This study used a non-random, self-selected sample of 11 foster parents who were attending a mandatory pre-service training to test the efficacy of the in-service training. Participants completed pre- and post-tests related to their level of knowledge and comfort in the area of infant nutritional needs. **Findings:** Participants reported significant improvements in their knowledge and understanding of infant nutritional needs. **Limitations:** This was only a pilot study; the sample was small and self-selected.
Family Resilience Project	**Emerging Practice**
Schwartz, J. P. (2002). Family resilience and pragmatic parenting practices. *Journal of Individual Psychology, 58,* 250-262. **Population:** Family-based treatment foster care	**Method:** This study describes the preliminary findings of the Famliy Resilience Project (FRP), an in-service training opportunity for Treatment Foster Care (TFC) families. The purpose of FRP was to offer TFC parents individualized training directly related to the parenting of those treatment foster care children residing with them. Based on the fundamental concepts of family resilience, an "Individual Review and Refocus" approach was developed and implemented with each family. This approach consisted of a six-step process: 1. Setting a goal. 2. Reviewing one or more times that have not led to success in attaining the goal. 3. Reviewing one or more times that have already been successful but have gone unrecognized as such in attaining the goal. 4. Describing the difference. 5. Refocusing on what has worked already, highlighting the differences described above and their consequences. 6. Practicing what has already worked; agree to do it more.

	Findings: Preliminary findings suggest that foster parents have reported success in experiencing this approach to increase successful parenting outcomes. **Limitations:** Preliminary findings only.
Preparing Foster Parents' Own Children for the Fostering Experience	**Emerging Practice**
Jordan, B. (1994). *Preparing foster parents own children for the fostering experience.* King George, VA: American Foster Care Resources, Inc.	**The Training:** *Preparing Foster Parents Own Children for the Fostering Experience* is designed to promote the stability of the fostering experience for the foster family by decreasing the opportunities for conflicts between the child in care and the foster family's children. The curriculum is organized in a three session format with each session scheduled for approximately one and one-half hours. Designed and presented in a loose leaf format, the curriculum also provides the trainer with numerous vignettes, role plays, suggestions for discussions and game and interaction ideas for reinforcing the concepts of each training session. The curriculum contains a copy of the Handbook (see below). • **Session One** promotes skills to: Identify the members of the foster care system; Understand the basic roles of each member of the system; Identify reasons youth come into the foster care system; Understand necessity for confidentiality; and, Identify potential changes in family relationships with a new child in the household. • **Session Two** strives to: Identify a variety of feelings/behaviors /problems brought into the home by foster children; Identify why certain feelings can cause these certain behaviors; Suggest methods of coping with these behaviors; Plan ways to discuss various behaviors with parents; and, Clarify the difference between being a "snitch" and telling parents when something is wrong. • **Session Three** helps children to: Identify activities and situations that will be new for the new child; Describe ways to help the new child be comfortable in the home and community; Discuss reasons that parents will have less time to spend with "own" children, but recognize that the love is still the same; Identify stages of separation and loss; Describe the grieving process in age appropriate terms; and, Clearly define the goals of family foster care. **Limitations:** This training has not yet been formally evaluated.

Support and Training for Adoptive and Foster Families (STAFF)	**Emerging Practice**
Burry, C. L. & Noble, L. S. (2001). The STAFF Project: Support and Training for Adoptive and Foster Families of Infants with Prenatal Substance Exposure. *Journal of Social Work Practice in the Addictions, 1*, 71-82.	**The Training:** The STAFF project was developed as a response to concerns about large members of infants with prenatal substance exposure being placed in foster care or for adoption with families who were not prepared for their special needs. The STAFF project focuses on meeting its goals of permanency for infants with prenatal substance effects through both training and support services. The STAFF curriculum was designed specifically as an in-service training program, so that participants had previously completed either pre-services foster parent training, adoption preparation training, or both. The curriculum includes both didactic and interactive activities, and includes five modules. The six-hour curriculum was designed to be delivered in a number of formats including, one six-hour session, two three-hour sessions, or as three two-hour sessions of training.
Training Modality	
Foster Parent College	**Promising Practice**
Buzhardt, J., & Heitzman-Powell, L. (2006). Field evaluation of an online foster parent training system. *Journal of Educational Technology Systems, 34,* 297-316.	**Method:** This study evaluated an online foster parent training system using a sample of seven social workers and 22 foster parents. Preliminary evaluations, as well as a pre- and post-test (following a 2-week training period) scores were analyzed. **Findings:** Foster parents made significant gains in their knowledge of challenging behaviors and legal issues following the training. Both foster parents and social workers were highly satisfied with the system. Foster parent dropout rate was 27%.
Pacifici, C., Delaney, R., White, L., Cummings, K., & Nelson, C. (2005). Foster parent college: Interactive multimedia training for foster parents. *Social Work Research, 29*, 243-251. **Population:** Family-based foster care	**Method:** This study utilized a pre-test/post-test design to examine the impact of the interactive multimedia training program, *Anger Outburst*, of the Foster Parent College. The study examined whether watching a course on DVD increased foster parents' knowledge about anger outbursts and/or improved foster parents' perceptions about their children's anger problems. 74 foster parents were randomly assigned into the intervention or control group. Participants in the intervention group received the Anger Outburst DVD and were instructed to view it at least once a week; parents in the control group did not receive any material. (Comparative analyses are not presented.) The Foster Parent College developed through Northwest Media, Inc. as an interactive multimedia training venue for foster parents. Users can take brief parenting training courses either online (http://FosterParentCollege.com) or on DVD on a variety of topics dealing with serious child behavior problems, including temper tantrums, assaultive

	behavior toward other children, rage toward the mother, and erratic or unpredictable anger. **Findings:** The study supported the efficacy of DVD training as a means of providing inservice training to foster parents at home. The specific training course provided an increase in parents' knowledge of the types and causes of serious anger problems and the appropriate interventions to use. The course also found an increase in foster parents' confidence in their ability to understand their child's anger outbursts. **Implications:** Participants in the study appreciated the convenience of the DVD training format. **Limitations:** The design was not a comparative study so it can not conclude that DVD training is more effective than traditional training.
Pacifici, C., Delaney, R., White, L., Nelson, C., & Cummings, K. (2006). Web-based training for foster, adoptive and kinship parents. *Children and Youth Service Review, 28*, 1329-1343. **Population:** Family-based foster care	**Method:** This study examined the effectiveness of two online courses (on lying and sexualized behavior) using a sample of 97 foster parents from the Foster and Kinship Care Education Program of California Community Colleges. The intervention used interactive multimedia formats. Parents were randomly assigned into one of two intervention groups that completed two courses in opposite order. Group A at each college received the course on lying first, and Group B received the course on sexualized behavior first. All parents completed the same set of questionnaires at pre-intervention before their first course, and again at the start of the second course. **Findings:** Findings showed that foster parents made significant improvements in knowledge for both courses. Gains in parenting perceptions reached significance only for the course on lying, but improvements for the course on sexualized behavior were in the expected direction and approached significance. The discussion board component added an important component for helping parents translate knowledge into practice. **Implications**: With coordination of systems and technology web-based training has the potential to reach a larger population of foster parents. **Limitations:** No control group was utilized. It is unclear if the trainings happened (via

	web) at the colleges, or if the colleges are the one's responsible for the technology piece/content, or just used for recruitment. Foster parents need internet access, and possibly access that supports large files (video, interactive components).
Group vs. Individual Training	
Hampson, R. B., Schulte, M. A., & Ricks, C. C. (1983). Individual vs. group training for foster parents: Efficiency/effectiveness evaluations. *Family Relations, 32*, 191-201. **Population:** Family-based foster care	**Method:** Twenty-nine foster parents received parent training in child rearing skills, utilizing a combination of behavioral and reflective approaches. Half of the families were trained in a traditional group training format, while the other half was trained individually in their homes. A total of 18 families received training, 9 in centralized groups and 9 individually at home. Both modalities used two basic books: *Parents Are Teachers* and *Between Parent and Child*. The trainings lasted for 11 weeks, The in-home training sessions met weekly for one hour; group training sessions met weekly for 1.5 hours. On average, the in-home parents each received approximately 6.1 hours of training, while each family received 11 hours of training. For the group trained families, each parent received approximately 6.2 hours of training and each family received approximately 13.2 hours of training, on average. Post-testing was conducted during the final week of training. Follow-up questionnaires were obtained six months after the conclusion of training. **Findings:** When the two groups were compared in terms of differential gains, relatively few differences were noted. As a general rule, group trained parents demonstrated slightly greater increases in parent attitude scores. Virtually all parents improved over the course of training, but parents with higher initial levels of attitude and knowledge remained in the higher rank orders following the training. The relative effect of group vs. individual training was not significantly different. Parents in the home trained group rated the overall improvements they perceived in their children's behavior as greater than group trained parents. There was a more durable pattern of satisfaction and perceived improvements for parents who were trained in home. **Limitations:** No control group to compare with (i.e. no graining group or training as usual, or those who didn't volunteer). There may be differences in the group of individuals who volunteered which made them more prone to improvements. The small sample size may have contributed to non-significant findings.

Evidence-Based Practice in Foster Parent Training and Support:

Implications for Treatment Foster Care Providers

Section II: Evidence-Based Practice in Foster Parent Support

Review of Literature

Though often viewed as a rewarding experience, foster care providers typically face additional stress associated with their role as parents to foster children and youth (Farmer, Lipscombe, & Moyers, 2005). Conduct problems, hyperactivity, and violent behavior by foster children and youth, and contact difficulties with biological families are known to increase foster parent stress. Increased stress can lead to higher placement disruption rates and poorer outcomes for foster children and youth. Support provided by foster care agencies and workers, other foster families, friends, and community members, on the other hand, can lessen the strain associated with foster care provision.

Recent studies have indicated that foster parents do not feel fully supported in their role as providers to foster children and youth. In a study of kinship and nonkinship caregivers, Cuddeback and Orme (2002) found that most caregivers had one or more unmet service needs, most notably in day care, recreational activities for children, health care costs not covered by Medicaid, transportation for medical appointments, and respite care. Few differences existed between kinship and non-kinship caregivers. In another study, three of the five unmet needs identified by foster parents were associated with the provision of services and support, namely financial supports, a range of support systems, and foster parent recognition of roles and responsibilities (Brown, 2007). Finally, in a study of foster parents who quit, consider quitting,

and plan to continue fostering, the major reasons foster parents provided for quitting included lack of agency support, poor communication with caseworkers, lack of say in children's futures, and difficulties with foster children's behavior (Rhodes et al., 2001). Thus it seems that increased stress combined with a lack of support can influence parents to discontinue their service to foster children and youth.

As the number of children and youth entering out-of-home placement continues to increase, so does the need for quality foster care homes (Sanchiricho, Lau, Jablonka, & Russell, 1998). Unfortunately, there is currently a shortage of family-based foster homes (Rhodes et al., 2001). There is a need to not only recruit new family-based foster homes, but more importantly, to retain the skilled, experienced foster parents who currently provide care for foster children and youth in an effort to reduce placement disruptions and improve outcomes for foster care children and youth.

In order to accomplish this we need to 1) understand the areas in which foster parents feel a lack of support, 2) develop programs of support to address those areas, and 3) evaluate the effectiveness of those various programs of support. Unlike studies of foster parent training, which are beginning to have widely disseminated curricula and evaluation data, service and support programs for foster caregivers and evaluations appear infrequently in the research literature.

This section of the report is intended to assist Foster Family-Based Treatment Association (FFTA) agencies identify the most successful practices of foster parent services and support by providing a comprehensive literature review and annotated bibliography of evidence-

based practices in foster parent support. This section focuses on studies that examine the effectiveness of interventions and models of support for foster parents, as well as preliminary research evidence regarding the benefits of various types of foster parent supports (when traditional evaluative research is not available). The following services and supports are covered in this section of the report: benefits (health insurance, service provision, and stipends), foster parent collaboration with agency staff and biological families, level of care, respite, support from agency workers and community members, support inventories, and integrated models of support and training.

Benefits

Health Insurance & Managed Care

Children and adolescents with special healthcare needs constitute a highly vulnerable subpopulation of the nation's youth. By definition, they experience ongoing health issues that require continuing interaction with the healthcare system. Their underlying chronic conditions put them at added risk for health complications that may undermine their normal functioning at school, in the family, and in the community (Newacheck, 2007). Families of youth with special health care needs may also sustain adverse emotional and financial consequences as a result of their child's health difficulties and elevated care needs. Receipt of timely and effective healthcare services is vital to maintaining and improving the health of these youth and the stability of their families.

Recent studies have indicated that many children do not have access to the medical services they need. One study found that over a third of the children with autism, over a fifth with mental retardation, and over a fifth with other types of special health care needs had problems obtaining needed care from specialty doctors in the preceding year (Krauss, Gulley, Sciegaj, & Wells, 2003). The most common problems included getting referrals and finding providers with appropriate training. Adolescents with special health care needs tend to have one more annual office visit per year and report three times the rate of unmet medical needs, despite higher rates of insurance coverage, than adolescents without those needs (Okumura, McPheeters, & Davis, 2007). Children in foster care, especially those receiving SSI benefits, account for a disproportionate share of medical expenditures (Rosenbach, Lewis, & Quinn, 2000).

Health insurance is imperative for children and youth with special health care needs in a treatment foster care population. In this population, health insurance is positively associated with both access and utilization of services (Jeffrey & Newacheck, 2006; Kraus et al., 2004). The families of insured children also experience significantly lower out-of-pocket burden and financial problems as compared to those families whose children are uninsured. Because of the large proportion of children with special health care needs who reside in treatment foster care, having insurance for these children is a significant support for treatment foster parents.

Among those children with health insurance, the role of managed care is widely debated. Medicaid coverage and public secondary health coverage have been associated with fewer access problems (Kraus et al., 2004). However the utilization of services within managed care health insurance is disputed. Some studies link Medicaid managed care insurance plans to reduced service utilization, which is interpreted as improved care coordination rather than a lack of care

resources (Davidoff, Hill, Courtot, & Adams, 2008). Studies which consider all managed care plans (not just Medicaid) find that service utilization differences don't exist between managed care and fee-for-service plans (Newacheck et al., 2001). Clearly research findings have not reached a consensus in this area.

Treatment foster care providers, although benefited by having insurance support, may be concerned with the continuation of care for adolescents once they reach adulthood. A recent study found that over 27% of adolescents with special health needs have public coverage (Okmura et al., 2007), and young adults who have coverage through a state health plan such as Title V (special health care needs), Medicaid, or a State Children's Health Insurance Program (SCHIP) face the prospect of discontinued coverage as they leave adolescence.

Managed Care & Service Provision

Agencies which operate under a performance-based, managed care purchase-of-service contract have been associated with reduced service utilization, which is interpreted as suppressed service provision that may lead to service disparities between foster children and families served under different market environments (McBeath & Meezan, 2008). Children in performance-based environments are also significantly less likely to be reunified and more likely to be placed in kinship foster homes and adopted, as compared with children in fee-for-service foster care agencies. Clearly the effect of managed care has ramifications for treatment foster care providers.

Stipends

In addition to providing care, foster parents must also financially support their foster children. Although the majority of standard services are covered, foster parents report that ordinary stipends are often inadequate to cover the cost of rearing the child in their care (Barbell, 1996; Soliday, 1998). African American foster parents, who tend to be older, single, and female, have expressed displeasure concerning reimbursement and allowances for children's care, even when reporting satisfaction with agency workers (Denby & Reindfleisch, 1996).

Adequate compensation is essential to attracting and keeping foster parents who can tolerate the demands of parenting and treating a troubled child (Meadowcroft & Trout, 1990). A recent study in Illinois demonstrated that a reduction of subsidies for relative caregivers by $120 per child per month (27%) was indicative of a 10-15% decrease in the propensity to provide care, and larger decreases for children who require mental health services, infants, and teenagers (Doyle, 2007). The reduction in subsidies was not related to child health, education, or placement outcomes.

Even modest increases in stipends have been found to relate to more positive outcomes for foster youth. One study found that a $100 increase in the basic monthly foster care payment reduces the number of children placed in group homes by 29% (with more children instead going to non-relative foster homes), and decreases placement instability by 20% (Duncan & Argys, 2007). Another study, utilizing a randomized controlled trial (RCT), demonstrated that providing enhanced support ($70/month) and training resulted in a dropout rate that was nearly two-thirds less than that of the control group. Dropout rates for the control, enhanced support, and enhanced

support and training groups were 26.9%, 14.3%, and 9.6% respectively. Clearly, providing more support in terms of increased stipends will greatly benefit treatment foster care providers.

Integrated Models

Several models that integrate foster parent training and supports exist, including KEEP, MTFC, MTFC-P, and STAFF. (See Section I: Evidence-Based Practice in Foster Parent Training for an overview of each program.) Although heavily based on training, these programs also provide foster parents with a variety of supports that may improve outcomes for foster parents and foster children alike. For example, the KEEP model assigns a section of its training to parental stress management, and utilizes weekly telephone calls to support parents in their use of newly acquired techniques at home (Price et al., 2008). The MTFC and MTFC-P models include close collaboration between all of those involved in the foster child's life, including the program supervisor, case worker, parole or probation officer, if any, the child's teachers and/or work supervisors, foster parents, and birth parents. Foster parents are contacted seven or more times per week regarding their foster child, including a two-hour group session, five ten-minute phone calls, and additional calls as needed for support and consultation (CEBC, 2008c, 2008d). The STAFF model's supportive services include a series of six newsletters, buddy families, a "warm line," and a resource library (Burry & Noble, 2001).

Models which integrate foster parent training with on-going support have been linked to foster parent satisfaction, the development and retention of effective parenting skills, reduced foster parent stress, and reduced child delinquency (Chamberlain, Leve, & DeGarmo, 2007;

Chamberlain & Moore, 1998; Chamberlain, Price, Reid, & Landsverk et al., 2008; Chamberlain & Reid, 1998; Eddy & Chamberlain, 2000; Eddy, Whaley & Chamberlain, 2004, 2004b; Fisher et al., 2000, 2005; Fisher & Kim, 2007; Harmon, 2005; Leve & Chamberlain, 2005, 2007; Leve, Chamberlain & Reid, 2005; Price et al., 2008). More importantly, these programs are consistently linked with improvements in foster children's behavior and placement permanency. These programs were also specifically designed to be implemented with children and youth with emotional and behavioral problems; the supports provided by these programs should help to alleviate some of the strains associated with providing care for TFC children and youth.

Involvement in Program (Collaboration/Partnering)

Treatment foster parents' involvement in collaborating and/or partnering with others in the treatment of foster care youth is viewed as highly important (Brown & Calder, 2002; Denby, Rindfleisch, & Bean, 1999; Hudson & Levasseur, 2002; Rhodes et al., 2001). Most often, collaboration occurs between treatment foster parents and foster care agencies or biological parents. This collaboration can take the form of involvement in service planning, parenting, and visitation.

One important aspect of collaborating with family members should be noted. Although kinship and non-kinship foster parents are similar in their perceptions of fostering rewards and stressors, and in their perceptions of factors that facilitate or inhibit successful fostering, differences regarding the birth family are more pronounced and complicated among kinship foster parents (Coakley, Cuddeback, Buehler, & Cox, 2007). Because kinship foster parents

possess knowledge about the birth families and are likely to have close dealings with them, training and services need to equip them to manage familial dynamics in ways that ensure the best outcomes for the children in their care. Unlike foster parents, kinship foster parents often do not plan to foster, but do so after a family crisis has occurred. Thus, EBPs in foster parent involvement need to be tailored to these special cases. Several models of foster parent involvement exist.

Co-Parenting

Co-parenting is a two-component intervention for biological and foster parent pairs which aims to improve parenting practices, co-parenting, and child externalizing problems (Linares, Montalto, Li, & Oza, 2006). The co-parenting intervention includes both a parenting and a co-parenting component. The parenting component is offered to groups of four to seven parent pairs for 2-hr sessions using the manualized *Parents and Children Basic Series Program* (IY; Webster-Stratton, 2001). This course meets two days a week for a duration of 12 weeks. The co-parenting component is offered to individual families (biological and foster parent pair and target child) in a separate session using a curriculum developed by, and available from, L. Oriana Linares. During this session, parent pairs have the opportunity to expand their knowledge of each other and their child, practice open communication, and negotiate inter-parental conflict regarding topics such as family visitation, dressing and grooming, family routines, and discipline.

Co-parenting is rated as a ***promising practice***. It has been associated with improvements in positive parenting skills, clear expectations of children, and child externalizing problems (Linares, Montalto, Lee et al., 2006). Increases in parent-to-parent cooperation have been linked

to increases in positive discipline and decreases in harsh discipline for both biological and foster parents (Linares, Montalto, Rosbruch, & Lee, 2006). This relationship was observed even after controlling for child (e.g., age, gender, conduct problems) and parent (e.g., age, education , ethnicity, and marital status) characteristics. Co-parenting is a service that may serve to support treatment foster parents of children with a goal of family reunification.

Ecosystemic Treatment Model

The ecosystematic treatment (visitation centered) program uses weekly, court-ordered supervised visitation sessions to engage the foster care triad - birth family, foster family, and agency- in a collaborative effort to prevent foster care drift (Lee & Lynch, 1998). Birth parents, foster parents, the foster care worker, and a marital and family therapist meet in anticipation of each month's visitation schedule to decide what would best serve family reunification for the stage of model in which they currently reside. Stage 1 ensures that the child and biological family are in secure places; Stage 2 stabilizes the family; Stage 3 addresses the long-term needs of the family; and Stage 4 refers the parents to appropriate classes and approaches them about using psycho-educational interventions. Social workers, marital and family therapists, and child psychologists are available to the families.

The Ecosystemic Treatment Model is rated as an ***emerging practice***. Preliminary results of the program suggest that overcoming resistance by biological families, foster families, and agency staff is an ongoing struggle. The partnerships formed between foster families, biological families, and the agency seemed to have positive outcomes for the children and their families, although formal evaluations have not yet been conducted. Once the efficacy of this program is

demonstrated, the ecosystemic (visitation centered) treatment model may be a helpful support for treatment foster care providers who wish to work in collaborative efforts with biological families.

Family Reunification Project (FRP)

The goals of the Family Reunification Project are to: 1) provide a neutral, nurturing, and educational environment for foster children, foster parents, and biological parents in which regular visits can take place while the children are in foster home placement; 2) help biological parents and foster children maintain their relationships during the placement period; 3) assist biological parents in improving their parenting skills; 4) assist foster parents in understanding their roles in the foster care system; 5) provide educational and supportive services to foster parents in order to enhance the stability of foster home placements; 6) provide access, after reunion, to those services necessary for the family to function appropriately; and 7) accumulate data that could be used by agencies and courts in making reunification decisions. FRP serves families with children ranging in age from birth through 12 years, in three modules: infant/toddler (zero to three years), preschool (three to five years) and school age (six to 12 years).

In FRP each visit lasts two hours. The first hour consists of a structured session (group activity facilitated by an art therapist) for the foster children and their biological parents. During these visits, short (20-minute) individual family therapy sessions are conducted by the staff social worker. Each parent and child leaves the group to be observed as a family unit. Upon completion of this segment, the child is sent back to the group and the parent has a short conference with the social worker to reinforce positive changes in his or her style of parenting.

During the structured biological family session, a foster parent support and training group meets in a separate location. At the conclusion of the visit the foster parents and the children leave and a second hour consists of a support group for the biological parents.

No formal evaluations of FRP have been reported; therefore it is rated as an ***emerging practice***. If this project's efficacy can be established it may provide TFC providers with a great opportunity to ease the stress associated with visitation and provide support for other problems the parents are encountering.

Foster Parent Involvement in Service Planning

A substantial decline in the number of qualified foster homes and a sharp increase in the number of children in need of foster care have led child welfare professionals to place greater emphasis on foster parent retention (Sanchirico, Lau, Jablonka, & Russell, 1998). While agencies can do little to retain foster parents who leave the system for personal reasons, those who leave because of dissatisfaction with agency policies and practices may be retained if the reasons for their dissatisfaction are identified and eliminated. One factor commonly identified as one of the strongest influences on foster parents' satisfaction is involvement in service planning (Denby, Rindfleisch, & Bean, 1999; Rhodes et al., 2001; Sanchirico et al., 199).

Collaboration among foster care providers and agency workers needs to occur at the agency level as well. One study found that even though directors reported that the agency informed foster parents of previous sexual abuse prior to placement, only half of all foster parents in the study admitted knowledge of the children's abusive experiences prior to placement (Henry et al., 1991). When asked about specialized training and education for this population,

agency staff indicated that they provided adequate training and education to foster parents, but foster parents noted that the services were not adequate for their needs.

No specific models exist for foster parents' involvement in service planning. Clearly, collaboration in service planning and agency processes is imperative to retaining experienced treatment foster care providers. There is a need for collaborative models to be developed and tested as a means of retaining foster parents.

Shared Family Foster Care (SFC)

Shared Family Care refers to the planned provision of out-of-home care to *parent(s) and their children* so that the parent(s) and host caregivers simultaneously share the care of the children and work toward independent in-home care by the parent(s) (Barth & Price, 1999). SFC combines the benefits of in-home and out-of-home child welfare services. SFC has been used to prevent the separation of parents from their children, and to reunify families by providing a safe environment in which to bring together families and children who have been separated. SFC may also promote more expedient decision-making by helping parents make the choice to terminate their parental rights; it provides stability for children while alternative permanency plans are being made.

Whereas traditional out-of-home care requires family separation and typically offers little support to assist parents in becoming better caregivers, SFC involves "reparenting," in which adults learn the parenting and living skills necessary to care for their children and maintain a household while concurrently dealing with their own personal issues and establishing positive connections with community resources. SFR allows parents to receive feedback about their parenting styles and skills on a 24-hour basis and across many and diverse parenting tasks in a

safe, family environment. SFC can help families learn to make better decisions, to handle typical day-to-day stresses, and to live together as a family. By simultaneously ensuring children's safety and preserving a family's ability to live together, SFC may be effective at preventing unnecessary family separation, decreasing the number of children reentering the child welfare system, and expediting permanency for children.

In the SFC model, one social worker works with approximately eight to nine families at a time, and participates, along with each client and host family, in developing a written contract outlining each party's responsibilities. Clients generally maintain primary responsibility for the care of their children, and the host families serve as advocates, resources, and mentors in parenting and daily living skills. Host families are licensed child family foster homes.

SFC is rated as an ***emerging practice***. Although several models of Shared Family Foster Care have been developed and are currently in operation (e.g., Adolescent Mothers' Resource Homes Project of the Children's Home and Aid Society of Illinois, Whole Family Placement Program, and A New Life Program), none have been formally evaluated. Preliminary results revealed that of the 110 families that had participated in HSA's Whole Family Placement Program, 53 parents moved with their children as a family unit on to independent living; 24 parents placed their children for adoption; 19 parents left their children in care where they remained until alternative plans were made; and 14 families were still in placement. Of the 53 families who moved on to independent living, none of them had subsequent involvement with child protective services within six months after placement termination. This is in contrast to a 12% reentry rate for children who were reunified with their families after a regular non-relative

foster care placement in the same state. Because of the intensity of these programs, good matching between foster and biological families is imperative.

SFC may be one way for TFC providers to be more involved with biological families. SFC may be an alternative to step-down and may help to alleviate some of the placement instability and re-entry that TFC youth experience. More research on the efficacy of SFC is warranted.

Shared Parenting

The Shared Parenting program is an innovative model of foster care in which the role of the foster family gradually becomes one of an extended rather than a substitute family (Landy & Munro, 1998). In the Shared Parenting program the role of foster care families is to offer support, advice, and guidance as a means of enhancing the parenting skills of natural parents. Biological and foster families are intended to work as a team with the family service and foster care workers in order to develop and plan strategies to best meet the child and family needs. Although the child remains in a traditional foster care setting, on-going contact between the child and the biological families is encouraged at all times. Earlier forms of contact tend to occur in the foster home, with more of the child's time spent in the biological family's home later on in the program. Family interactions are thought not only to benefit the child through reducing his/her separation anxiety, but to provide foster parents with the opportunity to assist the biological parents to transfer knowledge and skills to their own environment.

The objectives of the Shared Parenting program are to: 1) reduce the number of placement breakdowns of children and to reduce time in foster care either by earlier return of

children to their natural parents or by earlier permanency planning decisions, such as adoption; 2) enhance biological parents' existing parenting abilities, modify inappropriate skills, and learn more effective approaches; 3) improve family functioning so that biological parents are able to create a stable home environment to which the child will gradually return; and 4) enhance the retention and recruitment of foster parents by recognizing their expertise as vital change agents for natural families.

Much like SFC, Shared Parenting may be one way for treatment foster care providers to be more involved with biological families. Shared Parenting may be an alternative to step-down and may help to alleviate some of the placement instability and re-entry that TFC youth experience. Additionally, Shared Parenting offers a gradual re-introduction of children back into the biological family, possibly helping to ease the transition on both parents and children. Preliminary evidence has shown that approximately one third of families completed this program (i.e., were reunified); half of the other families had successful permanency planning. More stable families were likely to have success. This program may not be more beneficial than traditional family-based foster care. This program is rated as an ***emerging practice***; more research on the efficacy of Shared Parenting is needed.

Level of Care

Youth entering TFC are more likely to be entering from within the child welfare system and stepping up to a higher level of care (Baker & Curtis, 2006). These children and youth (and the treatment foster parents caring for them) will need special supports to ensure a stable placement and positive permanency outcome. The following models are designed to provide

supports to children and youth in treatment foster care so that they have the best outcomes possible.

Positive Peer Culture (PPC)

Positive Peer Culture is a peer-helping model designed to improve social competence and cultivate strengths in troubled and troubling youth aged 12-17 (Vorrath & Brendtro, 1985). The defining element of PPC is care and concern for others. Caring is made fashionable and any hurting behavior is deemed totally unacceptable. As youth become more committed to caring for others, they abandon hurtful behaviors. PPC assumes that as group members learn to trust, respect, and take responsibility for the actions of others, norms can be established. These norms not only extinguish antisocial conduct, but more importantly, they reinforce pro-social attitudes, beliefs, and behaviors. PPC utilizes 90-minute structured group sessions (8-12 youth per group) which meet five times per week over a six to nine month period to assist youth in skill development that will prepare them for less restrictive care (CEBC, 2008).

PPC is rated as an ***effective practice***. The outcomes of participating in PPC include the development of positive attitudes and social skills, reduced delinquency, and moral development for foster children and youth (Leeman, Gibbs, & Fuller, 1993; Nas, Brugman, & Koops, 2005; Sherer, 1985).

Re-ED

Re-ED is an ecological competence approach to helping troubled and troubling children and youth (aged 0-22) entering child serving systems with their families (Hobbs, 1982, 1994).

Six elements (viewed as essential by Re-ED staff) significantly differ from the views of staff in more traditional programs: 1) replace pathology with a wellness view; 2) use an ecological orientation; 3) focus on competence and learning; 4) value teaching and counseling roles; 5) build relationships; and 6) encourage a culture of questioning and information-based decision-making.

Re-ED can be delivered in multiple settings, including residential facilities, and in birth, adoptive, and foster homes (CEBC, 2008). Typically, children and youth who have language functioning adequate for group interaction meet multiple times each day. These meetings last from 15 minutes to more than an hour, and are each held for specific purposes (i.e., planning, problem solving, evaluation, strengths focused meetings, etc.). Additional groups (formed for other purposes) meet regularly on differing schedules. The intensity of the services varies, depending on the service type; services range from a matter of days (e.g., for assessment and referral) to the calendar or school year (e.g., day treatment or intensive home treatment; CEBC, 2008).

Re-ED is rated as an ***emerging practice***. Exploratory studies have linked participation in Re-ED to the improvements in child behavior (maintained for six months; Fields, Farmer, Apperson, Mustillo, & Simmers, 2006; Weinstein, 1969), and reductions in criminal activity and levels of care (Hooper, Murphy, Devaney, & Hultman, 2000). Re-ED was designed for the population of youth who enter TFC and can be implemented in TFC homes; TFC foster parents and youth may benefit greatly from this service.

Stop-Gap

The Stop-Gap model incorporates evidence-based practices within a three-tiered service delivery approach in residential treatment settings (CEBC, 2008). The goals of the Stop-Gap model are to 1) interrupt the youth's downward spiral imposed by increasingly disruptive behavior, and 2) prepare the post-discharge environment for the youth's timely re-integration. Youths enter the model at Tier I, where they receive environment-based and discharge-related services. The focus at Tier I is on the immediate reduction of "barrier" behaviors (i.e., problem behaviors that prevent re-integration) through intensive ecological and skill teaching interventions (e.g., token economy, social and academic skill teaching, etc.). Simultaneously, discharge-related interventions, which include connecting the child with critical community supports, begin. To the extent that problem behaviors are not reduced at Tier I, intensive Tier II interventions (including function-based assessment and support) are implemented. Depending on the needs of the child, the duration of these services may last from 90 days to one year.

The Stop-Gap model is rated as ***promising practice***. This model recognizes the importance of community-based service delivery while providing intensive and short-term support for youths with the most challenging behaviors. Stop-Gap has been associated with improved child behavior (McCurdy & McIntyre, 2004). Although this service occurs in a residential treatment facility, TFC foster parents who are caring for youth who have stepped down from a residential treatment facility would be benefited by knowing the techniques used to improve youth’s disruptive behaviors.

Respite

Respite care provides treatment foster parents with a break from parenting, and allows them to have time alone or time with their own children. Respite care can be an important deterrent to burnout (Meadowcroft & Grealish, 1990). A recent evaluation of respite care programs viewed as "effective" by child welfare experts and public officials revealed that no single model of respite exists (Brown, 1994). Commonalities of "effective" programs included: 1) respite care was established to meet a specific need, 2) each program was affiliated with an established organization that served foster children, 3) all promoted teamwork and trust, and 4) each program screened, trained, and monitored providers. However, programs differed on program management and requirements; criteria and settings for respite care; types of respite care providers; payment methods; and target populations.

Though no formal evaluations of any specific model of respite care exist in the empirical literature, respite care as a practice has been linked to decreases in parenting stress following the use of respite care (Cowen & Reed, 2002) and generally positive opinions about the delivery of respite care services (Ptacek et al., 1982). Providing high quality respite care that is accessible to treatment foster parents is seen as an essential component of retaining experienced, satisfied caregivers.

Social Support

Research has demonstrated that support and collaboration from the social worker is one of the strongest influences on foster parents' satisfaction (Denby et al., 1999; Fisher, Gibbs,

Sinclair, & Wilson, 2000). In general, qualities of a good social worker, as reported by foster parents, include: 1) showing interest in how carers are managing; 2) being easy to contact and responsive when contacted; 3) following through on plans; 4) being prepared to listen and offer encouragement; 5) taking account of the family's needs and circumstances; 6) keeping foster parents informed and included in planning; 7) ensuring that payments, complaints, etc. are processed as soon as possible; and 8) attending to the child's interests and needs, and involving foster parents where appropriate (Fisher et al., 2000). Support provided during times of crisis plays an especially important role in the attitudes formed by foster parents of social workers (Fisher et al., 2000).

Foster parent retention is also associated with agency and worker support. Negative relationships with professional agency staff are linked with foster parents who are considering quitting (Rodger, Cummings, & Leschied, 2006). Foster parents who actually quit may perceive they lacked information about the unique parenting demands of foster children, whereas in qualified homes planning to quit agency relationships might be the deciding factor (Rhodes et al., 2001). When dealing with loss, such as the death or removal of a child from a foster family's home, agency services and supports are reported to be valuable factors of foster parent retention (Urquhart, 1989).

Treatment foster parents may also benefit from sources of support outside of the agency. Direct access to on-site professionals such as mental health care providers, case workers, and family advocates is viewed as helpful in gaining access to needed resources and referrals, obtaining available information about children's backgrounds, and helping to resolve child behavior problems in the home (Kramer & Houston, 1999). Although informal sources of agency

provided support are viewed as helpful, foster/adoptive parents frequently turn to indigenous sources of support networks.

Results of interventions for enhancing foster parents' levels of social support are mixed. A recent study indicated that a support enhancing intervention increased the levels of social support among caregivers of children with HIV/AIDS (Hansell et al., 1998). Additionally, an on-line training program has been shown to be effective in increasing self-efficacy, teaching computer skills, enhancing social support, and building common ground between children and kinship caregivers (Strozier et al., 2004).However, another study found that even when provided with increased internet access, the frequency of using online social support is low for foster care parents and youth. Only a minority of parents and children increased their use of the internet to give and receive help, communicate with other foster families, and e-mail with their foster care worker (Finn & Kerman, 2004).

In sum, it is important to have professional staff who have training regarding sensitivity and understanding toward, and who can create and support a working relationship with, TFC providers. Providing agency-based sources of social support as well as helping TFC providers build informal (more home-based) sources of support may be critical to helping foster parents feel supported and satisfied. No specific model of social support has been formally evaluated; there is a need for developing and testing models that may promote and/or enhance the social support of TFC providers.

Support Inventories

Casey Foster Family Assessments

The overall goals of the Casey Foster Family Assessments are to improve recruitment, selection, development, and retention of foster parents as a means of improving outcomes for children in foster care (Orme & Cox et al., 2006; Orme, Cuddeback, Buehler, Cox, & Le Prohn, 2006). Developed by the Casey Family Programs and the University of Tennessee's College of Social Work, the CFFA consist of two sets of standardized measures to assess foster family applicants: the *Casey Foster Applicant Inventory (CFAI)* and the *Casey Home Assessment Protocol (CHAP)*. The tools complement each other; both tools are designed to be used during the foster family application and selection process, but they can be used after this process as well. The tools assess a broad range of characteristics of foster parents in order to identify strengths and areas for needed development and support.

The Casey Foster Applicant Inventory (CFAI), available online, takes approximately 20 minutes to complete (CEBC, 2008a). In general, this measure has acceptable levels of both reliability and validity (Orme & Cuddeback et al., 2006). The CFAI shows promise for use in both research and practice, where is might be used to improve decisions about how to support, monitor, and retain foster families, and to match, place, and maintain foster children in foster homes.

The Casey Home Assessments Protocol (CHAP) varies in length; therefore, the completion times vary from 5 to 20 minutes (CEBC, 2008a). This measure has acceptable levels

of reliability; its validity is not currently known (Orme, Cherry, & Rhodes, 2006). Researchers suggest that the measure could be used to help foster parents think deliberately about 1) who might provide them with support, and 2) how to identify additional support sources.

It is recommended to administer the assessments once approximately 75% of the way through the foster care licensing process, before the home study. Child welfare workers have also administered it at re-licensure for some foster families to further explore training needs. These measures could be quite valuable to treatment foster agencies as a means of assessing 1) the support that foster parents need, and 2) likely sources of support. The Casey Foster Family Assessments are rated as an ***emerging practice***.

Treatment Foster Care

Research has shown that enhanced services and supports in the form of comprehensive programs, including specialized training, professional support, and increased stipends, have been found to positively affect foster caregiving quality and outcomes (Soliday, 1998). TFC programs aim to meet the needs of children requiring the intensive structure of residential care in a family home environment, and caregivers receive training and support services (like those listed above) to implement in home therapeutic interventions (Reddy & Pfeiffer, 1997). Although a review of the effectiveness of treatment foster care is outside of the realm of this report, two recent studies on TFC are noteworthy. First, Galaway, Nutter, and Hudson (1995) assessed the effects of TFC program characteristics on type of discharge and restrictiveness of post-discharge living arrangements for youth. The findings of this study revealed that the program characteristics of caseload size, number of clients permitted per providers' home, and cost per client per year, were

not related to the outcomes of whether the youth's discharge was planned or unplanned, or to the restrictiveness of post discharge living arrangements. However, youth were more likely to be discharged on a planned basis from high-cost, low-caseload programs than from low-cost, high-caseload programs. In a report on a TFC program that offered caregivers intensive preservice training, respite, and consistent supervision, foster parents were retained approximately three times longer than a treatment foster care program offering traditional forms of support (Daly & Dowd, 1992).

Wraparound

Wraparound is a collaborative planning process designed to provide individualized and coordinated family-driven care (CEBC, 2008). It is designed to meet the complex needs of children who are 1) involved with multiple child and family-serving systems (e.g. mental health, child welfare, juvenile justice, special education, etc.); 2) at risk of placement in institutional settings; and 3) experience emotional, behavioral, or mental health difficulties. The Wraparound process requires collaboration amongst families, service providers, and key members of the family's social support network as a means of creating a plan that responds to the particular needs of the child and family. These team members then implement the plan and continue to meet regularly to monitor progress and make adjustments to the plan as necessary. The team continues its work until members reach a consensus that a formal Wraparound process is no longer needed.

Wraparound (as a general service planning process) has received consistent support in the empirical literature and is associated with reductions in foster parent stress, and improvements in

foster child attitudes, behavior, and mental health (Bickman, Smith, Lambert, & Andrade, 2003; Bruns, Rast, Peterson, Walker, & Bosworth, 2006; Carney & Butell, 2003; Crusto et al., 2008; Myaard, Crawford, Jackson, & Alessi, 2000). Wraparound has also been associated with improved educational outcomes for foster youth (Carney & Butell, 2003; Hyde, Burchard, & Woodworth, 1996), less restrictive placements (Bruns et al., 2006; Hyde et al., 1996), and reduced criminal activity (Pullman et al., 2006). Treatment foster parents may benefit from the involvement in service planning and collaboration with other team members using this approach.

Family-Centered Intensive Case Management (FCICM)

Family-Centered Intensive Case Management is a model of wraparound that acknowledges that families need a comprehensive array of services and supports to help them keep their children at home (Evans et al., 1994; Armstrong, Dollard, Evans, Armstrong, & Kuppinger, 1996). It has an emphasis on the family's central role in accomplishing treatment goals for the child. The model uses an in-home approach to service delivery, with both a case manager and a parent advocate offering regular in-home services. The team works with a maximum of eight families at any time. The parent advocate is a parent of a child who has or has had SED. The team's goals are to 1) keep the child at home and in school, and 2) provide the family with the resources and supports to make this possible. Teams are available 24 hours a day, seven days a week. Each cluster of eight families has two respite families available to provide both planned and emergency out-of-home, short-term respite care as needed. Respite families receive training, supervision, and support from a therapeutic foster family program. FCICM also allocates flexible service dollars and behavior management skills training to biological parents.

FCICM is rated as an ***efficacious wraparound practice***. Children in FCICM have shown a significant decrease in mental health symptoms and problem behaviors after receiving one year of services (Evans, Armstrong, & Kuppinger, 1996). Children in FCICM also improved on behavior, moods, emotions and role performance. Preliminary estimates indicate that FCICM children are doing as well or better than children who were assigned to New York's model of TFC. Future studies of this model may indicate which children are best served by TFC as opposed to those best served by wraparound (in-home) supports.

Fostering Individualized Assistance Program (FIAP)

The Fostering Individualized Assistance Program was developed at the University of South Florida to provide individualized wraparound supports and services to foster children with emotional and/or behavioral disturbance (EBD) and their families, including biological, adoptive, and foster families (Clark & Boyd, 1992). The goals of FIAP are to 1) stabilize placement in foster care and develop viable permanency plans, and 2) improve foster children's behavior and emotional adjustment. These goals are achieved through four major intervention components: strength-based assessment, life-domain planning, clinical case management, and follow-along supports and services - natural supports found within families' homes, schools, and community settings. FIAP is rated as a ***promising practice*** and is associated with improvements in children's behavior, reductions in delinquent behavior, and placement stability (Clark & Prange, 1994).

Summary

Foster parents' primary motivation for fostering is to make a positive difference in children's lives (MacGregor, Rodger, Cummings, & Leschied, 2006; Rodger, Cummings, & Leschied, 2006). However, foster parents, and treatment foster parents in particular, cannot successfully meet the needs of youth in their care without a variety of supports from agencies, community and family members, and policymakers.

A variety of services to support treatment foster care providers currently exist, including the provision of benefits (such as health insurance and stipends), opportunities for foster parent collaboration with agency staff and biological families, interventions designed to make changing levels of care flow more smoothly, respite, social support, inventories to assess needs and current sources of support, and models of training which include an on-going support component. Specific models of services and supports have not yet been developed for, and/or tested in, a treatment foster care population. However the limited research that exists in the published, peer-reviewed literature suggests the following:

- Foster care providers are benefited when their foster children have health insurance that adequately provides for the needs they have and covers the expenses that incur as a result of seeking services. Supportive services and an adequate monthly stipend assist foster parents in paying for additional costs associated with caring for children with behavioral issues (such as TFC youth) and have a positive impact on foster parent retention.

- Foster parents express desire to be involved in the service planning for children in their care. Involvement in planning and professionalization is linked to increased foster parent satisfaction and retention. Several specific models of foster parent involvement with biological parents have been developed. These models may show promise for their utility in a treatment foster care population.
- Several useful models exist for assisting youth step-down from a residential setting to less restrictive levels of care, such as treatment foster care. These models may be altered to assist TFC youth prepare for less restrictive levels of care as well, such as reunification with family, traditional foster care situations, or adoption.
- Respite care is linked to increases in foster parent satisfaction and retention. Treatment foster care agencies who utilize customer satisfaction surveys to evaluate their respite care services on an ongoing basis as a means of ensuring the provision of the most effective respite services for treatment foster parents may see increases in treatment foster provider satisfaction and retention.
- Social support is highly beneficial to traditional and treatment foster care providers. Social support of foster parents is linked to greater foster parent satisfaction and resources, as well as improved child behavior. The relationship between the social worker and foster family is key to increasing the satisfaction and retention of foster parents. Foster parents indicate the need for an open, positive, supportive relationship with the worker. Treatment foster parents may be benefited by increased collaboration with agency workers and by the development

of support models that 1) create additional formal agency supports, and 2) help treatment foster parents identify current support needs and expand their informal support networks. The Casey Family Foster Inventories may be helpful in this process.

Though a variety of supports exist for foster parents, specific models of providing support for traditional and treatment foster parents need to be developed, especially in the areas of benefits, respite care, and social support. Once these models are created, more research evaluating their effectiveness in a treatment foster care population can be completed.

Evidence-Based Practice in Foster Parent Training and Support: Implications for Treatment Foster Care Providers

Section II: Evidence-Based Practice in Foster Parent Support

Annotated Bibliography

Citation	Study	Level of EBP
Benefits		
Health Insurance & Managed Care		
Davidoff, A., Hill, I., Courtot, B., & Adams, E. (2008). Are there differential effects of managed care on publicly insured children with chronic health conditions? *Medical Care Research and Review, 65,* 356-372. **Population:** Publicly insured children	**Method:** This study used data from the 1997-2002 National Health Interview Survey, which included 13,550 children eligible for and enrolled in either Medicaid or State Children's Health Insurance Plan (SCHIP) to examine the effects of managed care (MC) on children. **Findings:** The effects of MC are concentrated on children with chronic health conditions (CWCHC); CWCHC experience reductions in the use of specialists, mental health, and prescription drugs (though no effects of perceived access were found). Capitated programs (those requiring fixed monthly payments to MC) in which mental health or specialty services are provided through other mechanisms are associated with greater number and larger decreases in service use compared to integrated capitated programs – programs that provide a full range of services. The authors believe that the net effects of MC on service use represent improvements in care coordination and not a lack of care resources.	
Jeffrey, A. E. & Newacheck, P. W. (2006). Role of insurance for children with special health care needs: A synthesis of the evidence. *Pediatrics, 118*, 1027-1038. **Population:** Families	**Method:** The purpose of this review was to assess and synthesize recent research in the peer-reviewed literature pertaining to the role of insurance for children with special health care needs. A systematic literature review was conducted on the effects of insurance status, insurance type, and insurance features on access, utilization, satisfaction, quality, expenditures, and health status. **Findings:** The strongest evidence emerged for the positive effects of insurance on access and utilization. Limited evidence on the effect of insurance on satisfaction with care showed improved satisfaction ratings for the insured. The studies with findings relevant to out-of-pocket expenditures for insured versus uninsured children with special health care needs all found significantly higher out-of-pocket	

	burden and financial problems among the uninsured. Evidence was mixed for the effects of insurance type and insurance characteristics on outcomes. None of the studies attempted to assess the impact of health insurance on health outcomes. **Implications:** The review of the literature found plentiful evidence demonstrating the positive and substantial impact of insurance on access and utilization. There is also clear evidence that insurance protects families against financially burdensome expenses. **Limitations:** Many of the studies rely on cross-sectional, correlational designs which lack random assignment.
Krauss, M. W., Gulley, S., Sciegaj, M., & Wells, N. (2003). Access to specialty medical care for children with mental retardation, autism, and other special health care needs. *Mental Retardation, 41,* 329-339. **Population:** Children with special health care needs (could include foster children but not exclusive)	**Method:** This article examined access to specialty medical care among children with mental retardation, autism, or other types of special health care needs from a national survey. In 1998-1999, 2,220 families of children with special health care needs in 20 states responded to a survey conducted by Brandeis University and Family Voices, a national organization of family and friends of children with special health care needs. The sample was drawn from two sources, 1) 42.6% of the sample was form state-based mailing lists of Family Voices, and 57.4% of the sample were families whose children received service from the participating stat's Title V program. Of the 2,220 children on whom survey data were collected, virtually all (97%) were covered by a health plan. Almost half (46%) were covered by health plans purchased privately and over a third (39%) had their primary plan paid for by Medicaid. A total of 1,799 children (81% of total sample) were included in the analyses. Three groups were compared: those with mental retardation (n = 434), those with autism (n = 152), and children with special health care needs with other conditions (n = 1,213). **Findings:** Over a third of the children with autism, over a fifth with mental retardation, and over a fifth with other types of special health care needs had problems obtaining needed care from specialty doctors in the preceding year. The most common problems included getting referrals and finding providers with appropriate training. Children with unstable health conditions, autism, or those whose parent were in poor health were at greater risk for problems. Primary Medicaid coverage and public secondary health coverage were associated with fewer access problems.

	Limitations: This study did not include a control group; all medical conditions (i.e. asthma) would be considered in the third category. This study was dependent on self-reported data by the primary care giver.
Newacheck, P. W., Hung, Y., Marchi, K. S., Huges, D. C., Pitter, C., & Stoddard, J. J. (2001). The impact of managed care on children's access, satisfaction, use and quality of care. *Health Services Review, 36*, 315-334. **Population:** Non-institutionalized children	**Method**: This descriptive study explored the effects of managed care on access, satisfaction, utilization, and quality of pediatric health services. Study used data from the 1996 Medical Expenditure Panel Survey (MEPS). The MEPS collects data at both the person and household levels and, when weighted, provides nationally representative estimates of health care access, satisfaction, utilization, quality, expenditures, sources of payment, and insurance coverage for the U.S. civilian, non-institutionalized population. Interviews were conducted in person with one adult member of each participating household using a computer assisted personal interview methodology. A total of 5,995 children ages 0-17 were represented in all three rounds and are used in the analyses that follows. **Findings**: Among the 18 outcome indicators examined, the bivariate analysis revealed only three statistically significant differences between children enrolled in managed care and children in traditional health plans: children enrolled in managed care were more likely to receive physician services, more likely to have access to office-based care during evening or weekend hours, and less likely to report being very satisfied with overall quality of care. However after controlling for confounding factors, none of these differences remained statistically significant. **Limitations:** This study used self-reported data; the researchers were not able to verify the type of insurance and plan. The level and quality of care were subjective to parents' report.
Okumura, M. J., McPheeters, M. L., & Davis, M. M. (2007). State and National estimates of insurance coverage and health care utilization for adolescents with chronic conditions from the national survey of children's health, 2003. *Journal of Adolescent Health, 41,* 343-349.	**Method:** This descriptive study examined health and insurance characteristics of adolescents (aged 14-17) with special health care needs at both state and federal levels. Data came from the National Survey of Children's Health 2003, a nationally representative sample of children in the U.S. Estimates are based on 102,353 interviews completed from January 2003 through July 2004. **Findings:** Approximately 22% of adolescents 14-17 years old have a special health care need. On average, adolescents with special health needs have one more annual office visit per year than adolescents without these needs. Additionally, adolescents with special health needs reported three times the rate of unmet medical needs, despite higher rates of insurance coverage. Overall 26.9% of these

Population: Children and adolescents with special health needs.	adolescents had public coverage. Nationally, more than half of those adolescents lived in households with incomes above 100% of the federal poverty level, which puts them at risk for losing coverage when they age into adulthood. **Limitations:** Data was collected through primary caretaker proxy reporting, which could lead to inaccurate reporting. Telephone surveys are biased against households without telephones.
Rosenbach, M., Lewis, K., & Quinn, B. (2000). Health conditions, utilization, and expenditures of children in foster care. Final Report. Submitted to U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. **Population:** Children in the foster care system	**Method:** This descriptive study used data from the State Medicaid Research Files (SMRF) to examine health conditions, utilization, and expenditures for foster children enrolled in Medicaid. Three states were studied, California (1994-1995 time period), Florida (1994 – 1995 time period, and Pennsylvania (1993-1994 time period). The selection of sample took place in several steps: 1) create a subset by age, 2) identify foster care children, 3) create comparison groups, and 4) exclude children enrolled in managed care. **Findings:** Children in foster care accounted for a disproportionate share of Medicaid expenditures, relative to their share of Medicaid enrollment. Children in foster care comprised between 1.1 and 3.3 percent of the children enrolled in Medicaid in 1994, but accounted for 3.6 to 7.8 percent of Medicaid expenditures. Children receiving SSI used a larger share of resources than children in foster care, while AFDC children used fare fewer resources than their share of enrollment would suggest. Children in foster care had less continuous Medicaid coverage than children receiving SSI benefits and those in families receiving adoption assistance. Children in foster care were more likely than other groups of Medicaid children to have a mental health or substance abuse condition – either alone or in combination with a physical condition. There was considerable variation across states in health care utilization patterns. In general, foster care children in California were less likely to receive health care services than those in the other two states. Expenditures varied widely across states; in general expenditures were highest for the SSI population and second-highest for foster care children. **Limitations:** Generalizability and reliability of results are limited due to reliance on data from three states. The data was from the early-to mid 1990s. Other limitations are due to the SMRF data itself; these include not having an indicator of provider specialty on SMRF files, not all states reported basic data such as diagnoses, and there is no central database that indicates which SMRF files contain which data elements and to what degree of completeness.

Service Provision & Managed Care	
McBeath, B. & Meezan, W. (2008). Market-based disparities in foster care services provision. *Research Social Work Practice, 18,* 27-41. **Population:** Family-based foster care	**Method:** This study examined in-agency and out-of-agency service provisions in a sample of 243 foster children and their families. Data came from a longitudinal study of foster children and families served by non-profit agencies that were operating under either a performance-based, managed care purchase-of-service contract or a fee-for-service reimbursement mechanism. **Findings:** Children and families served by agencies with performance-based managed care contracts received fewer of three of five types of services than those served by agencies reimbursed through fee-for services contracts. Results suggest that performance-based, managed care contracting is related to suppressed service provision and may lead to service disparities between foster children and families served under different market environments **Limitations:** The five measures of service provision, which were counts of the number of contacts or different services provided to children and families, were limited. Unavailability of any pre-pilot measures of service provision made it impossible to determine whether the service disparities observed were results of differences in agencies contracting environments or unobserved difference in service provision that existed before the inception of data collection.
Meezan, W. & McBeath, B. (2008). Market-based disparities in foster care outcomes. *Children and Youth Services Review, 30*, 388-406. **Population:** Family-based foster care	**Method:** This study reported findings from a longitudinal experiment that examined the effectiveness of performance-based, managed care contracting mechanism on foster care outcomes. 243 foster children and families that were served by nonprofit child welfare agencies in Wayne County, Michigan from 2001 to 2004 participated in the study. Agencies were contracted to provide foster care services under one of two payment mechanisms: a fee-for-services system, or a performance-based, managed care system. Foster children in the county were assigned to nonprofit service providers on a rotating basis that was unrelated to case characteristics. **Findings:** At the end of the study, 80 children (33%) were reunified with their biological parents, 36 children (15%) were placed with relatives, 51 children (21%) had biological parents whose parental rights had been terminated but had not yet been placed in an adoptive home, and 57 children (24%) either had their adoption finalized or had been placed in an adoptive home and were awaiting finalization. Only 19 of the children (8%) had not achieved permanent placement by the end of the study period. Initial analyses identified significant differences in the final

	dispositions experienced by foster children in the performance-based environment opposed to those served by child welfare agencies who were reimbursed though fee-for-services contracts. Children in performance-based environments were significantly less likely to be reunified and more likely to be placed in kinship foster homes and adopted, as compared with other children at the close of the study. **Limitations:** Small sample size limited the regression models.
Stipends	
Campbell, C. & Downs, S. W. (1987). The impact of economic incentives on foster parents. *Social Service Review, 61,*599-609. **Population:** Family-based foster care	**Method:** This descriptive study utilized secondary data to investigate the Impact of economic incentives on foster parents. The data originated from a study from the 1980 Survey of Foster Parents in Eight States, conducted by Westat, Inc. The eight states involved were Alabama, Arkansas, North Dakota, Rhode Island, Texas, Utah, Virginia, and Wisconsin. Participants included foster family homes that were certified, licensed, or approved by the state as a foster home. A random sample of about 200 in each state was selected to be interviewed with a standard questionnaire. The response rate was 79%. **Findings:** The study found limited support for the hypothesis that a direct relation exists between level of board rate and the supply of foster care. The choice foster parents make about how much foster to offer is two-fold, and include 1) deciding whether or not to have any foster children in the home, and 2) deciding how many children to have. The study supports the hypothesis that the amount of time available for fostering affects the number of foster children currently in the home. In addition absence of problems with the social service agency is related to having more foster children in the home. **Limitations**: The article did not indicate what was included in the board rate or specifically define variables (board rate, time for fostering, agency problems).
Denby, R. & Reindfleisch, N. (1996). African Americans' foster parenting experiences: research findings and implications for policy and practice. *Children and Youth Services Review, 18*, 523-551.	**Method:** This study compared African American and White foster parents on their foster experiences. The survey examined reasons for fostering, willingness to continue fostering, opinions about fostering and training, stress, support, satisfaction, and predictions about future licensing status. The sample was composed of two groups. The first consisted of all (809) foster homes that closed in eight urban counties from November 1991, through October 1992. The second group was composed of 809 active foster homes randomly chosen from the population of active homes in the selected counties as of December 1992. Because

Population: Family-based foster care	of incorrect classifications, the true sample size of active homes was 804 and 720 for closed homes. There was a 68% survey return rate on active cases and a 42% return rate for closed cases, resulting in 539 usable active home surveys and 264 for closed homes. Of the active homes, 280 were African American and 259 were White. Of the closed homes, 111 were African American and 154 were White. **Findings:** African American foster parents' experiences with agency workers were generally favorable. Areas of displeasure focused on such macrostructural issues as agency policy concerning reimbursement, training content, allowances for children's care, amount of services provided to parents, types of children placed with parents, and involuntary closure of homes. The study profiles the African American foster parent as an older, single female who has a primary to secondary educational background and whose income is limited and can be derived from public maintenance programs and her work as a foster parent. **Limitations**: The findings are based on survey results.
Doyle, J. J. (2007). Can't buy me love? Subsidizing the care of related children. *Journal of Public Economics, 91,* 281-304. **Population:** Kinship family-based foster care	**Method:** The case records for 8511 Illinois foster children were examined to test the effect of a change in the cost of caring for related children on the willingness to provide care and the quality of care provided. **Findings:** With the reform in Illinois reducing the subsidies for relative caregivers by an average of $120 per child per month, or 27%, the estimates suggest that the propensity to provide care decreases by 10 – 15%. The estimate Is closer to 15% for cases where the family Is not involved in the abuse report and larger for children who require mental health services, infants and teenagers. Child health, education and placement outcomes do not appear to suffer following the decline in the subsidy offer.
Duncan, B., & Argys, L. (2007). Economic incentives and foster care placement. *Southern Economic Journal, 74,* 114-142. **Population:** Family-based foster care	**Method:** The AFCARS case records from 92,078 children from 34 states were examined to determine whether foster care subsidy rates and other foster care regulations affect the type of child placements that occur. **Findings:** A $100 increase in the basic monthly foster care payment reduces the number of children placed in group homes by 29%, with more children instead going to nonrelative foster homes. Children moved out of group homes are equally likely to be placed in two-parent and single-parent homes, but they are disproportionately placed with caregivers who do not share the child's race or

	ethnicity. A $100 increase in foster care payment will decrease the number of times the average child is moved from one foster placement to another by 20%.
Chamberlain, P., Moreland, S., & Reid, K. (1992). Enhanced services and stipends for foster parents: effects on retention rates and outcomes for children. *Child Welfare, 71*, 387-401. **Population:** Family-based foster care	**Method:** This study utilized an RCT to examine the impact of increased support and stipends on the dropout rates for foster parents. Participants were families of children (aged 4-7) who were expected to be in foster care for at least three months. The foster parents of children who fit this criteria were randomly assigned to one of three groups: 1) enhanced support and training (ES&T) plus an increased payment of $70/month (n = 31); 2) increased payment of $70/month only (IPO) (n = 14);or 3) foster care as usual- neither enhanced support/training nor increased payment (n =27). Group 1 – ES&T, participated in enhanced services including weekly group sessions (two hours) and telephone contact with program staff members three times a week **Findings:** During the project, 12 of the 72 participating families (16.6%) discontinued providing foster care. The statewide dropout rate overall is 40%. The dropout rate was as follows: 9.6% for the ES&T group, 14.3 for the IPO group, and 25.9% for the control group. The combination of additional stipends and support/training resulted in a dropout rate that was nearly two-thirds less than that observed in the control group. The retention rate of parents in the foster care system was increased by providing foster parents with enhanced training and support services and a small increased monthly stipend. **Limitations:** Overall for all groups the dropout rates were lower than the state average. This could be accounted for by variation in case workers or regional economic factors.
Involvement in Program – Collaboration/Partnering	
Co-Parenting	**Promising Practice**
Linares, L. O., Montalto, D., Li, M., & Oza, V. S. (2006). A promising parenting intervention in foster care. *Journal of Consulting and Clinical Psychology, 74,* 32-41.	**Method:** This study utilized an RCT to evaluate the effectiveness of a two-component (2-hr parenting course and a 1-hr co-parenting program 2 days a week for 12 weeks) intervention for biological and foster parent (pairs) to improve parenting practices, co-parenting, and child externalizing problems. 40 treatment parent pairs & 24 control pairs (randomly assigned) of children (aged 3-10) with a substantiated history of maltreatment (80% were neglected), who resided in a non-kin foster home, and had a goal of family reunification participated. Children with

Population: Family-based foster care	substantiated reports of sexual abuse and those suffering from developmental disabilities or profound sensory impairment were excluded. Children were identified by one foster care agency in NYC. **Findings:** Biological and foster parents made significant gains in positive parenting and collaborative co-parenting following the intervention. At follow-up, intervention parents sustained greater improvement in positive parenting, showed gains in clear expectations, and reported a trend for fewer child externalizing problems. **Limitations:** Outcome data were based on parent self-reports; the sample is highly selective; and this study was a single-site study.
Linares, L. O., Montalto, D., Rosbruch, N., & Li, M. (2006). Discipline practices among biological and foster parents. *Child Maltreatment, 11,* 157-167. **Population:** Family-based foster care for children (aged 3-10)	**Method:** This exploratory study examined the supportive role of parent-to-parent cooperation on positive discipline practices for biological and foster parents with children in foster care. 124 parents (62 pairs of biological and foster parents) of children (aged 3 – 10) with a substantiated history of maltreatment (80% were neglected), resided in a non-kin foster home, and had a goal of family reunification participated. Children with substantiated reports of sexual abuse and those suffering from developmental disabilities or profound sensory impairment were excluded. Children were identified by one foster care agency in NYC. **Findings:** There was a positive association between parent-to-parent cooperation and effective discipline strategies. Quality of parent-to-parent relationship increased positive discipline and decreased harsh discipline for both biological and foster parents. This association was found even after controlling for child characteristics (e.g., age, gender, conduct problems) and parent characteristics (e.g., age, education, ethnicity, and marital status). **Limitations:** Current results may not generalize to parents with histories of abusive parenting, or to families with differing characteristics, such as those with infants or adolescents, in kinship arrangements, in long-term placement, living in a different geographical area than NYC, and with other than a family reunification permanency goal. Also, given the social ecology of foster care, self-reports or direct observations of parenting practices are likely to be influenced by measurement issues related to social desirability and response reactivity.
Ecosystemic Treatment Model	**Emerging Practice**
Lee, R. E., & Lynch, M. T. (1998). Combating foster care drift: An ecosystemic	**Method:** The ecosystemic model used the weekly court-ordered, supervised visits to bring all the players together at one table, in addition to the family's working with

treatment model for neglect cases. *Contemporary Family Therapy, 20,* 351-370. **Population:** Family-based foster care	the foster family and the agency. This program made social workers, marital and family therapists, and child psychologists available to the families. The steps involved in the ecosystemic program included: • Making sure the child and biological family are in secure places; • Stabilizing the family; • Addressing the long-term reality needs of the family; and • Referring the parents to appropriate classes and approaching them about using psycho-educational interventions. **Findings:** Overcoming resistance to the program by biological families, foster families, and agency staff was an ongoing struggle. The agency, however, was dedicated to seeing this program succeed and trained staff and foster families accordingly. According to anecdotal evidence, the partnerships between foster families, biological families, and the agency seemed to have positive outcomes for the children and their families. Program evaluation will be conducted in the future.
Family Reunification Project	**Emerging Practice**
Simms, M. D. & Bolden, B. J. (1991). The Family Reunification Project: Facilitating regular contact among foster children, biological families, and foster families. *Child Welfare, 70*, 679-690.	**Method:** The aim of this pilot project was to create a neutral setting for structured visits with biological parents, children in placement, and foster parents with structured activities. A total of eight foster children (aged 5-9), three biological mothers, one biological father, and four foster mothers participated in the project. The Family Reunification Project included 16 weekly sessions (visits) that lasted for two hours. The first hour consisted of a structured session for the foster children and their biological parents. A foster parent support and training group met concurrently in a separate location. After the children left the second hour consisted of a support group for the biological parents. The structured visit included, group activities facilitated by an art therapist and free play, with two or three staff members observing and providing assistance to parents. The space included toys, books, a small playground with a swing and slide. A clinical social worker conducted the group for foster parents in a separate room from the visiting area. After the foster parents took the children home, the biological parents met as a group with the social worker.

	Findings: This project provided a unique provision of direct services for foster parents, foster children, and their biological parents in a single coordinated program. The use of both group and individual activities stimulated useful parent-child interactions. Observations of parent-child interactions during the sessions were collected and given to agency caseworkers, but because too few families were involved for a relatively short amount of time, effect on case planning was not determinable. **Limitations:** This study utilized a very small sample. No clear outcome measures were available to determine pre-program and post-program functioning; the study relied on self-report of participants.
Foster Parent Involvement in Service Planning	
Denby, R., Rindfleisch, N., & Bean, G. (1999). Predictors of foster parents' satisfaction and intent to continue to foster. *Child Abuse and Neglect, 23,* 287-303. **Population:** Family-based foster care	**Method:** This descriptive study examined foster parents' satisfaction and its relationship to their continuation to provide foster care services. 544 active foster parents from the eight largest counties in Ohio participated in the study. **Findings**: Results revealed a high overall level of satisfaction with foster parenting and intent to continue as a licensed foster home. The study found that 1) parenting competencies, 2) feeling drawn to foster care, 3) accepting of investments in foster care, 4) age of foster mother, 5) support and collaboration from social worker had the strongest influences on foster parents' satisfaction. **Limitations:** This study was descriptive in nature and did not utilize any controls (i.e., comparison groups, confounding variables, etc.).
Henry, D., Cossett, D., Auletta, T., & Egan, E. (1991). Needed services for foster parents of sexually abused children. *Child and Adolescent Social Work*, *8,* 127-140. **Population:** Family-based foster care	**Method:** This article reports on a descriptive study of the service provided to foster parents who care for sexually abused children. Agency directors, social workers and foster parents were asked to respond to mailed questionnaires, which focused on the foster parents' knowledge of the abusive events, their responses to the children's most problematic symptoms, and available and needed services. Subjects were selected from the first 100 cases of children referred over a two year period to The Child Sexual Abuse Diagnostic and Treatment Center. Thirty of these children were identified as foster children. Telephone contact was initiated with 21 foster families. Eight foster agencies, 12 social workers (for 16 sexually abused children) and 8 agency directors were identified. Participants also completed telephone interviews.

	Findings: All directors reported that the agency informed foster parents of previous sexual abuse prior to placement, but only half of foster parents in the sample admitted knowledge of the children's abusive experiences prior to placement. All respondents agreed that foster parents of sexually abused children needed specialized training and education. Agency staff indicated that they provided adequate parent training and education to foster parents; foster parents noted the services were not adequate for their needs. More than half of the foster parents in the sample indicated the need for more training. Foster parents expressed need for ongoing support and training throughout the entire placement period. Results suggest that more collaboration is needed between foster parents and agency workers in agency processes. **Limitations:** The manner in which the questionnaires were written allowed the possibility of multiple interpretations of questions.
Rhodes, K. W., Orme, J. G., & Buehler, C. (2001). A comparison of family foster parents who quit, consider quitting, and plan to continue fostering. *Social Service Review, 75*, 84-114. **Population:** Family-based foster care	**Method:** This descriptive study examined why some foster families continue to foster whereas others do not. Data for the analysis were from the National Survey of Current and Former Foster Parents (NSC&FFP), which was conducted in 1991. Only current foster homes started by 1985 are examined in the study. Of the total sample of 1,048 current foster homes, 336 were approved in 1985 or after. Of these 317 completed the long interview form (94%). Of the sample of 267 current foster families was further divided into parents who planned to continue fostering families was further divided into parents who planned to continue fostering and parents who planned to quit. Of the sample of 265 former foster homes, 144 completed the long interview form (54%). **Findings:** Most foster parents cited more than one reason for discontinuing foster care. Common reasons included lack of agency support, poor communication with workers, and children's behaviors. The findings from comparing former foster parents with those who planned to quit soon suggest that several variables are more critical to current parents who are planning to quit than to foster parents who already quit. Frequent reasons included, health problems, full time employment, inadequate reimbursement, lack of day care, not having a say in child's future, seeing children leave, and problems with child's biological families. Less than one third of foster parents reported having enough information about the legal aspects

	of foster care, or about working with children who were of a different race, handicapped, or sexually abused. Findings suggest that after quitting, foster parents might perceive they lacked information about the unique parenting demands of foster children, whereas agency relationships might be a deciding factor that results in qualified homes planning to quit. Training appeared to positively impact a foster parents continued fostering, that is if a foster parent received additional training, they were more likely to continue fostering. Many of the foster parents who intend to quit fostering believed that their families and foster children are not receiving adequate services and that they have no say in the children's futures. Limitations: Use of a point-in-time sample might have led to overrepresentation of current foster families with longer services. Study focused only on nonkinship foster family retention. Relatively few of the comparisons made indicated statistically significant differences between continuing, planning to quit, and former foster parents. NSC&FPP used a retrospective rather than prospective research design.
Sanchirico, A., Lau, W. J., Jablonka, K., & Russell, S. J. (1998). Foster parent involvement in services planning: Does it increase job satisfaction? *Children and Youth Services Review, 20,* 325-346. **Population:** Family-based foster care	**Method:** This descriptive study examined the impact of foster parent involvement in service planning on foster parent job satisfaction. In addition, this study examined the effects of foster parent training and the role of caseworkers in the relationship between involvement and satisfaction. Data was drawn from a survey of 1500 current New York State foster parents. 616 foster parents completed the mailed questionnaire. **Findings:** 84% of foster parents reported that they have cared for foster children who exhibited special needs. Less than half (48.5%) of parents received pre-service training in service planning. More than one third of parents (37.0%) received in-service training in service planning. Forty percent of respondents did not receive any training on how to carry out service plans or how to be an active partner in the service planning process. Parents who had in-person contact with the child's caseworker reported a higher quality of involvement in service planning than those who lacked such contact. While both pre-service training and in-service training were both related to quality of involvement, only pre-service training produced a statistically significant effect in the multivariate analysis. Educational

	attainment had a negative effect on both the quality of involvement in service planning and job satisfaction. Respondents who cared for special needs children reported a lower quality of involvement in service planning than those who had not cared for such children. **Limitations:** The low response rate threatens internal validity of the study due to the possibility that respondents differed from non-respondents in ways that may have been influenced in the findings. The data were obtained from a survey conducted in a single state.
Shared Family Foster Care	**Emerging Practice**
Barth, R. P., & Price, A. (1999). Shared family care: Providing services to parents and children placed together in out-of-home care. *Child Welfare, 78*, 88-107. **Population:** Family-based foster care (including TFC)	**Method:** The National Abandoned Infants Assistance (AIA) Resource Center at the School of Social Welfare of the University of California at Berkeley has developed *Shared Family Care Program Guidelines* and has helped to establish an additional seven pilot programs to determine if shared family foster care can become a viable alternative to traditional family foster care. Results are yet to be published. **Findings:** SFFC is not appropriate for everyone although it shows promise in protecting children and preserving families. **Limitations:** Parents must demonstrate a real desire to care for their children and a readiness to participate in the plan to improve their parenting skills and life situation. Parents who are actively using drugs, involved in illegal activity, violent, or severely mentally ill (and not receiving treatment) are unlikely to benefit. Parents in recovery, those with developmental disabilities, those who are socially isolated and those with poor parenting skills, are good candidates for SFFC. Mentors must be of high quality and well-matched with their foster parents. Family services and supports should remain in place for the parents. Costs are higher than traditional FC but less than TFC.
Shared Parenting	**Emerging Practice**
Landy, S., & Munro, S. (1998). Shared parenting: Assessing the success of a foster parent program aimed at family	**Method:** This study attempted to (1) assess the effectiveness of the Shared Parenting Project, a model of family reunification, which united the role of parent aide and foster parent; and (2) determine which characteristics of the families with

reunification. *Child Abuse and Neglect, 22* 305-318.	children in care were associated with reunification. Participants were recruited from five child protection agencies in Ontario, Canada. Foster parents were to act as extended family rather than as a substitute family. Because of strict criteria, only 13 families were eligible to participate (n=13). **Findings**: Very few families who met the program criteria could be reunited. Only 31% of families completed the entire program. Permanency planning was successful for 50% of other cases. More stable families were more likely to have success. **Limitations:** The authors suggest that the program may not work for many families because of their high number of risk factors. Parents were reluctant to participate in the study. **Implication and Limitations**: The sample was only 13 families (of which only four families were actually successfully reunified). The literature review was thorough and listed many good sources on studies of parental involvement while children are in out-of-home-care.
Level of Care	
Positive Peer Culture (PPC)	**Efficacious Practice**
Leeman, L. W., Gibbs, J.C., & Fuller, D. (1993). Evaluation of a multi-component group treatment program for juvenile delinquents. *Aggressive Behavior, 19*, 281-292. **Population:** Youth (mean age = 16 years) admitted to a medium-security correctional facility	**Method:** This study utilized an RCT to evaluate the efficacy of the PPC in readying youth who were admitted to a medium-security correctional facility for a lower level of care. A total of 57 youth (mean age = 16 years) were randomly assigned to receive the EQUIP program, based on the *Positive Peer Culture* model, or one of two control conditions. Simple control youths were told that measures were being used for research on delinquency. Motivational control youths were given a 5-minute motivational induction urging them to help other inmates. PPC is a peer-helping model designed to improve social competence and cultivate strengths in troubled and troubling youth. Rather than demanding obedience to authority or peers, PPC demands responsibility. PPC assumes that as group members learn to trust, respect, and take responsibility for the actions of others, norms can be established. These norms then serve to extinguish antisocial conduct

	and reinforce pro-social attitudes, beliefs, and behaviors. Acceptance of these norms is expected to make the transition to lower levels of care possible. **Findings:** All groups gained in moral judgment scores; they did not differ significantly at the end of the study. The PPC group gained significantly more than other groups in social skills. The PPC group also showed significant improvements in conduct and lower recidivism rates over 12 months as compared to the control groups. **Limitations:** The interpretation of the results of this study is limited by a small sample size.
Nas, C. N., Brugman, D., & Koops, W. (2005). Effects of the EQUIP programme on the moral judgement, cognitive distortions, and social skills of juvenile delinquents. *Psychology, Crime, & Law, 11*, 421-434. **Population:** Youth (aged 12-18) in high-security juvenile correction facilities	**Method:** This study utilized a controlled design to evaluate the efficacy of the Positive Peer Culture (PPC) model. A total of 56 youth (aged 12-18) in high-security juvenile correction facilities participated in the study. The study compared youth in an EQUIP program (n=31), which employs the *Positive Peer Culture* model, at their facility with a control group (n=25) made up of youth from two other facilities. **Findings:** The EQUIP group had lower cognitive distortion scores on covert behavior, self-centeredness, blaming others, minimizing/mislabeling, stealing and lying than did the comparison group following treatment. The treatment group also had more negative attitudes toward delinquent behavior. No differences were found for moral judgment, social skills or social information processing.
Sherer, M. (1985). Effects of group intervention on moral development of distressed youth in Israel. *Journal of Youth and Adolescence, 14*, 513-526. **Population:** Adolescent gang members (aged 15-18)	**Method:** This study used a controlled design to test the effectiveness of the PPC model in developing healthy adolescent morals. Participant gang members (32 boys and 16 girls, aged 15-18) were assigned to one of three groups. The PPC group consisted of gang members who volunteered to participate in a PPC course. The first comparison group consisted of randomly chosen members of the same gangs to which the PPC groups belonged. (Only one gang member was included in the PPC course from each gang.) The second comparison group consisted of randomly chosen members of gangs who had no contact with the PPC course or course participants. **Findings:** PPC group members scored higher on resistance to temptation and moral development after completing the course. Both the PPC group and same-gang comparison group scored better on feelings after offense and severity of

	punishment than the no-contact comparison group. The authors conclude that the PPC group may have had a positive effect on other members of their gangs.
Re-Education of Children with Emotional Disturbance (Re-ED)	**Emerging Practice**
Fields, E., Farmer, E. M. Z., Apperson, J., Mustillo, S., & Simmers, D. (2006). Treatment and posttreatment effects of a residential treatment using a Re-education model. *Behavioral Disorders, 31*, 312-322. **Population:** Youth (aged 7-13) who had at least one psychiatric diagnosis and who were admitted to a residential treatment facility	**Method:** This exploratory study utilized a pre-test/post-test design to examine the outcomes of the Re-ED model. 98 youth (aged 7-13) who were admitted to a state-sponsored residential treatment facility participated in the study. Participants were children with at least one psychiatric diagnosis, most with ADHD, externalizing disorders, and or mood disorders. Re-ED is an ecological competence approach to helping the range of troubled and troubling youth entering child serving systems, with their families. Re-ED is based on 1) replacing pathology with a wellness view, 2) using an ecological orientation, 3) focusing on competence and learning, 4) teaching and counseling roles, 5) building relationships, and 6) encouraging a culture of questioning and information-based decision-making. **Findings:** Youth showed significant improvement in child behavior and personal strengths, as measured by the *Child Behavior Checklist (CBCL)* and *Behavioral and Emotional Rating Scale (BERS)*, respectively. Scores deteriorated somewhat over 6 months, but continued to be significantly better than pre-intervention. The majority of children reached and maintained scores within the normal range on the *BERS* and about half did so on the *CBCL*. For the *BERS*, youth who were younger, male, and from higher SES families improved most by discharge, but these variables were not related to scores taken later. Length of stay in the program predicted higher later *BERS* scores. The authors note that children with a shorter stay in the program were less likely to consistently receive recommended services after discharge. **Limitations:** Conclusions from this study are limited by the lack of a comparison group and random assignment to treatment groups.
Hooper, S. R., Murphy, J., Devaney, A., & Hultman, T. (2000). Ecological outcomes of adolescents in a psychoeducational residential treatment facility. *American Journal of Orthopsychiatry, 70*, 491-500.	**Method:** This exploratory study used a pre-test/post-test design to investigate the efficacy of the Re-ED program. 111 youth (aged 13-16) who were admitted to a state-run re-education residential treatment program participated in the study. **Findings:** An average of 58% of youth were functioning adequately in all three domains (legal, school, and level of care) across the 2 year time span of the study,

Population: Youth (aged 13-16) admitted to a state-run re-education residential treatment facility	with the lowest number (28%) remaining at that level 24 months following the intervention. Functioning adequately in each domain was defined as no new illegal activity (legal); attendance, graduation or obtaining a GED (school); and no unplanned hospitalization or more restrictive level of treatment after discharge (level of care). By the criterion of satisfactory function in at least two domains, between 71% (24 months) and 97% (6 months) reached the required level. The most successful students tended to be younger, female, have higher IQ and reading skills, have better scores on parent-rated internalizing symptoms, and to have been discharged more recently. **Limitations:** Limitations include a lack of comparison group and the use of subjective satisfactory ratings across domains. Although this study measured functioning across time (i.e., at 6, 12, 18, and 24 months), each participant was contacted only once.)
Weinstein, L. (1969). Project Re-Ed schools for emotionally disturbed children: Effectiveness as viewed by referring agencies, parents and teachers. *Exceptional Children, 35*, 703-711. **Population:** Youth (aged 10-11 at enrollment) referred to residential treatment	**Method:** This exploratory study utilized a pre-test/post-test design to examine the efficacy of the Re-ED model. 103 youth (aged 10-11 at enrollment) who were Children referred by child welfare agencies to residential treatment participated in the study. **Findings:** At six months following treatment, youth symptoms and undesirable behaviors were rated as significantly lower than at pre-treatment, and the parents' and child's ratings were more in agreement. Students were rated by teachers as significantly improved on all dimensions after the Re-Ed intervention as well. **Limitations:** This study lack of a comparison group.
Stop-Gap	**Promising Practice**
McCurdy, B.L., & McIntyre, E.K. (2004). "And what about residential...?" Re-conceptualizing residential treatment as a stop-gap service for youth with emotional and behavioral disorders. *Behavioral Interventions, 19*, 137-158.	**Method:** This study utilized a controlled design to examine the efficacy of the Stop-Gap model in changing youth behavior. Two units of a residential treatment center, one of which introduced Stop-Gap after seven months, served as comparison groups for this study. Approximately 25 female youth (aged 13-18) were in each group. Groups were matched on population number, gender, and disability. The Stop-Gap model incorporates evidence-based practices that are environment-based, intensive, and discharge related to service delivery for residential treatment

Population: Female adolescents (aged 13-18) in a residential treatment program	settings. The goals of the Stop-Gap model are to interrupt the youth's downward spiral imposed by increasingly disruptive behavior and prepare the post-discharge environment for the youth's timely re-integration. Youths enter the model at tier I, where they receive environment-based and discharge-related services, The focus at tier I is on the immediate reduction of "barrier" behaviors (i.e., problem behaviors that prevent re-integration) through intensive ecological and skill teaching interventions (e.g., token economy, social and academic skill teaching). Simultaneously, discharge-related interventions commence. To the extent that problem behaviors are not reduced at Tier I, intensive Tier II interventions that include function-based behavior support planning are implemented. **Findings:** At twelve months, the Stop-Gap residence showed a decline in therapeutic holds, while the comparison group showed an increase over the same period. **Limitations:** This study used a small sample size in its analyses. A long-term follow-up and statistical procedures to determine the significance of between group differences at baseline and outcome measurement were also lacking from this design
Respite Care	
Brown, J. G. (1994). Respite care services for foster parents – Six case studies. Department of Health and Human Services, Office of Inspector General. **Population:** Family-based foster care	**Method:** Six programs were selected from 27 that child welfare experts and public officials operating child welfare programs recognized as effective at providing respite care. Interviewees included program officials and experts at HHS, selected state counties, and various organizations that had an interest in foster care. The respite services provided were analyzed by program. The experts were interviewed on their opinion of the effectiveness of respite care programs on several factors: 1) respite care program longevity, 2) widespread reputation in the child welfare field for excellent respite and foster care, 3) increases in the number of foster care families served by respite care providers since starting a respite care program, and increases in the number of respite care providers, 4) decreases in turnover of foster parents and disruption of placements of foster children, and 5) clear policies and procedures for respite care. **Findings:** No single model program was found; instead the six programs each had different ways of providing respite care. Some of the differences included: program management, program requirements for respite services, criteria for providing

	respite care, settings for respite care, types of respite care providers, payment methods, and target populations. Some commonalities included that respite care was established to meet a specific need, each program was affiliated with an established organization that served foster children, all promoted teamwork and trust, and each program screened, trained and monitored providers. **Limitations:** The results are based on selected "leaders" in the field, and those individuals' opinion of programs. The study does not indicate how many individuals were interviewed.
Cowen, P. S. & Reed, D. A. (2002). Effects of respite care for children with developmental disabilities: Evaluation of an intervention for at risk families. *Public Health Nursing, 19*, 272-283. Population: Biological and family-based foster parents of children with developmental disabilities	**Method:** This study describes sociodemographic characteristics, parenting stress levels, foster care placement, and founded child maltreatment rates in families of children with developmental disabilities who were using respite care services in a rural Midwestern state. The purpose was to determine if utilization of the respite care intervention program impacted parenting stress, foster care placement, and founded child maltreatment. The sample included all families parenting a child with developmental disabilities and residing within the four intervention counties. The sample consisted of 148 self-referred families and their 256 children with developmental disabilities who received respite care program interventions from the community agencies. **Findings:** Comparison of matched pretest and post-test parenting stress scores indicated significant decreases in total stress scores, parenting domain scores, and child domain scores after the provision of respite care. The statistical trends indicate that parenting stress significantly decreased following respite care intervention resulting in a decreased risk for the development of dysfunctional parenting behavior. **Limitations:** It is unclear if receipt of services at the community agencies were tied to participation. Also this study did not have a control group. Also, the sample does is not fully described; it is difficult to ascertain whether foster parents participated in the study.
Ptacek, L. J., Sommers, P. A., Graves, J. Lukowicz, P., Keena, E., & Haglund, J. (1982). Respite care for families of children with severe handicaps: An evaluation study of parent satisfaction. *Journal of Community Psychology*, *10*, 222-227.	**Method:** This descriptive study evaluated parent satisfaction of respite care provided by the Comprehensive Child Care Center of the Marshfield Clinic (Wisconsin) for children with disabilities from 1976-1979. Survey questionnaires were administered to parents of 68 children with severe disabilities from eighteen Wisconsin counties. Fifty-seven surveys were returned for an 84% return rate.

Population: Family-based foster care for families of children with severe disabilities	**Findings:** Results from the study indicated that consumers had positive opinions (satisfaction ratings of 70% or higher) about the delivery of respite care services for their children with severe disabilities. The study also asked for recommendations; responses included 1) respite care is very much needed at low rates, 2) every parent needs a break from the day-in, day-out requirements of a handicapped child; and 3) develop other forms of respite. **Limitations**: Survey questions were very general so that parents of children with a variety of severe disabilities could relate to them.
Social Support	
Denby, R., Rindfleisch, N., & Bean, G. (1999). Predictors of foster parents' satisfaction and intent to continue to foster. *Child Abuse and Neglect, 23,* 287-303. **Population:** Family-based foster care	**Method:** This descriptive study examined foster parents' satisfaction and its relationship to their continuation to provide foster care services. 544 active foster parents from the eight largest counties in Ohio participated in the study. **Findings**: Results revealed a high overall level of satisfaction with foster parenting and intent to continue as a licensed foster home. The study found that 1) parenting competencies, 2) feeling drawn to foster care, 3) accepting of investments in foster care, 4) age of foster mother, 5) support and collaboration from social worker had the strongest influences on foster parents' satisfaction. **Limitations:** This study was descriptive in nature and did not utilize any controls (i.e., comparison groups, confounding variables, etc.).
Finn, J. & Kerman, B. (2004). The use of online social support by foster families. *Journal of Family Social Work, 8,* 67-85. **Population:** Family-based foster care	**Method:** This study utilized a controlled design to assess the impact of the Building Skills-Building Futures (BSBF) program - a pilot project to reduce the digital divide among foster children in long term care. A total of 64 foster families participated in the study. All parents and foster children participated in the pretest measures and the vast majority of parents (45, 84.9%) and youth (36, 73.5%) participated in the posttest measures. Thirty-four of the families participated in the BSBF program (a total of 53 parents and 49 foster children). A comparison group of families (n = 30), agreed that one foster parent and one foster child per household would complete a survey. **Findings:** The majority of foster family members, whether part of the BSBF program or the comparison group were found to use the Internet for social support infrequently. Most families did not receive or provide help over the Internet, did not communicate with other foster families online, and did not participate in online

	groups; those who did, did so infrequently. The study did find that foster parents and foster children use e-mail for communication. **Limitations:** This study relied on a small sample. Additionally, there was a low response rate initially in the control group for the mailed surveys; therefore results were obtained via the phone.
Fisher, T., Gibbs, I., Sinclair, I., & Wilson, K. (2000). Sharing the care: the qualities sought of social workers by foster carers. *Child and Family Social Work, 5,* 225-233. Population: Family-based foster care	**Method:** This descriptive study examined the views of foster carers about social workers, developed a testing measure of foster carer attitudes about social workers, identified factors that influence these attitudes, and assessed the relationship between these attitudes and the impact on continuation of fostering. The study was conducted in London, and participants were from seven local authorities (two London boroughs, two urban unitary authorities, one metropolitan borough, and the remaining two are large and diverse shire counties). A general questionnaire, which asked about foster parent support, satisfaction, experience of fostering, and attitudes toward fostering, was sent out to every foster carer registered in the participating authorities in 1997. The survey produced 944 usable questionnaires (overall response rate of 62%). A follow-up was conducted 17-18 months later to see if they were continuing to foster. Those who indicated on the general questionnaire that they were willing to complete further questionnaires on a specific child (80%) were sent a specific questionnaire. This generated 487 usable questionnaires (82% of those sent). **Findings:** The study identified the following as needed for a good social worker: 1) showing an interest in how carers are managing; 2) being easy to contact and responsive when contacted; 3) doing what they say they are going to do; 4) being prepared to listen and offer encouragement; 5) taking account of the family's needs and circumstances; 6) keeping them informed and included in planning; 7) ensuring that payments, complaints, etc are processed as soon as possible; and 8) attending to the child's interests and needs, and involve foster carers in this where appropriate. The study found that good relationships with the family placement worker influenced decisions to continue fostering. In addition support during times of crisis played an important role in the attitudes formed by foster parents of social workers. **Limitations:** Since the participants were not randomly sampled the sample may give a slightly more favorable picture of attitudes toward social workers.

Hansell, P. S., Hughes, C. B., Caliandro, G., Russo, P., Budin, W. C., & Hartman, B. et al. (1998). The effect of a social support boosting intervention on stress, coping and social support in caregivers of children with HIV/AIDS. *Nursing Research*, *47*, 79-86. **Population:** Biological and foster families with children who have HIV/AIDS	**Method**: This exploratory study examined the effect of a social support boosting intervention on levels of stress, coping, and social support among caregivers of children with HIV/AIDS. Participants were recruited from clinics and outreach centers that provide care to women and children with HIV/AIDS. Participants needed to meet the following criteria: identified themselves as the biological parent, blood relative, or foster parent, were legally assigned as the primary caregiver of a child who has symptomatic HIV/AIDS infection, resided in the New York/New Jersey metropolitan area, and could read and write in English or Spanish. The sample included 70 caregivers (biological parents n= 39, extended family n=12, and foster parents n=19) who completed all interventions and measures at the six month follow-up. The social support boosting intervention used a modified case management approach that was implemented over a 12-month period through monthly contact (30-60 minutes) between and investigator and the caregiver. **Findings**: Initial findings showed no significant differences between experimental and control groups on any of the dependant variables (stress, coping and social support). However, when HIV status of the caregiver was controlled, researchers found that HIV-infected caregivers (biological parents) had significantly greater stress levels and used fewer coping strategies as compared with HIV negative caregivers (extended family members and foster parents). The results also suggest that the intervention resulted in increased levels of social support for extended family and foster parents (in the experimental group). **Limitations:** Attrition was a major concern in the study, most likely due to the degenerative and progressive nature of HIV/AIDS. Attrition rates were 47% from study entry to the six month follow-up and 68% and the 12 month follow-up.
Kramer, L. & Houston, D. (1999). Hope for the children: A community-based approach to supporting families who adopt children with special needs. *Child Welfare, 78,* 611-635.	**Method:** This descriptive study explored the need for and use of support by pre-adoptive families of children with special needs in the Hope for the Children (HFTC) program. Participants included 12 families (17 parents) with at least one parent from each of the families. Each HFTC parent was a licensed foster care provider who was caring for one or more children (aged 2-17) who lived with them for at least six months.

Population: Pre-adoptive families for special needs children (aged 2-17)	**Findings:** HFTC parents indicated that direct access to on-site professionals such as mental health care providers, case-workers, and family advocates was helpful in gaining access to needed resources and referrals, obtaining available information about children's backgrounds, and helping to resolve child behavior problems in the home. HFTC parents also reported being very satisfied with their non agency formal resources, including doctors, medical specialists, teachers, and child development and educational specialists, who they contacted for health and medical problems and for child development and educational problems. Informal agency based resources were also seen as helpful, but parents continued to turn to indigenous support networks. At times parents did see the close proximity of agency personnel, HFTC parents, and community volunteers as an intrusion upon their family privacy. **Limitations:** This study included a small sample with no comparison group. Additionally, information was provided predominantly from foster/adoptive mothers. Limited demographic information about children and parents was provided.
Rodger, S., Cummings, A., & Leschied, A. W. (2006). Who is caring for our most vulnerable children? The motivation to foster in child welfare. *Child Abuse & Neglect, 30*, 1129-1142. Population: Family-based foster care	**Method:** The purpose of this descriptive study was to understand the motivations and needs of foster parents in order to improve recruitment and retention. A sample of 652 foster parents (from a possible 1283 families, 51%) completed a survey of 139 items including the Foster Parent Satisfaction Survey. All active ("open") foster homes in April, 2004 in Southwestern Ontario received the survey. In the majority of cases, foster mothers completed the survey (80%). **Findings:** Foster parents were motivated by wanting to be loving parents to children and by saving children from harm. Foster parents' satisfaction was related to their perceptions about teamwork and communication. Their reasons for fostering reflected foster parents' altruistic and internal motivations to foster. Negative relationships with professional staff from the child welfare agency were linked to considering quitting fostering. Therefore it is important to have professional staff who have training regarding sensitivity and understanding toward foster parents and who can create and support a working relationship. **Limitations:** the decision of subjects to participate or not to participate. Lengthiness of the questionnaire, not having a control group of closed foster homes.

Rhodes, K. W., Orme, J. G., & Buehler, C. (2001). A comparison of family foster parents who quit, consider quitting, and plan to continue fostering. *Social Service Review, 75*, 84-114. **Population:** Family-based foster care	**Method:** This descriptive study examined why some foster families continue to foster whereas others do not. Data for the analysis were from the National Survey of Current and Former Foster Parents (NSC&FFP), which was conducted in 1991. Only current foster homes started by 1985 are examined in the study. Of the total sample of 1,048 current foster homes, 336 were approved in 1985 or after. Of these 317 completed the long interview form (94%). Of the sample of 267 current foster families was further divided into parents who planned to continue fostering families was further divided into parents who planned to continue fostering and parents who planned to quit. Of the sample of 265 former foster homes, 144 completed the long interview form (54%). **Findings:** Most foster parents cited more than one reason for discontinuing foster care. Common reasons included lack of agency support, poor communication with workers, and children's behaviors. The findings from comparing former foster parents with those who planned to quit soon suggest that several variables are more critical to current parents who are planning to quit than to foster parents who already quit. Frequent reasons included, health problems, full time employment, inadequate reimbursement, lack of day care, not having a say in child's future, seeing children leave, and problems with child's biological families. Less than one third of foster parents reported having enough information about the legal aspects of foster care, or about working with children who were of a different race, handicapped, or sexually abused. Findings suggest that after quitting, foster parents might perceive they lacked information about the unique parenting demands of foster children, whereas agency relationships might be a deciding factor that results in qualified homes planning to quit. Training appeared to positively impact a foster parents continued fostering, that is if a foster parent received additional training, they were more likely to continue fostering. Many of the foster parents who intend to quit fostering believed that their families and foster children are not receiving adequate services and that they have no say in the children's futures. Limitations: Use of a point-in-time sample might have led to overrepresentation of current foster families with longer services. Study focused only on nonkinship foster

	family retention. Relatively few of the comparisons made indicated statistically significant differences between continuing, planning to quit, and former foster parents. NSC&FPP used a retrospective rather than prospective research design.
Strozier, A. L., Elrod, B., Beiler, P., Smith, A., & Carter, K. (2004). Developing a network of support for relative caregivers. *Children and Youth Services Review, 26*, 641-656. **Population:** Kinship foster care	**Method:** This study utilized a pre-test/post-test design to evaluate the efficacy of an on-line training program to improve self-efficacy, enhance career skills, augment social support, and increase confidence in kinship foster carers ability to help educate the children in their care. 46 kinship foster carers participated in the study. **Findings:** Kinship foster care providers made significant gains in self-efficacy, computer skills, confidence to educate the children in their care. Additionally, kinship foster carers developed social support networks consisting of their peers in the program, and learned to access social support using on-line methods (i.e., message boards, email, etc.). **Limitations:** A small sample size and researcher-created measures were utilized in this study.
Urquhart, L. R. (1989). Separation and Loss: Assessing the impacts on foster parent retention. *Child and Adolescent Social Work, 6*, 193-209. **Population:** Family-based foster care	**Method**: A comparative census survey of statewide foster parent population was conducted. Currently licensed homes were compared with those previously licensed on factors pertaining to the separation and loss experience. A total of 376 foster parents participated in the study, 275 (43% response rate) from open homes and 101 (15% response rate) from closed homes. All foster parents are or were licensed in the state of New Mexico. **Findings:** Significant differences were found in two major dimensions: 1) training and 2) agency services and supports. Both dimensions were indicated to be valuable factors of foster parent retention. **Limitations:** There was a low response rate of closed homes, and reliance on self-reported survey measures in this study. Additionally, the survey was constructed in an “always” or “never format.
Warde, B., & Epstein, I. (2005). Urban minority kinship and non-kinship foster parents: A multivariate analysis of factors contributing to role satisfaction. Doctoral Dissertation, City University of New York,	**Method:** This dissertation examined the satisfaction of minority kinship and non-kinship foster parents in a single foster agency in New York City. 172 urban foster minority kinship (n=74) and non-kinship (n=98) foster parents who had at least one child placed in their foster home for a continuous six months period during January 2001 and December 2003 participated in the study.

New York City. **Population:** Family-based (minority kinship and non-kinship) foster care	**Findings:** Both urban minority kinship and non-kinship foster parents' role satisfaction was associated with the support they perceived from the foster care agency and their caseworker. No statistically significant differences were found between urban minority kinship and non-kinship foster parents in their responses to the four rating scales used in the study, (role satisfaction, perceived agency support, perceived casework support and role perception). Nonetheless, the findings suggest that both kinship and non-kinship foster parents are generally dissatisfied with the level of agency support received, particularly with regard to the provision of respite services and transportation to and from the foster child's miscellaneous appointments. Conversely, both kinship and non-kinship foster parents generally reported high levels of perceived casework support. **Limitations:** This study is limited by a small sample, and differences in the ethnic representation of the two groups (kinship vs. non-kinship). Additionally, all participants were from the same agency and the author was the director of the agency.
Support Inventories	
Casey Foster Family Assessments	**Emerging Practice**
Orme, J. G., Cherry, D. J., & Rhodes, K. W. (2006). The help with fostering inventory. *Children and Youth Services Review, 28*, 1293-1311. **Population:** Family-based foster care	**Method:** This descriptive study included a sample of 304 foster mothers and 111 foster fathers as a means of testing the reliability of the *Help with Fostering Inventory.* **Findings:** The subscale on worship group support had excellent reliability for foster mothers and fathers; the subscale on professional support was not tested on fathers but found good reliability for mothers; and the subscale on kinship support found adequate reliability for mothers but only marginal reliability for fathers. The measure could be used to help foster parents think deliberately about who might provide them with support and how to identify additional support.
Orme, J. G., Cuddeback, G. S., Buehler, C., Cox, M. E., & Le Prohn, N. S. (2007). Measuring foster parent potential: Casey Foster Parent Inventory- Applicant Version, *Research on Social Work Practice, 17,* 77-92.	**Method:** This study describes the reliability and validity of the *Casey Foster Applicant Inventory – Applicant Version* (CFAI-A) -a new standardized self-report measure designed to assess the potential to foster parent successfully using data from a sample of 304 foster mothers from 35 states. **Findings**: 6 CFAI-A subscales were identified and internal consistency reliability for these subscales ranged from .64 to .95. The construct validity of all but one of

Population: Family-based foster care	these subscales is promising. The CFAI-A shows promise for use in research and practice, where it might be used to improve decisions about how to support monitor, and retain foster families and to match place, and maintain foster children in foster homes. **Limitations:** This study relied on a non-probability sample of licensed foster mothers, a cross-sectional design, and a small sample of kinship foster mothers.
Treatment Foster Care	
Galaway, B., Nutter, R. W., & Hudson, J. (1995). Relationship between discharge outcomes for treatment foster-care clients and program characteristics. *Journal of Emotional & Behavioral Disorders, 3,*46-54. **Population:** Treatment Foster Care	**Method:** This descriptive study utilized data collected from a survey of treatment foster-care programs to investigate relationships among type of discharge (planned or unplanned), restrictiveness of post discharge living arrangements, and characteristics of the TFC program. Data were available for 1,521 youth discharged from 210 treatment foster-care programs in the U.S. and Canada. Snowball sampling techniques were used, and programs were obtained from a list of registrants at the Third North American Treatment Foster Care Conference and a list maintained by the FFTA. Of the 1,521 former clients, 8% were less than 6 years old at discharge, 24% were in the age range of 6 to 11 years, 25% were aged 12 to 14 years, and 43% were aged 15 to 17 years when discharged. **Results:** No meaningful associations were found between the program characteristics of caseload size, number of clients permitted per care providers' home, cost per client per year and the outcome variables of whether the discharge was planned or unplanned and restrictiveness of post discharge living arrangements. Meaningful differences were only found at the extremes: youth were more likely to be discharged on a planned basis from high-cost, low-caseload programs than from low-cost, high-caseload programs **Limitations:** This study did not measure the level of individual clients' functioning at admission and/or the reason for referral to TFC. Information was gathered from TFC programs and not the actual clients. Additionally, the relationship between program-level data and actual care experiences by youth remain unknown. Finally, this study was descriptive in nature, without control groups, random assignment, pre-tests and post-tests, etc.

Wraparound	
Family-Centered Intensive Case Management (FCICM)	**Efficacious Practice**
Evans, M. E., Armstrong, M. I., & Kuppinger, A. D. (1996). Family-centered intensive case management: A step toward understanding individualized care. *Journal of Child and Family Studies, 5*, 55-65. **Population:** Children (aged 5-12) referred to services for serious emotional disorders	**Method:** This study utilized an RCT to evaluate the efficacy of the Family-Centered Intensive Case Management (FCICM) model in a sample of 42 children (aged 5-12) and families referred to services for serious emotional disorders. Families were randomly assigned to Family Based Treatment (FBT) or to Wraparound services, here called Family-Centered Intensive Case Management (FCICM). FBT is New York State's version of treatment foster care and is based on the premise that treatment parents need training and support to effectively care for children with SED. FCICM model acknowledges that families need a comprehensive array of services and supports to help them keep their children at home. It has an emphasis on the family's central role in accomplishing treatment goals for the child. **Findings:** Children in FCICM showed a significant decrease in symptoms and problem behaviors after receiving one year of services. *CBCL* scores, which were assessed by parents, did not change for either group. The children in FCICM also improved significantly on behavior, moods, emotions and role performance as measured by the *CAFAS*. Family outcomes did not differ across groups on the *FACES III*, although caseworkers did note greater improvement for FCICM families on ability to understand children's problems, willingness to access services, provide structure, making children feel loved and wanted, identifying appropriate discipline and knowing when to call the treatment team. **Limitations:** At one year only 17 families provided complete data.
Fostering Individualized Assistance Program (FIAP)	**Promising Practice**
Clark, H. B., Prange, M. E. (1994), Improving adjustment outcomes for foster children with emotional and behavioral disorders: Early findings from a controlled study on individualized services. *Journal of Emotional and Behavioral Disorders, 2,* 207-218.	**Method:** This study evaluated the efficacy of the Fostering Individualized Assistance Program (FIAP) using a controlled design. The program is driven by permanency and family-focused values and involved the wrapping of services around children, based on their individual needs and the needs of their families. Participants included children (aged 7-15) in the state foster care system who were living in a regular foster home or in an emergency foster shelter facility and having behavioral and emotional disturbances (or at risk of such). A total of 132 foster children participated.

Population: Family-based foster care for at-risk children (aged 7-15)	The FIAP program's goal is to: a) stabilize placement in foster care and develop viable permanency plans, and b) improve their behavior and emotional adjustment of the children receiving FIAP services. These goals are achieved through four major intervention components: strength-based assessment, life-domain planning, clinical case management, and follow-along supports and services. **Findings:** Somewhat better adjustment outcomes for children with EBD who were served by an individualized services approach than for an equivalent group of children in standard practice foster care. Of the children in designated permanency home placements, the FIAP subsample showed significantly better emotional and behavioral adjustment than the SP subsample. The children in the FIAP were significantly less likely than children in the SP group to run away, engage in serious criminal activity, or be incarcerated. **Limitations:** This study used a small sample. Additionally, during the study, state regulations and policies changed which limited the amount of time children could remain in temporary care.
Clark, H. B., Lee, B., Prange, M, E., & McDonald, B. A. (1996). Children lost within the foster care system: Can wraparound service strategies improve placement outcomes? *Journal of Child and Family Studies, 5,* 39-54. Population: family-based foster care – high behavioral/emotional disturbance	**Method:** This study used an RCT to test the efficacy of the FIAP as compared to standard practice foster care (SP). 132 children (aged 7-15 years) who were determined by caseworkers to be at-risk, due to substance use, or to situational indicators such as failed placement or more restrictive placement in the past 6 months were randomly assigned to receive wraparound services or to standard practice conditions. **Findings:** The FIAP group experienced a decrease in placement changes (whereas standard practice placement changes increased) during the two and a half year time period. Additionally, the FIAP group had significantly fewer placement changes than the SP group following placement (2.2 vs. 4.9 changes per year, respectively). For those children who ran away while in care, the FIAP group spent fewer days away from the foster home during runaway periods (38.7 vs. 110.9 days, respectively). Children who experienced incarceration while in care were 1.6 times more likely to have been incarcerated for more than half the time. FIAP children were significantly more likely to be place in a permanency home than the SP children (44.4% vs. 37.2%, respectively).

General Wraparound Services	
Bickman, L., Smith, C., Lambert, E. W., & Andrade, A. R. (2003). Evaluation of a congressionally mandated wraparound demonstration. *Journal of Child and Family Studies, 12*, 135-156. **Population:** Military youth (aged 4-16) who were referred for services	**Method:** This study utilized a controlled design to test the efficacy of the wraparound process in a sample of youth (aged 4-16) years who were dependents of members of the military and were referred for services. The study compared a sample of families who had been referred to a Department of Defense mandated wraparound demonstration implementation (n=71) to a sample who were referred to the demonstration and refused or were ineligible on some criteria (n=40). Criteria for ineligibility for wraparound services included long-term residential treatment, persistent substance abuse, persistent, untreatable antisocial behavior and conviction of sexual perpetration or predatory behavior. Wraparound is a team-based planning process intended to provide individualized and coordinated family-driven care. Wraparound is designed to meet the complex needs of children who are involved with several child and family-serving systems (e.g. mental health, child welfare, juvenile justice, special education, etc.); who are at risk of placement in institutional settings; and who experience emotional, behavioral, or mental health difficulties. The Wraparound process requires that families, providers, and key members of the family's social support network collaborate to build a creative plan that responds to the particular needs of the child and family. Team members then implement the plan and continue to meet regularly to monitor progress and make adjustments to the plan as necessary. The team continues its work until members reach a consensus that a formal Wraparound process is no longer needed. **Findings:** Both groups showed some improvement, but there were no differences between groups, on functioning, symptoms, life satisfaction, or serious events. Wraparound costs were greater, due to the use of expensive traditional services and addition of nontraditional services. **Limitations:** This study utilized a short time span. Also the authors questioned the fidelity of the demonstration project.
Bruns, E. J., Rast, J., Peterson, C., Walker, J., & Bosworth, J. (2006). Spreadsheets, service providers, and the statehouse:	**Method:** This study utilized a controlled design to evaluate the efficacy of the wraparound process. 97 children with severe emotional disorders who were involved with child welfare services participated in the study. Children who were

Using data and the wraparound process to reform systems for children and families. A*merican Journal of Community Psychology, 38*, 201-212. **Population:** Children with severe emotional disorders who were involved with child welfare services	placed into a wraparound process were matched with a comparison group receiving traditional casework on age, sex, race, current residential placement and severity of mental health problems. **Findings:** Youth receiving wraparound services moved to less restrictive placements more often than those in the comparison groups after 18 months (82% versus 38%) and more comparison group youth moved to more restrictive placements than wraparound group youth (22% versus 6%). The severity and impact of mental illness were lower for the wraparound group after 6 months than for the comparison group.
Carney, M. M, & Butell, F. (2003).Reducing juvenile recidivism: Evaluating the wraparound services model. *Research on Social Work Practice, 13*, 551-568. **Population:** Delinquent youth (mean age 15 years) entering the juvenile justice system	**Method:** This study utilized an RCT to evaluated the efficacy of the wraparound process on a group of delinquent youth who were entering the juvenile justice system. Youth were randomly assigned to the wraparound services (n=73) or conventional services (n=68) conditions. **Findings:** Youth in the wraparound group had fewer absences and suspensions from school, and fewer incidents of running away from home. They were also less assaultive and less likely to be picked up by police. No significant differences were found in arrests or incarceration during the course of the evaluation at 6, 12, and 18 months.
Crusto, C. A., Lowell, D. I., Paulicin, B., Reynolds, J., Feinn, R., & Friedman, S. R. et al. (2008). Evaluation of a wraparound process for children exposed to family violence. *Best Practices in Mental Health, 4*, 1-18. **Population:** Children (aged 5 or younger) enrolled in the Child FIRST program who had been exposed to violence and/or received services for family violence	**Method:** This exploratory study utilized a pre-test/post-test design to assess the efficacy of wraparound services in a sample of 82 children (aged 5 or younger) who were enrolled in the Child FIRST program and who had been shown to have been exposed to violence and/or received services for family violence. **Findings:** Both family and non-family violence events significantly decreased following wraparound service receipt, as did overall traumatic events. Children showed significant reductions in post-traumatic stress-intrusive thoughts and avoidance. Parents also reported reductions in total stress, parental distress, parent-child dysfunctional interaction, child difficulty levels. Many of these outcomes were positively correlated with number of service hours and/or length of time in the program. **Limitations:** This study did not utilize randomization or control groups.
Hyde, K. L., Burchard, J. D., & Woodworth, K. (1996). Wrapping services in an urban	**Method:** This study utilized a controlled design to test the efficacy of the wraparound process in an urban setting. 121 youth who were at risk for out of home

setting. *Journal of Child and Family Studies, 5*, 67-82. **Population:** Youth (mean ages 15-20) at risk for out of home placements and youth diverted from out-of-state residential treatment centers	placements and youth who were diverted from out-of-state residential treatment centers participated in the study. Four groups of youth were compared. Two groups received wraparound services. Both groups were diverted from out-of-state residential treatment centers. The Wraparound Return (WR) group included youth (mean age 17.5) returning from residential treatment. The Wraparound Diversion group included those who were at-risk of residential treatment (mean age 15.6). Two other groups received traditional services. The Pre-Wraparound (PW) group had been returned from out-of-state residential programs in the year before the implementation of wraparound services (mean age 20.1). The Non-Wraparound group returned from residential treatment at the same time as the WR group, but did not receive wraparound services (mean age 16.9). **Findings:** Higher percentages of youth in both wraparound groups were rated as Good or Fair (as opposed to Poor) in adjustment than in the other two groups. (Adjustment included restrictiveness of living, school attendance, job/job training attendance, and harmful behaviors.) Those in the NR group had the poorest ratings, with none achieving a rating of Good and 60% being rated as Poor. The same patterns held for ratings of the number of youth with more than 10 days of community involvement. **Limitations:** The levels of statistical significance for differences were not reported. Also this study utilized a small sample that was predominantly African American and the lacked normative data for the measures used.
Myaard, M. J., Crawford, C., Jackson, M., & Alessi, G. (2000). Applying behavior analysis within the wraparound process: A multiple baseline study. *Journal of Emotional and Behavioral Disorders, 8*, 216-229. **Population:** Youth (aged 14-16) who had severed emotional and behavioral problems	**Method:** This exploratory study utilized a case study with a multiple baseline design to explore the efficacy of wraparound services in a sample of four youth (aged 14-16) with severe emotional and behavioral problems who were referred into wraparound services. **Findings:** All 4 youths demonstrated improvement in compliance, peer interaction, reduction of physical aggression, and reduction of alcohol and drug use. (One of the participants had no aggressive incidents or alcohol/drug use prior to introduction of wraparound.) **Limitations:** Measures were subjective in nature. Additionally, the sample size was small, and randomization and control groups were not used.

Pullman, M. D., Kerbs, J., Koroloff, N., Veach-White, E., Gaylor, R., & Sieler, D. (2006). Juvenile offenders with mental health needs: Reducing recidivism using wraparound. *Crime and Delinquency, 52*, 375-397. **Population:** Youth (aged 15 at intake) involved in the juvenile justice and mental health systems	**Method:** This study utilized a controlled design to test the efficacy of the wraparound process in a sample of youth involved with the juvenile justice and mental health systems. Youth receiving Wraparound services (n=106) were compared to youth who had been in the same system prior to implementation of Wraparound (n=98). **Findings:** Youth in the comparison group were significantly more likely to commit an offense and to commit an offense sooner after entering services than the Wraparound group. This pattern was repeated when only considering felony offenses as well. All of the comparison group youth served detention at some point in the follow-up time, compared to 72% of youth receiving wraparound services.

Evidence-Based Practice in Foster Parent Training and Support:

Implications for Treatment Foster Care Providers

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Evidence-Based Practice in Foster Parent Training and Support:

Implications for Treatment Foster Care Providers

APPENDIX I - Quick Reference Guide

The *Evidence-Based Practice in Foster Parent Training and Support: Implications for Treatment Foster Care Providers* report is intended to assist Foster Family-Based Treatment Association (FFTA) foster care agencies identify the most effective practices of foster parent training and support, as determined by the state of current empirical research. This report is based on a comprehensive review of published empirical literature conducted by the Center for Advanced Studies in Child Welfare (CASCW) at the University of Minnesota's School of Social Work. The report outlines models of foster parent training, including pre-service trainings, parenting programs for foster parents, specialized foster parent trainings, and alternate training modalities, as well as a variety of services that may support foster parents, including benefits (health insurance, service provision, and stipends), foster parent collaboration with agency staff and biological families, level of care, respite, support from agency workers and community members, support inventories, and integrated models of support and training.

The Quick Reference Guide provides a brief summary of findings from the full report. Included in this guide are key findings and tables outlining empirically-based relationships among evidence-based practices in foster parent training and support, and key child welfare outcomes. Descriptions of the various models of foster parent training and support, and a complete description of the scales utilized in rating the level of effectiveness of the various models are presented in the full text of the report.

Defining Evidence-Based Practice

It is important to think of EBP as a *process* of posing a question, searching for and evaluating the evidence, and applying the evidence within a client- or policy-specific context (Regehr, Stern, & Shlonsky, 2007). EBP blends current best evidence, community values and preferences, and agency, societal, and political considerations in order to establish programs and policies that are effective and contextualized (Gambrill, 2003, 2006; Gray, 2001).

The Quick reference guide assists practitioners with one important step in this process by outlining the effectiveness of various models of foster parent training and support. Two things are important to note: 1) because this guide relies solely on practices that have been documented in the peer-reviewed, published literature, some field practices may not be included, and 2) the effectiveness of models presented in this guide may not have been developed for, or tested in, all populations of foster care youth. Practitioners wishing to utilize one of the models in this guide should draw on their expertise to determine if a practice is appropriate for a given client and context.

Evidence-Based Practice in Foster Parent Training

Table A provides an overview of evidence based practices in foster parent training. The table gives the evidence-based rating for each model of foster parent training as well as empirically-based relationships among practices in foster parent training and key child welfare outcomes. For reference, the levels of EBP for given practice models reflect the following (CEBC, 2008e):

1 = Effective Practice: a practice which is well-supported by research that utilizes multiple site replication and random assignment of participants to control and treatment groups; the practice's intended effects (e.g., improvements in child behavior, parenting skills, etc.) have been sustained for at least one year.

2 = Efficacious Practice: a practice which is well-supported by research that utilizes random assignment of participants to control and treatment groups: the practice's intended effects have been sustained for at least six months.

3 = Promising Practice: a practice which is supported by research that utilizes non-randomized control and treatment groups; the intended effects of the practice have been demonstrated.

4 = Emerging Practice: a practice which is generally accepted in clinical practice as appropriate for use with children receiving services from child welfare or related systems and their parents/caregivers; no formal evaluations of the practice have been completed or the research base of this practice is descriptive or exploratory in nature (i.e., does not utilize control groups).

Table A. Outcomes of Evidence-Based Practices in Foster Parent Training

Evidence-Based Practice	Level of EBP	Outcome												
		Foster Parent								Foster Child				
		Satisfaction	Licensing	Retention	Attitudes	Stress	Confidence	Knowledge	Skills	Behavior	Mental Health	Delinquency	Placement Stability	Permanency
1-2-3 Magic	2								X	X				
Attachment & Biobehavioral Catch-Up (ABC)	3									X				
Behaviorally-Oriented Training	4			X						X				
Caring for Infants with Substance Abuse	3							X	X					
Cognitive Behavioral Therapy (CBT)	4	X					X							
Communication & Conflict Resolution	3								X					
Early Childhood Developmental & Nutritional Training	4							X						
Family Resilience Project	4								X					
Foster Parent Skills Training Program (FPSTP)	3								X					
Incredible Years (IY)	1								X	X				
Keeping Foster Parents Trained & Supported (KEEP)	3								X	X				X
Multidimensional Treatment Foster Care (MTFC)	1	X								X		X		X
Multidimensional Treatment Foster Care - Preschool (MTFC-P)	2					X			X	X				X
NOVA	4		X										X	
NTU	4	X								X	X			
Nurturing Parenting Program (NPP)	3				X				X					
Parent Resources for Information, Development & Education (PRIDE)	4							X						
Parent-Child Interaction Therapy (PCIT)	1					X			X	X				
Parenting Wisely (PAW)	3							X	X	X				
Positive Parenting Program (PPP)	1					X	X		X	X				
Teaching Family Model (TFM)	3									X	X	X		X

**Note*. Emerging practices which have not been linked to specific outcomes (i.e., MAPP, Preparing Foster Parents Own Children for the Fostering Experience, and STAFF) and training modalities are not included.

Overall, the review of research on foster parent training suggests that a variety of pre-service and in-service foster training programs (from which treatment foster care agencies may wish to draw) exist. These include general pre-service trainings, foster parent trainings in parenting, and specialized foster parent training programs, such as those for foster parents of infants with substance abuse effects, nutritional training for young children and infants, etc. Most of the trainings show promise in a traditional foster care population, while others have been developed for, and tested in, populations of children and youth that resemble those traditionally served in treatment foster care settings (i.e., MTFC, MTFC-P, Family Resilience Project, 1-2-3 Magic, IY, PCIT, etc.).

The training programs outlined in the report are most useful in creating positive changes in parenting knowledge, attitudes, self-efficacy, behaviors, skills, and to a lesser extent, child behaviors. Training programs that 1) incorporate many partners (teachers, foster parents, social workers, etc.) with clearly defined roles, and 2) are comprehensive in nature may be the best for addressing the complex training needs of treatment foster parents. Much like for the traditional foster care population, the use of effective training programs in TFC may lead to increased treatment foster parent satisfaction, licensing rates, retention, and placement stability and permanency for TFC youth.

Evidence-Based Practice in Foster Parent Support

Table B provides an overview of evidence based practices in foster parent services and supports. The table presents the evidence-based rating for each model of foster parent training as well as empirically-based relationships among evidence-based practices in foster parent support services and key child welfare outcomes.

The review of literature indicates that the provision of 1) benefits (such as health insurance and stipends), 2) opportunities for foster parent collaboration with agency staff and biological families, 3) interventions designed to make changing levels of care flow more smoothly, 4) respite, 5) social support, 6) inventories to assess needs and current sources of support, and 7) models of training which include an on-going support component are all current sources of support for foster parents. Specific models of support have been developed and have been tested in collaboration with foster and biological parents as well as in interventions that are designed to assist youth "step-down" from residential treatment centers to less restrictive levels of care, such as TFC. The results of these models show promise for their utility in a TFC population. However, there is currently a lack of specific models in the empirical literature developed to address other treatment foster provider support needs, including benefits (health insurance and stipends), collaboration between agencies and treatment foster parents in service planning, delivery of respite services, and the delivery and enhancement of social support services. Effective support services may help TFC agencies recruit and retain experienced, satisfied treatment care providers, and have positive effects on TFC youth outcomes.

Table B. Outcomes of Evidence-Based Practices in Foster Parent Support

Evidence-Based Practice	Outcome															
		Foster Parent					Foster Child									
	Level of EBP	Satisfaction	Resources	Retention	Stress	Skills	Attitudes	Behavior	Moral Development	Mental Health	Delinquency	Education	Service Utilization	Placement Stability	Restrictive Living	Permanency
Co-Parenting	3					X		X								
Family-Centered Intensive Case Management (FCICM)	2					X		X								
Fostering Individualized Assistance Program (FIAP)	3							X			X			X		
Health Insurance	-	X	X										X			
Involvement in Service Planning	-	X		X												
Keeping Foster Parents Trained & Supported (KEEP)	3					X		X								X
Managed Care Service Provision	-												X			X
Multidimensional Treatment Foster Care (MTFC)	1	X						X			X					X
Multidimensional Treatment Foster Care-Preschool (MTFC-P)	2				X	X		X								X
Positive Peer Culture (PPC)	2						X	X	X		X					
Re-ED	4							X			X	X			X	
Respite	-	X			X											
Social Support	-	X	X	X		X		X								
Stipends	-			X										X		
Stop-Gap	3							X								
Wraparound	-				X		X	X		X		X			X	

**Note*. Emerging practices which have not been linked to specific outcomes (i.e., Casey Foster Family Assessments, Ecosystemic Treatment Model, Family Reunification Project, Shared Family Foster Care, Shared Parenting, and STAFF) are not included