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Evidence-Based Practice for Youth in Supervised Out-of-Home Care: A Framework for Development, Definition, and Evaluation

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Adolescents comprise more than half of the children in child welfare supervised out-of-home care. This article considers the evidence-base for an array of services to adolescents in out-of-home care and evaluates the existing research base for each program. This review advances a framework for considering the critical need to develop, define, and evaluate the essential elements of out-of-home care services for older foster youth. Policy, program, and evaluation recommendations are forwarded.

KEYWORDS Evidence-based practice, out-of-home care, foster youth

Adolescents comprise almost 40% of children in out-of-home care (OOHC) (U.S. Department of Health and Human Services, 2010), with nearly 160,000 in 2010. While the overall number of children in OOHC has declined slightly...
in recent years, the proportion of teenagers in foster care has increased (U.S. Department of Health and Human Services, 1999; 2000; 2001; 2002; 2003; 2004; 2005a). Yet, research regarding the effectiveness of programs supporting these youth is limited (Cook, 1994; Courtney, Piliavin, Grogan-Kaylor, & Nesmith, 2001). Recognizing the sparse research base and the need for quality programs, this article provides an overview of research on evidence-based interventions for older foster youth. First, a framework for the planning of evidence-based services for adolescents in foster care is introduced. Based on this knowledge, five current service models for older youth in OOHC are analyzed, reviewing each model’s evidence-base. Last, the authors discuss research, policy, and practice recommendations on how child welfare services can better incorporate evidence-based practices in an effort to more adequately address foster youth’s need for safety, well-being, and permanence.

Child welfare services (CWS) are designed to ensure children’s safety, well-being, and permanence. To enhance the provision of services to youth in foster care, the National Resource Center on Permanency Planning (NR-CPP, 2004) developed nine categories of adolescents’ needs reflecting the views that services to adolescents must be multifaceted and must concurrently address youth’s need for safety, well-being, and permanent, lifetime connections to families. The NR-CPP criteria include safety, shelter, education, life skills training, health, character development, connection to families of origin, development of lifetime permanent relationships, and social capital. Services that would be expected to best achieve the overarching goals of CWS would address this array of adolescent needs. In this article, for reasons of limited space and evidence, the authors review interventions that address adolescents’ need for safety, shelter, life skills training, and the development of lifetime permanent relationships.

While one of the key priorities of CWS is to ensure youth’s safety through stable and secure placements; upon entering care many foster youth’s lives continue to be in flux. Most often, adolescents enter OOHC due to victimization from child abuse and neglect. Placements in OOHC are often associated with youth’s conduct problems or their parents’ inability to provide them with safe and adequate care (Barth, Wildfire, & Green, 2006). Of children in OOHC, adolescents experience the highest rates of placement changes (Courtney & Barth, 1996). These placement changes typically lead to disruptions of schooling and may also increase adolescents’ risk of social and emotional problems (Courtney et al., 2001). Older youth in OOHC and former foster youth experience higher rates of behavioral and health problems than the general population. Further, adolescents in OOHC experience high levels of substance use and mental health problems (U.S. Department of Health and Human Services, 2005b). After exiting foster care, former foster youth also consistently note difficulties securing health insurance and medical care (Courtney et al., 2001).
The second priority of CWS—ensuring a youth’s well-being—is critical for foster youth because many experience educational difficulties, behavioral problems, and lack the skills to live independently. Children in foster care are more likely to have behavioral and discipline problems, more likely to experience gaps in education because of school transfers, more likely to be in special education, and less likely to attend college than youth not in foster care (Blome, 1997). Although there is evidence that foster youth often aspire to go to college (Courtney, Terao, & Bost, 2004) and signs of increasing enrollment of former foster youth in higher education are evident (Lemon, Hines, & Merdinger, 2005), many lack the preparation to even obtain a high school diploma. Historically, studies estimate that only 30% to 50% of teens in foster care graduate from high school or complete their GED before discharge (McMillen & Tucker, 1998; Scannapieco, Schagrin, & Scannapieco, 1995). Yet, adolescents who complete high school before leaving foster care have more stable employment and improved self-sufficiency as adults (Cook, Fleishman, & Grimes, 1991; Reilly, 2003).

Within two to four years after adolescents leave the foster care system at age 18, many confront unemployment, endure spells of homelessness, rely on public assistance, face young parenthood, and experience incarceration (Barth, 1990; Cook et al., 1991; Courtney & Piliavin, 1998). Additionally, studies find former foster youth have small earnings and frequently live well below the poverty line (Courtney & Dworsky, 2005; Dworsky, 2005; Pecora et al., 2005). Considering these challenges, several promising findings have emerged as programs expand services to youth up to age 21. When youth remain in care beyond their 18th birthday, they use more independent living services and achieve greater levels of education and employment (Courtney et al., 2004; Kerman, Wildfire, & Barth 2002).

Achieving permanent lifetime family connections—the third priority of CWS—is critical for adolescents whatever their case plan may be. For the past 25 years, federal legislation (i.e., P.L. 96-272 and P.L. 105-89) has guided permanency planning, limiting the timeframe youth spend in foster care and providing incentives to states which transition children from foster homes to adoption. Despite these legislative initiatives, a large number of older children are in foster care, as the foster care population is largely comprised of children who enter care when they are older than 10 years (Wulczyn, Barth, Yuan, Jones–Harden, & Landsverk, 2005). This large number of older foster youth who lack a permanency plan is in part because adoption, the most common strategy used for young children to achieve permanency, is not desired or achievable for many older youth. Older foster youth can, nonetheless, achieve emotional permanence where legal permanence is not a possible option. In this sense, the concept of permanency for older youth in foster care can be thought of as the opportunity to have a lasting and irrevocable connection to at least one committed and caring adult who will provide lifelong support (Frey, Greenblatt, & Brown, 2005).
Currently, services for adolescents in OOHC typically focus on preparing youth for “adulthood” without providing them assistance in securing these permanent lifetime relationships. Frey et al. (2005) describe four sets of circumstances that lead to a youth’s service plan goal being “independent living” or “long-term foster care,” neither of which constitute permanency: (a) the youth cannot safely be reunited with his/her birth family, (b) recruitment of an adoptive or guardian family has not been successful, (c) a decision is made that adoption or guardianship is incompatible with a youth’s age, special need, or complex circumstances, and/or (d) a youth says “no” to reunification, adoption, or guardianship. The authors emphasize that a service plan goal of “independent living” or “long-term foster care” does not mean that a youth no longer needs family permanency, but that CWS has not yet succeeded in achieving family permanency for them. As a result, these youth are more likely to age out of CWS without a permanent family, and face adulthood unprepared and unsupported to successfully meet its challenges. Given the unique histories of youth in OOHC and the challenges associated with transitioning to adulthood, assisting this population with achieving permanency should be a primary focus of service provision.

THE EVIDENCE-BASE FOR ADOLESCENT PROGRAMS

Evaluating the research evidence for programs serving youth in OOHC is critical to ensure adolescents receive care that effectively addresses their complex needs. At present, the empirical literature on programs for adolescents in OOHC known to these authors does not concurrently examine the three components of adolescent services: (a) family or group care living arrangements, (b) independent living services, and (c) permanency planning. The goal of this analysis is to integrate the research in these areas in the context of developing bodies of child welfare and children’s mental health services research. Reviewing a program’s evidence-base can be instructive with respect to ensuring that services achieve intended outcomes. Evidence-based practices are evaluated by using scientific methods to assess a service’s average impact (Hoagwood, Burns, Kiser, Ringeisen, & Schoenwald, 2001). While examining a study’s strength of evidence is a valuable tool, the absence of evidence on a program does not indicate that an intervention is neither safe nor effective (Steinberg & Luce, 2005). Further, consistent attention to the study’s population, location, and degree of implementation support must be part of the rationale for recommending the dissemination of a program. Despite these reservations, the authors believe assessing current services for youth in OOHC’s research base will provide a sense of the continuum of program effectiveness and help programs achieve better outcomes. Currently, a nascent body of research is emerging that documents the elements critical to successfully serving youth in OOHC.
A Conceptual Framework for Evidence-Based Practice

In examining each intervention, an overview of the program and an evaluation of its research are presented. Interventions were assessed using the California Evidence-Based Clearinghouse for Child Welfare’s Scientific Rating Scale (2006; see Table 1). The classification system’s criteria borrow from other evidence-based services frameworks (e.g., Saunders, Berliner, etc.).

<table>
<thead>
<tr>
<th>Research level</th>
<th>Supporting criteria</th>
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<td><strong>Level 1</strong></td>
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<td>Well-supported:</td>
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<tr>
<td>Effective practice</td>
<td>a. There is no clinical or empirical evidence or theoretical basis indicating that the practice</td>
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<td></td>
<td>constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.</td>
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<td>b. The practice has a book, manual, and/or other available writings that specify</td>
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<td>components of the service and describes how to administer it.</td>
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<td></td>
<td>c. Multiple Site Replication: At least 2 rigorous randomized controlled trials (RCTs) in different</td>
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<td>usual care or practice settings have found the practice to be superior to an appropriate comparison practice.</td>
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<td>The RCTs have been reported in published, peer-reviewed literature.</td>
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<td>d. The practice has been shown to have a sustained effect at least one year beyond the end of treatment, with</td>
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<td>no evidence that the effect is lost after this time.</td>
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<td>e. Outcome measures must be reliable and valid, and administered consistently and accurately across all</td>
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<td>subjects.</td>
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<td>f. If multiple outcome studies have been conducted, the overall weight of the evidence supports the</td>
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<td>effectiveness of the practice.</td>
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<td><strong>Level 2</strong></td>
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<td>Supported:</td>
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<tr>
<td>Efficacious practice</td>
<td>a. Meets Level 1a (no risk of harm).</td>
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<td>b. Meets Level 1b (treatment manual).</td>
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<td>c. Meets Level 1d (sustained effect &gt;1 year)</td>
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<td></td>
<td>d. Meets Level 1e (measures reasonable and valid).</td>
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<td>e. Meets Level 1f (evidence supports the efficacy).</td>
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<td><strong>Level 3</strong></td>
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<td>Promising practice</td>
<td>a. Meets Level 1a (no risk of harm).</td>
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<td>b. Meets Level 1b (treatment manual).</td>
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<td>c. At least one study utilizing some form of control (e.g., untreated group, placebo group, matched wait list,</td>
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<td>have established the practice’s efficacy over the placebo, or found it to be comparable to or better than an</td>
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<td>appropriate comparison practice. The study has been reported in published, peer-reviewed literature.</td>
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<td></td>
<td>d. Meets Level 1e (measures reasonable and valid).</td>
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<td>e. Meets Level 1f (evidence supports the efficacy).</td>
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<td><strong>Level 4</strong></td>
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<td>Acceptable:</td>
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<td>Emerging practice</td>
<td>a. There is no clinical or empirical evidence or theoretical basis indicating that the practice</td>
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<td>constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.</td>
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<td>b. Meets Level 1b (treatment manual).</td>
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<td>c. The practice is generally accepted in clinical practice as appropriate for use with children receiving</td>
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<td>services from child welfare or related systems and their parents/caregivers.</td>
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<td>d. The practice lacks adequate research to empirically determine efficacy.</td>
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<td><strong>Level 5</strong></td>
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<td>Evidence fails to</td>
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<td>demonstrate effect</td>
<td>a. Two or more randomized, controlled outcome studies (RCTs) have found that the practice has not resulted</td>
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<td>in improved outcomes, when compared to usual care.</td>
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<td>b. If multiple outcome studies have been conducted, the overall weight of evidence does not support the</td>
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<td>efficacy of the practice.</td>
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<td><strong>Level 6</strong></td>
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<tr>
<td>Concerning practice</td>
<td>a. If multiple outcome studies have been conducted, the overall weight of evidence suggests the intervention</td>
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<td>has a negative effect upon clients served; and/or</td>
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<td>b. There is a reasonable theoretical, clinical, empirical, or legal basis suggesting that, compared to its</td>
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<td>likely benefits, the practice constitutes a risk of harm to those receiving it.</td>
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& Hanson, 2003) but are specific to CWS. They are anchored in the following criteria: (a) a program’s clinical and/or empirical support, (b) written manualization, (c) acceptance within child welfare, (d) application to child welfare service clientele, (e) use of child welfare outcome indicators in their evaluation, and (f) potential risk for harm. This framework was selected because it is one of a small number of evidence-based criteria that the authors are aware of that is specifically designed for child welfare interventions, and because this system is one of the few that acknowledges that some interventions may have adverse effects.

RESIDENTIAL SERVICES

In this usage “residential services” encompasses both family care and group care and comprises that component of the adolescent experience that is focused on providing a safe and successful living environment. The U.S. Department of Health and Human Services (DHHS, 2005a) estimates that of the 515,000 children in OOHC in 2003, 118,771 were living in kinship care, 235,878 were living in a non-relative foster home, and 45,625 (8.9%) were living in a group home. Within foster care and group care, the program models and services vary widely and include treatment foster care, kinship care, and large and small group homes. Since the 1990s, children are increasingly being referred to treatment foster care over residential treatment or group care (Berrick, Courtney, & Barth, 1993). Additionally, a growing emphasis is now being placed on family-based care as family involvement consistently appears to strengthen children’s outcomes (Barth, 2005). This article assesses three community-based residential service models: Multidimensional Treatment Foster Care, the Teaching–Family Model, and Small Group Home Care. These programs were selected with particular attention to the degree that family involvement mediates children’s outcomes.

Multidimensional Treatment Foster Care

Multidimensional Treatment Foster Care (MTFC) is a family-based intervention rooted in the belief that when parents are skilled and supported they can have a positive and powerful socializing influence on troubled youth (Chamberlain, 1994). MTFC is rooted in research conducted since the early 1970s at the Oregon Social Learning Center in Eugene, Oregon and was developed as an alternative to residential and group care placement for juvenile offenders. Currently, about 12 agencies throughout the United States are using the MTFC model, as well as one in Sweden and one in Norway. The goals of MTFC are to decrease youth’s delinquent behavior and to increase their participation in developmentally appropriate prosocial activities. MTFC is derived from the principle that adolescents’ behavior will change through
close supervision, fair and consistent limits, predictable consequences for rule breaking, a supportive relationship with at least one mentoring adult, and limited exposure and access to delinquent peers. MTFC parents are the primary treatment agents and the youth’s kinship families participate in family therapy, home visits, and developing the adolescent’s treatment plan (Fisher & Chamberlain, 2000).

MTFC’s foster families are carefully recruited, and are provided with a high-level of pre-service training and ongoing support and supervision. MTFC parents maintain close contact with the youth’s case manager. Unique to MTFC, foster parents make “parent daily reports” (PDR) via telephone or internet connection in order to document data on the child’s problems and progress. MTFC parents attend weekly supervision and support meetings with the case manager and other MTFC parents and are expected to implement an individualized, detailed behavior management program within the foster home. Regarding program structure, MTFC is characterized by the separation and stratification of staff roles. Distinct roles include a behavior support specialist, youth therapist, family therapist, consulting psychiatrist, PDR caller, and a case manager/clinical team supervisor. This stratification enables MTFC to avoid having one staff member work across multiple domains, and creates multiple layers of staff involvement with the child, kinship family, and the foster family (Fisher & Chamberlain, 2000).

**MTFC effectiveness.** Given the research support, MTFC appears to be a developmentally appropriate, intensive, and family-focused treatment superior to group care at any point in an antisocial youth’s developmental trajectory. The Oregon Social Learning Center has produced the majority of research on MTFC. Most empirical studies of MTFC focus on its effectiveness with serious and chronic juvenile offenders, although researchers have begun to study MTFC’s applicability to maltreated youth and youth receiving CWS (Chamberlain et al., 2006). Since 1990, eight empirical studies on the efficacy of MTFC have been published in peer-reviewed literature. Overall, these eight studies suggest that MTFC is a highly efficacious alternative to regular foster care, group care, residential treatment, and incarceration for older adolescents with chronic disruptive behavior (Chamberlain, 2003). In rigorous external reviews of MTFC’s research base and program effectiveness, the intervention has been recognized as a model program by the Office of Juvenile Justice and Delinquency Prevention’s Blueprint Series, SAMHSA’s Center for the Study and Prevention of Violence, and the National Institute of Justice. Based on the California Evidenced Based Clearinghouse criteria, the authors conclude that MTFC obtains the second highest rating—supported-efficacious practice—however, MTFC was currently unable to achieve the highest rating because of limited testing with adolescents under child welfare supervision.

The eight rigorous studies of MTFC generally include randomized clinical trials (RCT) of youth in the juvenile justice system, with varying pop-
ulations (e.g., some only include females) and comparison conditions. In the first study of MTFC (Chamberlain, 1990), rates of incarceration for MTFC youth were compared with those of adolescents who received treatment from other community-based programs (total \( n = 32; \) ages 12–18). In the first RCT, Chamberlain and Reid (1991) showed the effectiveness of MTFC versus typical community treatment for 20 youth ages 9–18 leaving the state mental hospital. In both studies, youth in MTFC spent more time in the community and less time hospitalized or incarcerated in comparison with youth who received typical community treatment care.

MTFC’s studies on youth with histories of juvenile delinquency demonstrate that youth who receive MTFC have less delinquent behaviors and experience more stable placements than youth in group care (GC). Chamberlain and Reid (1998) used random assignment of 79 male adolescents (ages 12–18) who had histories of chronic delinquency to compare the relative effectiveness of GC \( (n = 45) \) and MTFC \( (n = 40) \). Results showed that boys in MTFC spent fewer days incarcerated and had higher rates of program completion than boys in GC. In a subsequent RCT study in Lane County, Oregon that examined the influence of family management skills and deviant peer association on youth antisocial behavior, Eddy and Chamberlain (2000) found family management skills and deviant peer association functioned as mediators of the effect of the treatment condition on later youth antisocial behavior. However, the reliability of these results must be interpreted with caution because the study’s small sample size (MTFC, \( n = 37; \) GC, \( n = 42 \)) was insufficient for analysis by structural equation modeling. Eddy, Whaley, and Chamberlain (2004) then examined the ability of MTFC to prevent subsequent violent offending as compared to services-as-usual group (GC) \( (MTFC, n = 37; \) GC, \( n = 42 \)). MTFC youth experienced significantly fewer criminal referrals for violence in the two years after baseline than GC youth, when controlling for other pre-baseline factors.

In addition, some of the MTFC demonstrations studies have squarely addressed children involved with CWS. The first MTFC study to address a child welfare population was Chamberlain, Moreland, and Reid’s 1992 study. Seventy foster families were randomly assigned to one of three conditions: (a) assessment only, (b) payment only, and (c) enhanced training and support. Results showed that for parents receiving enhanced training and support, significantly higher retention rates were achieved and the children had fewer disruptions in their placements in comparison with the assessment only and payment only groups.

A recent extension of MTFC is the first to employ it with existing kinship foster parents and conventional foster parents in CWS (P. Chamberlain, personal communication, January 20, 2005). Project KEEP gives strong indications of MTFC’s transferability to CWS. Project KEEP is somewhat distinct from MTFC and standard foster care in its training, support, and teaching methods, including its use of PDRs and weekly parent training. As a result,
attendance for parent training exceeded 80%. The Project KEEP study randomly assigned 640 sets of elementary and pre-adolescent children in San Diego, California entering a new foster placement, ages 5 to 12-years-old, to a treatment or control group. Children whose foster parents participated in Project KEEP were almost twice as likely to leave foster care for reunification or adoption, while children whose foster parents were not using Project KEEP were more likely to run away, have their placement disrupted, or have another negative exit from care (John Landsverk, personal communication, January 20, 2005). Although not a study of adolescents, these results and the prior history of the MTFC intervention with adolescents involved with juvenile justice suggests that MTFC is likely to be an effective child welfare intervention for youth in OOH.

In summary, studies of MTFC reveal a decrease in youth’s delinquent behavior and disruptions in placement. After program completion, MTFC was shown to reduce incarceration rates (Chamberlain, 1990; Chamberlain & Reid, 1998), decrease delinquent activity (Chamberlain & Reid, 1998), decrease criminal referrals for violence (Eddy et al., 2004), decrease association with delinquent peers (Leve & Chamberlain, 2005), and increase rates of reunification or adoption (Chamberlain et al., 2006). In addition, during treatment, MTFC increased foster parent retention (Chamberlain & Reid, 1991), decreased placement disruption (Chamberlain et al., 1992), and decreased runaway episodes (Chamberlain & Reid, 1998). Moreover, researchers are beginning to better represent the underlying complexity of MTFC by using advanced statistical methods that allow them to more richly represent the details of the causal process. Specifically, Eddy and Chamberlain’s (2000) and Leve and Chamberlain’s (2005) work furthers our knowledge of the mediating conditions of MTFC on certain treatment outcomes, thus providing a more in-depth understanding of the mechanisms that constitute MTFC. Last, increasing examination of MTFC with child welfare populations will be important to continue to better understand the transferability of this model to youth in OOH.

Teaching–Family Model

The Teaching–Family Model (TFM) is a family-focused residential treatment model where group home care is typically provided by a married couple in a family-style setting. TFM was founded in the late 1960’s, by behavioral psychologists with the University of Kansas’ Achievement Place Research Project. In TFM, a trained married couple (Teaching Parents) provide care to a group of six to eight youth, with the goal of establishing important societal behavior competencies through feedback, modeling, instruction, and support (Wolf, 1976). This approach is distinctive from the typical small group homes (e.g., six bed group homes) or residential care (larger facilities), although some larger facilities (e.g., Boys and Girls Town USA) have all their children
in TFM homes on one campus. There are approximately 21 TFM “sponsor” agencies, two “developing” agencies, and 21 “supportive” agencies throughout the United States and Canada, serving over 5,000 children, families, and adults with special needs (Fixsen & Blase, 2002). TFM is one of the best disseminated programs in child welfare history.

**TFM effectiveness.** Despite TFM's long history, limited quasi-experimental studies support its efficacy. Since its inception in 1967, only four empirical studies on the efficacy of TFM as a program of youth care have been published in the peer-reviewed literature. Overall, these four studies suggest that the TFM is an effective method of youth care for older adolescents, although the evidence is mixed regarding the maintenance of the positive effects after youth leave the program. Based on the limited research evidence, despite TFM's long standing use, the authors classify TFM as a “promising practice” (Level 3).

To date, the only national evaluation of TFM (Weinrott, Jones, & Howard, 1982) compared outcome data on 27 TFM homes with 26 other community-based residential group home programs serving delinquent youth. The 53 programs were in 10 states throughout the United States. During placement in TFM homes, youth had significantly higher (although only slightly) grade point averages and course completion rates (Jones, 1978 as cited in Thompson et al., 1996), and significantly fewer official reports of delinquent behaviors (Kumpfer, 1999) compared to youth in the other community-based residential group homes. However, these academic and behavioral outcomes were only observed while the youth were in the TFM homes, not continuing in the subsequent two years of follow-up (Jones, Weinrott, & Howard, 1981 as cited in Thompson et al., 1996; Kumpfer, 1999).

While, the additional three TFM studies provide evidence of positive effects, they lack strong comparison group to assess the impacts of the intervention. First, as part of a larger quasi-experimental longitudinal research project, Thompson et al. (1996) studied 587 youth (TFM, n = 503; treatment as usual, n = 84) at Father Flanagan’s Boys' Home in Omaha, Nebraska, the largest residential program using the TFM approach. The researchers found that TFM youth achieved significant improvements in both school performance and attitudes during placement, and that these differences were maintained over time after discharge. In a second study, Jones and Timbers (2003) examined the efficacy of the TFM for reducing the use of physical restraint and seclusion by two child care facilities before and after their respective transitions from conventional, vaguely specified programs of youth care to the TFM. Both facilities were traditional, campus-based, child care institutions providing long-term residential care to behaviorally difficult children and teens referred by social service and mental health agencies. After the centers’ transitions to TFM, there were statistically significant reductions in the use of locked quiet rooms and time out rooms, however, these reductions could be attributed to the use of a more coherent
program model and not specifically the TFM itself. Last, in a more recent study, Lewis (2005) assessed Utah Youth Village’s Families First program, an adaptation of the TFM with some elements of child welfare intensive family preservation services. In a controlled, three-year study, 150 families were randomly assigned to the treatment group (Families First, \( n = 105 \)) or control group \( (n = 45) \). The study found the treatment group demonstrated highly significant improvements in child behavior problems and family’s having concrete services/resources but no change was found with regards to parent effectiveness or the parent–child relationship. Other child welfare outcomes of placement stability, permanency, or safety were not assessed.

Although taken together the results of these studies are promising, to fully assess the efficacy of the TFM as a method of youth care for older adolescents, more studies using large samples, multiple methods, some standardized measures, comparison groups, and sufficient follow-up are certainly needed. One study (Jones, 1978 as cited in Thompson et al., 1996) found that academic and behavioral outcomes disappeared at follow-up, while another study (Thompson et al., 1996) shows that academic outcomes were upheld at follow-up. Additionally, TFM significantly reduced the use of two forms of seclusion, but not physical restraint, by two child care facilities for behaviorally difficult youth (Jones & Timbers, 2003), and helped parents significantly improve on problems relating to their child, their family situation, and their parenting abilities (Lewis, 2005). TFM earns the third highest rating of promising practice because there are not multiple rigorous randomized trials that show child welfare outcomes, but there are a series of well-controlled studies that suggest a positive benefit.

Small Group Home Care

Small group home care continues to be a widely practiced intervention, despite evidence questioning its efficacy. Small group homes typically consist of 6 to 10 youth, supervised by shift care. Group homes largely serve older children and adolescents between the ages of 13 and 19 (Berrick et al., 1993). In some states, as many as 40% of adolescents under child welfare supervision may be in group care (Webster, Barth, & Needell, 2000). An additional group of adolescents also in group care are under the auspices of mental health or juvenile justice services. GC as a placement option for youth in OOHC continues to be used at a steady rate despite the current policy and practice emphasis on permanency, and despite the fact that overall group care is far more expensive on a daily basis in comparison with foster care. Even though roughly 45,000 youth are placed in GC at any point in time each year and twice that many may spend some time in group care, relatively sparse information is available about the characteristics of these youth. The older the youth, though, the more likely s/he will be placed in a group care setting (Barth, 2002).
Yet despite the growing concern about GC’s ineffectiveness and high costs, this practice continues to be used extensively (Lyons, 2004). One possible explanation is the lack of a widely available alternative to this traditional placement option. As Dishion and Dodge (2005) indicate, the idea of serving children individually runs against the cultural current for youth services. Further, the continued use of group care may result from arguments by some that deviant youth are a risk to their non-deviant peers and should be segregated to protect them. These researchers argue for the need to clarify the circumstances in which mixing deviant and non-deviant youth do not pose a threat to non-deviant youth. For example, Duncan, Boisjoly, Kremer, Levy, and Eccles (2005) showed that youth may not be equally vulnerable to negative contagion across a range of high risk behaviors. Additionally, meta-analytic reviews of the outcome literature on group-based skills training with aggressive children suggest that treated youth do not become worse on measures of behavioral adjustment (Arnold & Hughes, 2000).

**Small GC effectiveness.** Although an argument can be made for iatrogenic effects of GC (Barth, 2005; Dishion & Dodge, 2005) the authors do not believe that the evaluations have been broad enough, or the follow-ups long enough, to determine that there are not times/circumstances in which an overall benefit is larger than the adverse effects. These concerns about small GC are not new, as Wolins and Piliavin (1964) in their 40-year old history of the 100 years of debate on foster care and GC. Yet, the concerns about GC have become more persuasive as studies emerge that directly test the question of foster care versus GC—especially the work from the Oregon Social Learning Center. Based on the criteria, GC is considered a practice where the “evidence fails to demonstrate effects” (Level 5). Since much of this work about GC was detailed in the prior discussion of MTFC, only one additional study of MTFC will be included among other comparative findings.

Comprehensive reviews of GC raise concerns about the appropriateness of wide spread use of this model. Goddard’s (2000) review of research on residential education in the United Kingdom found that the performance of GC programs, in the educational area, was generally quite poor. Yet, this analysis includes smaller children’s homes as well as larger residential facilities. Barfield (2002), working on behalf of the State of Kansas to identify best practices, reviewed the evidence on GC and concluded that there is significant evidence indicating that treatment foster care results in better outcomes, that no well-designed studies identified youth who would do better in GC; and among programs considered to be GC the TFM was the most effective. Perhaps only Little, Kohm, and Thompson (2005) find substantial reason for optimism about the outcomes of GC, albeit large GC. Combining information from research on boarding schools and residential programs in the United Kingdom with information from the United States, they conclude that there is some evidence of short-term improvement in development for some children, and in some cases these improvements are
lasting. At the same time, they recognize that some children experience harm from their time in residential care.

New evidence about negative behavior contagion in GC has emerged from re-analysis of data from two studies that randomly assigned youth to treatment foster care or GC. Leve and Chamberlain (2005) examined the moderating effect of deviant peer exposure among youth who were in MTFC or small group homes that used a shift care model with positive peer culture and cognitive behavioral treatment approaches. Among youth in MTFC who had more contact with deviant peers the differences in outcomes were no longer significant. These findings, and others (e.g., Laird, Pettit, Dodge, & Bates, 2005), suggest that this relationship between high levels of involvement with antisocial peers and delinquent behavior carries across gender and ethnic/racial groups, and provides support for peer mediation and programs reducing youth’s associations with delinquent peers.

Yet, peer groups can also shape positive behavior, as Wolins (1974) discusses in his classic article on successful group care. The work to determine the circumstances under which peer contagion is a problem is not complete. Some investigations have identified mixed results of aggregating deviant peers. Dishion and Andrews (1995) showed that a peer group intervention that included skill training improved family interactions, but was associated with worsening of smoking and conduct problems away from the family. Although there is more to learn, additional expansions of GC are unlikely. Longstanding concerns about the cost-effectiveness of GC and the recent research on its possible untoward effects has given these concerns louder voice.

In the interim, a recent review of GC outcomes, spanning large and small GC programs, indicates that family involvement is a key to better outcomes, especially lower recidivism (Barth, 2005). These data on the better outcomes with family involvement continue to find support—most recently in a study of recidivism in juvenile justice (Ryan & Yang, 2005). Youth who had more visits by family and more home visits had better outcomes—this could, of course, be attributable to their having more functional families that could successfully schedule and complete these visits. Although the benefits of family involvement shown in the delinquency outcome research may not generalize to CWS, these populations have considerable overlap (Jonson-Reid, 2004).

INDEPENDENT LIVING SERVICES

Although CWS have existed since 1935 (Title IV-B of the Social Security Act), federally funded independent living services have only been provided to foster youth for the last 20 years. Since 1985, states have used federal IV-E funds to make education and employment assistance, training in daily
living skills, individual and group counseling, and a written transitional plan available to youth between the ages of 16 and 18 to help ready them for life on their own. Independent living services were developed after several early studies (Festinger, 1983; Jones & Moses, 1984) identified difficulties older foster youth commonly experienced after leaving state care, and upon the recognition that for at least some youth, foster care had become “an unplanned long-term experience” (Festinger, 1983, p. xiii). Many of the early services were, however, limited to classroom based instruction in skills related to independent living, such as checkbook balancing or job application completion.

In 1999, independent living services were broadly revamped for the first time since their inception. This was carried out in an effort to ameliorate the difficulties associated with emancipation. The Foster Care Independence Act of 1999 (i.e., The Chafee Act), significantly enhanced states’ resources and flexibility to provide older youth with transitional and independent living services, including access to health care, educational opportunities, job training, housing assistance, counseling, and other support services. Supervised Independent Living and Independent Life Skills are two programs which specifically support the transition to adulthood for older adolescents in OOHC.

Supervised Independent Living Program

Supervised Independent Living Program (SILP) provides foster youth residence in an emancipation apartment while concurrently providing them psychosocial and employment support. Kroner (1999) defines these supervised apartments as a group of apartments in the same building owned by an agency where youth are primarily responsible for themselves but are supported by counseling, occupational support, and overnight staff supervision. This living arrangement offers a significant step toward full independent living, as youth are expected to take responsibility for their living space, time management, food preparation, and leisure activities. As a result, youth in SILP learn about the consequences of their decisions and daily actions, and youth are assisted in making the emotional adjustment between living in foster care and having more independence (Child Welfare League of America, 2005). Presently, the exact number of agencies nationwide that have developed projects for SILP is unknown, however, on September 30, 2003, there were approximately 5,570 youth in supervised independent living settings (U.S. Department of Health and Human Services, 2005a). Moreover, to date, very few studies have been conducted that evaluate the relative effectiveness of this particular living arrangement for foster youth.

SILP effectiveness. Although various nationwide independent living programs have been implemented for more than 15 years, the effectiveness of these programs remains elusive (U.S. General Accounting Office, 1999).
Based on the available research, we regard SILPs as a “promising practice” (Level 3). One of the few empirical studies of the effectiveness of an independent living program that includes a supervised residence is Mallon’s (1998) evaluation of Green Chimneys Children’s Services’ Gramercy Life Skills Residence Program and Supervised Independent Living Apartment Program in New York. Mallon’s study population consisted of all youth discharged from Green Chimneys to independent living between December 1987 and December 1994 ($n = 46$). This exploratory study indicated that youth’s participation in the Green Chimneys Life Skills program was related to improved self-sufficiency and suggests that youth can sustain these positive outcomes over time.

Similar to Mallon’s study, Colca and Colca (1996) found that a transitional foster home program in New York that offers youth more responsibility and freedom, and provides a foster parent, who assumes the role of a resource or a mentor to the foster youth, rather than being the traditional parental figure, yielded promising results. The investigators reported that since beginning the program in 1990, only two youth out of 19 had not demonstrated improvement in money management skills despite most youth living on a tight budget, and that most youth achieved strengthened daily living skills, including cooking, shopping, banking, and using public transportation.

Likewise, Furrh (1983) found that a supervised apartment living approach for delinquent and emotionally disturbed adolescents in Houston, Texas also realized hopeful results. Investigators reported that in the first five years of operation, starting in 1975, the program helped 402 adolescents. Of these, 70% moved into approved independent living and 20% returned to their families or extended families when they emancipated from OOHC.

One of the few larger scale studies on the effectiveness of different living arrangements for older foster youth is Mech and Che–Man Fung’s (1999) study on placement restrictiveness and educational achievement among emancipated foster youth in Illinois. Investigators found that 66% of the youth in less restrictive placement settings attended postsecondary education, compared to the one-third that was placed in highly restrictive settings, and that overall, nearly 85% of the enrollees in postsecondary education or training programs came from placements rated as low in restrictiveness. The study authors concluded that placements rated as low in restrictiveness, such as foster family homes and transitional apartments, are likely the most effective settings in which to prepare foster youth for independence.

In addition to these few empirical studies on the effectiveness of supervised independent living residences for foster youth, reviews of program models for this type of living arrangement have been published in the scientific literature, although they have not been very systematic. For example, Barth (1986) describes the range of emancipation services for youth in foster care, in the years before Chafee, including foster parent training, supervised group homes, independent living subsidy programs,
scholarship programs, and pre- and post-emancipation services. Massinga and Pecora (2004) provide examples of programs and strategies for serving older youth in foster care, emphasizing the essential elements of drawing on community resources, promoting a system of care, linking children to mentors, and teaching them life skills as holding promise for improving the lives of older foster youth. And, the most comprehensive descriptive handbook of alternatives for transitional living is found in Kroner (1999). Housing options and practical issues surrounding the operation of housing programs, including the supervised apartment model, are explored, with the author emphasizing the value of learning by doing with real-world consequences (Loman & Siegel, 2000).

As a whole, the four outcome studies reviewed here suggest that supervised independent living residences for older foster youth are an effective living arrangement for promoting self-sufficiency, but lack rigorous evaluation. Three of the four studies reviewed were based on specific agency programs and were therefore small-scale, exploratory, nonrandom, retrospective, and without comparison groups, while the fourth explored overall placement restrictiveness, not specifically assessing the effectiveness of transitional apartments. Although helpful for program planning, the usefulness of these studies for assessing program effectiveness is highly restricted. As with the TFM, evaluation studies using large samples, multiple methods, some standardized measures, comparison groups, and sufficient follow-up are certainly warranted.

Independent Life Skills

Independent Life Skills (ILS) programs provide life skills training to older foster youth with the goal of promoting self-sufficiency and the successful transition to independent living. Typically, ILS programs serve adolescents ages 16 and older. ILS training can be provided as a separate community-based service or in conjunction with residential independent living programs. ILS trainings commonly focus on life skills, self care, employment readiness, and transitional support services (Casey Family Programs, 2001). These skill-building classes are often supplemented with mentoring, individual counseling, and educational assistance.

ILS effectiveness. In November 1999, the General Accounting Office (GAO) published a report entitled “Foster Care: Effectiveness of Independent Living Services Unknown,” which highlighted the fact that little has been done to determine program effectiveness of independent living skill-building interventions. The GAO identified only one national study that was completed at the time, and only a few states that were attempting to measure the usefulness of independent living services in assisting youth with successfully transitioning to adulthood. Thus, although the federal Independent Living Program was established in 1985, the evidence-base for independent living
skill-building interventions is relatively nascent; therefore the authors regard them as a "promising practice" (Level 3).

Cook's (1994) study of the National Evaluation of Title IV-E Independent Living Programs for Youth in Foster Care examined foster youth's post-discharge outcomes and the effects of receiving independent living skills training. A multistage, stratified design with probability sampling at each of three stages of selection was employed: state, county clusters, and youth 16 and older who were discharged from foster care. Comparing youth who had received no skills training to those who had received any type of skills training revealed no significant relationship between skill training and outcomes. However, when specific groups of skills were examined in combination, they produced positive effects in the overall ability to maintain a job, obtain health care, not be a cost to the community, overall satisfaction with life, and on the composite measure of self-sufficiency.

In a local ILS evaluation, Scannapieco et al. (1995) performed a case record analysis on 44 teens who had received independent living services, and 46 teens that did not receive such services in Baltimore, Maryland. Results showed that independent living programming was associated with self-sufficiency at time of discharge. Specifically, youth who received independent living services were more likely to complete high school, have an employment history and employment at discharge, and were more likely to be self-supporting at the time of case closure. Additionally, in their 1997 study of independent living services, McMillen, Rideout, Fisher, and Tucker (1997) used focus groups to explore what former foster youth living in the community thought of the independent living services they received while in care in Missouri. Results showed youth found skill classes, instruction in money-management, and stipends for independent living were helpful and that the training services reduced the youth's stigmatization and isolation of being in foster care. Results from the focus groups also showed that foster parents and specialized independent living workers helped ease the transition to independence, however regular public child welfare caseworkers were not useful in this capacity.

In another evaluation, Lindsey and Ahmed (1999) studied the North Carolina Independent Living Program, comparing outcomes for program participants and non-participants in housing, education, employment, and financial self-sufficiency one to three years after discharge from foster care. Independent living program participants were more likely to be living independently or paying all of their housing expenses while living with others and have higher educational attainment; however, no significant differences were found for employment or financial self-sufficiency.

In their recent study of the potentially beneficial role of independent living programs for foster youth, Lemon et al. (2005) used data from the larger Pathways to College study for comparative and ethnographic analyses. Program participants were more likely to be African American or Mexican
American/Latino, and while in foster care, they were more likely to be placed in nonrelative placements, have more out-of-home placements, and to have been taught independent living skills than non-program participants. Ethnographic analysis revealed that independent living services are normally delivered through an instructional model in which discrete and concrete skills considered associated with self-sufficiency are taught. Ethnographic analysis also made clear that program coordinators believe recent legislation has increased funding and flexibility in independent living services.

Last, another recent study also examined young adult perspectives regarding independent living services received while in foster care (Georgiades, 2005). Using a convenience sample, 358 youth between the ages of 18 and 21 who were eligible for independent living services during their stay in foster care in District 11, Florida were contacted by mailed letters. The final study sample consisted of 67 former foster youth, 49 of which had received independent living preparation while in foster care. Youth reported unhappiness with the financial pressures of adulthood and thought that independent living programs are best at preparing youth for educational advancement and worst at teaching parenting skills. Youth recommended improving independent living programs by having the counselors develop closer relationships with youth, strengthening curriculum on parenting and organizational skills, moderating the program eligibility requirements, and increasing the monthly independent living stipend.

Teen Permanency Initiatives

Within child welfare, an emerging adolescent and young adult permanency paradigm is driving changes in the philosophy and programmatic approaches to services for youth in OOHC. Although the Chafee Act doubled the funding and greatly expanded services to older foster youth, the legislation did little to address these youth’s permanency needs. As such, many youth’s service plans continue to lack a permanency focus. Even when the service plan goal is “independent living” or “long-term foster care,” permanency planning is still possible when it is reconceptualized as the cultivation of interdependence and relationships (Propp, Ortega, & NewHeart, 2003). Specifically, the authors believe permanency for older youth can best be understood as “a permanent connection with at least one committed adult who provides a safe, stable and secure parenting relationship, love, unconditional commitment, lifelong support, and a legal relationship if possible” (Frey et al., 2005, p. 3).

Increasingly local and state initiatives are working to incorporate this reconceptualization of permanency planning into their programs, policies, and philosophy toward working with adolescents in OOHC. The Annie E. Casey Foundation’s Family to Family Initiative identified several key themes to incorporate into permanency planning initiatives: (a) every child, no mat-
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ter how old, can achieve permanence and should have a case plan for permanence; (b) kinship families are an underused resource; and (c) older youth should be involved in their own permanency planning (2005). Despite this growing consensus, few projects have been implemented, or evaluated.

Illinois and New York City are examples of two jurisdictions that have started to reconceptualize permanency for older youth. In Illinois, the state initiated Performance Based Contracting which has led to a three-fold increase in the number of foster children who achieved permanency; although, the overall rates of permanency achievement for older foster youth were significantly lower. In 2003, New York City’s Administration for Children’s Services’ (ACS) mandated that Family-Based Concurrent Planning for Youth be put in place in an effort to find permanent, adult connections for youth at risk of aging out of foster care. Adoption of these guidelines represented “a culture shift aimed at ensuring that no youth ages out of foster care without a life-long connection that is as legally secure as possible to a caring adult committed to functioning in a parental capacity” (Bell, 2003, p. 1).

Another New York City initiative, the Longest Waiting Children Project, has also achieved significant success in helping many of the 100 of the longest staying children in New York City’s foster care system achieve permanence. The three-year project began in 2001 and used $900,000 in federal grant money in their efforts (Badeau, 2005). The program’s first step was to create and support permanency through team meetings centered on developing an adolescent’s individual permanency plan. These meetings included the adolescent and the adults that were important and significant in the adolescent’s life. Case workers spent significant amounts of time preparing for these meetings by identifying all sources and potential sources of support for each adolescent and worked to build a strong network related to the adolescent’s interests, talents, strengths, and needs (Badeau, 2005).

The Longest Waiting Children Project focuses on five key areas for broadening the current permanency framework. First, the program seeks to understand the barriers that prevent permanency from occurring and what is required to overcome them. The program then begins the brainstorming process by asking what new and previously used strategies may be beneficial. This exploration of all ideas and avenues has been successful in helping adolescents achieve permanency outcomes. After the brainstorming stage, the team develops a plan to concurrently pursue multiple placement strategies. Last, the adolescent is consistently involved in planning for his/her permanence. After attempting to join these 100 youth with enduring, lifelong adult connections through the project, 78 of these children achieved permanency—some not until they were more than 21-years-old.

Teen permanency effectiveness. The research base supporting teen permanency initiatives is limited; therefore the authors regard this type of teen permanency planning as a practice where the evidence is so scant that it fails to reach the level of promising practice and warrants a classification of “fails
to demonstrate effect” (Level 5). Whereas, this very new approach has not had a century to develop its evidence-base—as has GC—this rating reflects the urgent need to systemize methods and commence evaluations. This is certainly warranted because research on adolescent life course development and research in risk and resilience supports ensuring teens in OOHC have at least one permanent relationship with a caring adult. Youth leaving foster care are generally considered to be at some developmental risk (Collins, 2001). Abruptly being pushed into adult roles can result in negative long-term consequences (Chassin et al., 1992 as cited in Collins, 2001), as the timing that many youth in OOHC transition to adulthood is before their same age peers (Marini, Shin, & Raymond, 1989, as cited in Collins, 2001). Thus, when foster youth exit the child welfare system at age 18, they generally have few, if any, of the supports available to their counterparts in the general population.

The presence of at least one caring adult who offers social support and connectedness has been identified as a protective factor for youth across a variety of risk conditions (Fraser, Kirby, & Smokowski, 2004). Research suggests that youth living in high-risk environments that possess a supportive relationship with a nurturing adult increases their capacity for resilience even in the face of multiple adverse risks. Several key studies have demonstrated links between the presence of an important non-parental adult and better child outcomes (i.e., Garmezy, 1985; Rutter, 1987; Werner & Smith, 1982). One recent study showed that natural mentors play a positive role in adolescent development by being beneficial to at-risk youth for both problem and school attitude outcomes (Zimmerman, Bingenheimer, & Notaro, 2002). Similarly, the Big Brothers/Big Sisters program has been shown a significant positive effect on youth by reducing the likelihood of using illegal drugs or alcohol, hitting someone, or skipping school, and increasing youth’s confidence about their school work and ability to get along with their families (Grossman & Tierney, 1998). The risk and resilience perspective highlights that even when legal permanence is not an option, achieving emotional permanence can be beneficial for youth in OOHC.

IMPLEMENTATION

This review of services for youth in OOHC shows that knowledge of effective programs is still quite nascent. Therefore, implementation recommendations are cautious and give careful attention to the readiness of CWS to incorporate evidence-based practices (EBP). The developing nature of EBP for adolescents in OOHC certainly offers an opportunity to assess the most productive linkages between research and practice. CWS programs clearly need to move away from practice as usual to a framework emphasizing practices that demonstrate promise (Huang, Hepburn, & Espiritu, 2003; Thomlison, 2005).
MTFC appears to be an intervention with strong promise for child welfare. Through TFC Consultants, Inc. in Oregon, training and implementation supports to establish MTFC programs and to maintain fidelity to the treatment model are available. In most cases, new sites can be fully operational within a year from start-up of the implementation. Twelve agencies throughout the United States are now using the MTFC model, as well as one in Sweden and one in Norway. However, while MTFC demonstrates promise, additional research with child welfare populations and agencies is necessary to better understand the breadth of MTFC’s applicability to youth under child welfare supervision.

Similarly, as one of the best disseminated programs in child welfare history, TFM continues to be an intervention with strong promise for child welfare. Like TFC Consultants, Inc., the Teaching–Family Association (TFA) ensures the quality of care provided by professionals who actively pursue the goals of humane, effective, individualized treatment using the TFM for treatment and support. Program supports, including on-going treatment planning and implementation support, systematic evaluation, quality assurance, and supportive administration, made available by TFA are critical to TFM implementation. These supports are designated to enhance the existing strengths of the sponsor agency, and thus protect the fidelity of the model. The TFA certifies applicant organizations in the TFM model, and they become members by meeting the standards that reflect the basic elements of the TFM. However, while TFM also demonstrates promise with its series of well-controlled studies that suggest a positive benefit, there have not been multiple rigorous randomized trials that show child welfare outcomes.

Supervised Independent Living and ILS programs both have burgeoning research bases which show promise as a component of a comprehensive program assisting youth in OOHC. Yet, unlike MTFC and TFM, these approaches are challenged by their lack of a strong technical assistance or implementation base. Development of a research base for permanency planning and the expanded vision of what constitutes permanency will help us to better understand how these initiatives impact youth’s outcomes. Last, research on Small Group Home Care emphasizes that programs need to move away from its general use to more family-based care (like TFM) and that it be used for only short term treatment (Barth, 2005).

The challenge for CWS is to bridge the gap between what is known and what is practiced regarding effective interventions. Children’s mental health researchers have identified numerous cautions in implementing EBP which are equally pertinent to CWS. Huang and colleagues (2005) emphasize that even when promising interventions are available they cannot be applied uniformly. Emphasized in particular is the importance of prioritizing research in culturally diverse communities to help account for variations in a programs’ implementation based on the population and cultural context. Hoagwood
et al. (2001) caution that researchers must design studies to account for the continued discordance between research and practice. These authors propose a “front end” strategy focused on research in practice settings where the interventions will be implemented to help ensure the practice’s sustainability and practitioners’ commitment (Hoagwood et al., 2001). Caution is also warranted because what works in a controlled clinical setting can be expected to need modification when implemented in less supported and less funded practice settings (Barth et al., 2005).

In implementing EBP programs, reform is not possible without concurrent changes in funding structures and policies. Funding structures need to provide the upfront support for testing interventions in the communities where they will be based. If programs have multiple components, they need to be funded in full. Additionally, funding should be provided to jump start the use of promising programs with a developing evidence-base. Without such seed funding, alternatives to questionable or potentially harmful programs will not be realized. The current federal entitlement for CWS placements—virtually no matter how restrictive or long—acts as a disincentive to finding alternatives. GC is reimbursed at high rates under federal entitlement funding despite its expense and questionable overall benefit. In contrast, efforts to achieve lifetime connections for children must rely on foundations and demonstration support to achieve their far more lasting goals. Furthermore, although federal entitlement funding is also available to reimburse providers of MTFC, agencies that want to develop MTFC programs often lack funding to gain the mastery needed to implement the program with fidelity.

In summary, this review has taken a different approach than many prior reviews by being developmentally-focused rather than solely intervention-focused. This is a worthwhile approach that is too little used. That is, the authors first provided a conceptual framework that clarifies the developmental needs of the population, in this case adolescents in child welfare supervised OOHC. This offers a framework for assessing the evidence on the interventions that are available to address these common client needs. Finally, some guidance to readers regarding the availability of implementation assistance for the dissemination of these programs was offered. The field will have progressed when subsequent reviews can better articulate the needs of this population and review a broader set of studies on the efficacy of these interventions.

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