

INTERNATIONAL PERSPECTIVES ON FOSTER CARE

Treatment Family Foster Care: Its History and Current Role in the Foster Care Continuum

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ABSTRACT

This article reviews the historical development in the United States of treatment family foster care as an alternative to the psychiatric hospitalization or long-term residential treatment of children and youth with serious emotional and behavioral disorders. Treatment family foster care has developed in three discrete systems of care: juvenile justice, child welfare, and mental health. The authors examine the relative contribution of each of these systems to its development, its current role in the provision of services to children with emotional and behavioral challenges, and the evidence-base for this form of care.

Treatment family foster care¹ in the United States has evolved from three discrete traditions: (1) traditional foster care as provided in the child welfare system (Thomlison, 1991); (2) residential treatment of children and youth in the mental health system (Hudson, Nutter, & Galaway, 1994); and (3) as an alternative to incarceration in the juvenile justice system (Chamberlain & Moore, 1998). These three systems of providing care and services for at-risk children and youth share a common goal of protection and treatment, but historically have served populations with different needs. Foster care in the child welfare system is reserved for children whose primary need is for a safe and stable home environment. Residential treatment through the mental health system serves those who require thera-

peutic treatment in a highly structured and contained setting, commonly using interventions such as behavior modification, psychological services, and/or educational supports. The juvenile justice system provides secure congregate care for youthful offenders with serious externalizing behaviors. Its primary goal is to protect the community and to contain and punish the youthful offender.

While each of these systems has historically focused on meeting different aspects of children's needs, increasingly they share common concerns regarding the emotional and behavioral disturbances of the children and youth in their care. In the child welfare system, as a link began to be realized between the early life trauma of abuse and neglect and later problems in adjustment and functioning, the need for a more therapeutic level of foster family care was acknowledged. Although in the early years of the founding of the juvenile court much attention was paid to the psychological functioning of juvenile

¹ Although this form of foster care is variously referred to in the literature as treatment, therapeutic, or specialized foster care, treatment foster care is the term used in this discussion.

offenders, emphasis on incarceration and punishment took precedence as juvenile services evolved. Only in the last decade or two has there been a resurgence in recognition of the extensive mental health needs of delinquent youth with an accompanying search for therapeutic models of care, particularly for incarcerated youth ready for release back into their home communities. Finally, as managed care programs have increasingly restricted funding for in-patient psychiatric hospitalization as well as for long-term residential care of children and youth with severe emotional and behavior disturbances, the children's mental health system has also sought cost-effective community-based treatment alternatives for youth with special mental health needs.

Development of Treatment Family Foster Care

In the 1970s, as a result of the public policy and judicial push away from treatment in large congregate facilities and toward community-based care, agencies began experimenting with placing children who would have normally been served in some form of residential treatment into specially designed therapeutic foster care homes. These homes provided the stability of a home environment in combination with psychosocial treatment of the child, a combination that was designed to ameliorate emotional and behavioral disturbances. In some cases, psychiatric hospitals developed their own therapeutic foster homes (Bryant & Snodgrass, 1992), but in many other instances, voluntary child welfare agencies added this form of care to their array of foster care services. Often there was not much preparation for the level of demand that children with serious emotional and behavior disorders would place on foster families and communities.

During the mid-1980s, federal policy mandating a continuum of mental health services for children with serious emotional disorders resulted in increased reliance on treatment foster care as an alternative to institution-based care (Mikkelsen, Bereika, & McKenzie, 1993; Stroul & Friedman, 1986). As a result, treatment foster care programs proliferated across the United States and Canada (Hudson, Nutter, & Galaway, 1990; Snodgrass & Bryant, 1989). A North American organization of agencies providing treatment foster care, the Foster Family-Based Treatment Association (FFTA), was founded in 1989, with 100 agencies signing on as members. Its membership stands at about 430 agencies today. One of the roles of the FFTA was to establish a set of standards defining treatment family foster care.

The FFTA codified the following as essential elements of treatment family foster care (Hudson, et al., 1994; Chamberlain, 1994; Evans, Armstrong, Dollard, Kuppinger, Huz, & Wood, 1994; Meadowcroft, Thomlison, & Chamberlain, 1994):

1. Treatment foster care serves behaviorally challenged and/or severely emotionally disturbed children who would otherwise be placed in an institutional setting;
2. Treatment foster parents are trained specifically to meet the needs of challenging children;
3. Treatment foster parents are treated as full-fledged members of the treatment team;
4. Treatment foster parents are compensated at a higher rate than traditional foster parents;
5. Treatment families receive respite and support services in addition to compensation; and
6. Care is provided in a private home.

In addition to these program characteristics, treatment foster care programs generally include (Chamberlain, 2002; Galaway, Nutter, & Hudson, 1995; Meadowcroft et al., 1994):

1. Placement of one or, very rarely, two children per treatment foster family;
2. Twenty-four hour emergency coverage for the treatment family, if requested;
3. A small caseload for the case manager (the FFTA recommends no more than 12 children per worker);
4. Frequent meetings (most programs meet weekly) with all involved members of the treatment team.

Although the standards promulgated by FFTA were an effort to establish uniformity in the definition of treatment foster family care, there is currently a wide range of approaches to providing this form of foster care (Farmer, Burns, Dubs, & Thompson, 2002; James & Meezan, 2002; Reddy & Pfeiffer, 1997). To some extent the services offered in a particular treatment foster care program reflect the history of the provider agency. Agencies that began as providers of general or long-term foster care to maltreated children tend to stress the salutary effects of a stable family environment above provision of therapeutic services in their treatment foster care programs (Staff & Fein, 1995; Galaway, et al., 1995). These programs are more likely to serve youth with histories of severe maltreatment who exhibit challenging behavior, often from a very early age, who have experienced multiple out-of-home placements, and who have limited ties to their biological families. Prior to the public policy emphasis on permanency for children as represented by reunification with the biological family or placement in an adoptive home, these programs tended to view themselves as long-term alternatives to more restrictive forms of care such as residential treatment.

Galaway (1989) refers to this type of approach to treatment as normalized, emphasizing the development of social networks. According to this model, treatment foster parents need training and support to ensure that children with special needs experience normative family life. The emphasis is on the ameliorative power of family living rather than on creating a treatment milieu. Networking activities are used

to assist youth in developing informal social support systems and accessing formal services, such as mental health services, in the community (Galaway et al., 1995).

Periodic federal initiatives to fund alternatives to incarceration for juvenile offenders led to the development of treatment homes that generally provide a step down model for youth returning to the community from incarceration in a youth correctional facility. For these treatment foster homes, attention to behavior management and control is essential for the protection of the community in addition to helping the youth learn more appropriate self-management skills. These programs often have the most highly trained foster parents who are required to adhere to a well-specified model of operant conditioning. The beneficiary effects of the family milieu are less emphasized in such programs, as is attention to psychological change. These programs also tend to be short-term and to have as their goal the return of the youth to his or her biological family or other more normalized setting. The Oregon Social Learning Center model described later in this article is the best known example of this effort.

Treatment foster homes established by residential treatment centers in the mental health system are also often designed to step down children and youth to a less restrictive form of community-based care (Jensen, Hoagwood, & Petti, 1996), although increasingly they may also serve as an alternative to a more restrictive form of treatment such as psychiatric hospitalization. Like the treatment homes established in the juvenile justice system, they may employ a highly structured, behaviorally-oriented treatment model requiring a significant degree of training of foster parents and oversight by a treatment team. The child may attend a day hospital or partial hospital program during the day, or receive wraparound services to enable him or her to function in the home and community. These treatment foster homes are usually not seen as a permanent placement for a child, but as an interim placement from six months to two years that enables the child to adjust to family and community life through a gradual process with a high level of support (Farmer, Wagner, Burns, & Richards, 2003). In the past 10 years, as managed care has significantly reduced the time spent in residential facilities for many children with serious emotional disturbances, treatment foster care has increasingly come to be seen as an alternative to residential care rather than as an adjunct to it (Bryant & Snodgrass, 1992).

Program Models in Treatment Foster Care

Common Characteristics

As with most social interventions, treatment family foster care programs generally reflect a particular theoretical framework regarding human functioning and change. The theoretical frameworks most often seen in treatment foster care programs include cognitive/behavioral, social learning,

systems/ecological, family systems, or psychodynamic theories. Hudson's survey of treatment foster care programs in the early 1990s found that two-thirds reported training caregivers in a particular intervention approach, and most used behavioral techniques (Hudson, et al., 1994). Despite operating from a specific theoretical orientation, an important underlying component of every treatment foster care program is that the model has the capacity to individualize services to fit the needs of children and families.

Also despite theoretical differences, most treatment foster care programs offer multiple services, including behavior management and problem-solving training; special education; counseling; acquisition of independent-living skills; intensive case management; and individual, family, and group services for children and biological parents. Many respected treatment foster care programs empower children and families by involving all parties in decisions regarding a child's treatment planning, placements, transfers, and departure from care (Ruff, Blank, & Barnett, 1990; Redding, Fried, & Britner, 2000).

One difference between treatment and non-treatment foster care is the intensity and frequency of activities in which foster families participate. Treatment foster parents are carefully selected and trained to provide specialized care, and they receive additional support and assistance from professionals who carry limited case loads. Parents are viewed as members of the professional team and are reimbursed at higher rates than typical foster parents (James & Meezan, 2002).

Most youth in treatment foster care have been in other out-of-home settings prior to entering this form of care (Chamberlain, 1994; Farmer, et al., 2003). Treatment foster care seems to be effective in encouraging discharge to less-restrictive settings and may be effective in promoting community-based living after discharge (Chamberlain & Reid, 1998; Reddy & Pfeiffer, 1997; Farmer et al., 2003). In this way, it is a step-down placement for youth from more restrictive settings (Jensen et al., 1996; Farmer et al., 2003).

Clinical Models of Treatment Foster Care

While there is a well-articulated treatment family foster care program model promulgated by the FFTA, and certain features are generally common across programs (Redding et al., 2000), the clinical application of treatment foster care varies across agencies, particularly in the structure and intensity of services, population served (child welfare, mental health, juvenile justice), and staff and foster parent characteristics (Farmer, et al., 2002; Meadowcroft, Thomlison & Chamberlain, 1994). Moreover, within agencies implementation may vary across workers. Because of this variation, many agencies appear to have a difficult time articulating their clinical model or formalizing their approach to treatment foster care.

A brief telephone survey of FFTA member agencies, conducted by the second author in 2002, found that many

agencies could not clearly articulate their clinical model of treatment foster care, although, upon further exploration, most appeared to reflect the traditional treatment family foster care model described previously. Agencies' program models generally reflected FFTA standards and best practices. For example, the PATH program in Minnesota limits the number of children in treatment homes and licenses experienced and skilled foster parents who are given 30 training hours per year. A social worker visits the home twice a month and has ongoing contact with the foster family. Treatment foster children are in therapy with a clinician, and therapy support is given to foster parents for up to three hours per week.

Alternative Family Services and KidsPeace report similar program components, but programs do vary on caseload size, staff requirements, the number of children permitted in a home, hours of required training, frequency of contact with a social worker, and requirements of foster parents' 24-hour availability. The KidsPeace program in Pennsylvania, for example, uses Bachelor-level caseworkers (who have caseloads of eight to ten children and who make weekly home visits), and does not generally provide training specific to therapeutic foster parents. All agency foster parents partake in the same 6 hours of pre-service training, with 12 hours of in-service training the first year, decreasing to 6 hours per year by year four.

Some agencies in California (such as Seneca and Families First) use an intensive treatment foster care (ITFC) model, which is specifically designed for children who have come from institutional care, have multiple placement failures, or who would be placed in institutions without this intensive program. In ITFC, a social worker from the agency is placed in the home, usually for up to eight hours per day. These programs provide intense support to treatment families, who must receive 60 hours of pre-certification. The clinical social worker in this program carries a caseload of six to eight families, and there are two social workers and three support counselors per team.

Outcome Research on Treatment Foster Care

Research on outcomes for children in treatment foster care is currently quite limited in scope and scientific rigor. Few agencies in our informal telephone survey acknowledged collecting outcome data. Most outcome research to date has focused on discharge status (restrictiveness of subsequent placements), placement stability (number of disrupted placements and/or moves while in care), program completion, rates of institutionalization, and reentry into care following program discharge (Bryant & Snodgrass, 1992; James & Meezan, 2002), but it is not clear if these outcomes represent improved behavioral or social outcomes (James & Meezan, 2002; Reddy & Pfeiffer, 1997). While several studies have suggested improved behavior during placement, these improvements were not generally shown to be sustained post-discharge. In addition, no

studies have attempted to determine the threshold of behavioral problems appropriate for treatment family foster care (Curtis, Alexander, & Lunghofer, 2001).

It is difficult to rely on past studies of treatment foster care because very often the models of care being studied are not clearly specified. Data resulting from studies of treatment foster care are not meaningful without understanding the models being examined. Another limitation to current research is that control or comparison groups are seldom used. As a result, findings cannot indicate whether observed changes are due to the treatment foster care program or to other factors. When comparison groups are utilized, differences between groups are usually not accounted for. For example, children placed in treatment foster care are generally not comparable demographically or in their psychosocial functioning to those placed in regular family foster care or institutional settings—groups to which they are often compared—so comparisons in outcomes between these groups may not be appropriate. Courtney (1998), in fact, found that children placed in treatment foster care in the communities he studied were more often African-American, had a history of placement in residential settings, and had higher internalizing and externalizing behavior problems than children in regular foster or kinship care. In general, children in treatment foster care show more disturbance than the general foster care population, resembling children in more restrictive settings such as residential treatment in terms of their backgrounds and level of disturbance (Colton, 1990; Hudson et al., 1994; James & Meezan, 2002).

According to a review by Redding et al. (2000), children who appear to function best in treatment foster care are those who have had fewer prior foster home placements, institutional placements, and negative placement outcomes; fewer behavioral problems; good relationships with foster families; and some control over visits with birth families. A qualitative interview study of foster parents and caseworkers by Dore and Eisner (1993) found child-related factors associated with positive treatment foster care outcomes to include the ability to tolerate intimacy, low impulsivity, ability to recognize and manage fear of rejection, lack of interpersonal aggression, and average or above-average self-esteem. Successful outcomes of treatment foster family care also have been associated with authoritative, sensitive parenting; higher levels of social, emotional, and informational support; and well-defined treatment and service delivery models. Treatment foster care has been found to work best when (a) all parties feel supported and have a voice (Jivanjee & Parnet, 1999); (b) there is a clear service plan and supportive resources to ensure stable placements as well as clear conditions for returning the child to the biological family (Staff & Fein, 1995); (c) there is a good fit between foster child and family (Green, Braley, & Kisor, 1996); and (d) there is sufficient training and preparation of foster parents (Wells &

D'Angelo, 1994; Redding et al., 2000). However, the scientific rigor of most of these studies is questionable, so these findings are not definitive.

Behavioral/Social Outcomes

Findings regarding the behavioral and social outcomes for youth who have experienced treatment foster care are mixed. A review by Bates, English, and Kouidou-Giles (1997) indicated that treatment foster care and group care do not differ in their abilities to improve behavior. Similarly, when Colton (1988, 1990) compared treatment foster care to institutional care, he found no statistically significant differences in behavior among youth who had participated in the two forms of care.

In contrast, Reddy and Pfeiffer's survey of the literature on treatment foster care outcomes (1997) found that no studies showed negative outcomes, some showed positive outcomes, and others indicated equivocal findings. The largest effects were found in improvements in children's social skills and placement stability. Medium effects were found in reduced behavioral problems, decreased post-treatment foster care placement restrictiveness, and increased psychological adjustment at discharge. Unfortunately, no studies cited in Reddy and Pfeiffer's review provided follow-up data regarding behavioral problems, psychological adjustment, or social skills, and it is unclear if these studies were comparing treatment foster care outcomes to institutional care or regular foster care.

One older study (Bogart, 1988) examined an experiment that used semi-randomized assignment to treatment and regular foster care programs through a community mental health center in Memphis. Compared to the treatment foster care program, the regular foster care program in this agency had fewer restrictions placed on the number of children in the home, as well as fewer educational and training requirements of foster parents. When children in these two types of care were compared, those in regular foster care had poorer behavioral outcomes (as measured by three standardized instruments: Child Behavior Checklist (CBCL), the Vineland Adaptive Behavior Scales, and the Level of Care Survey Instrument) after six months in care than those placed in treatment foster care. Clark, Prange, Lee, Boyd, McDonald, and Stewart (1994) found that a group of children receiving the following treatment foster care services had better behavioral and social functioning than a comparison group receiving standard family foster care: a case manager to coordinate services, the use of family-centered clinical casework, home-based counseling, collaboration with children's caseworker, and intensive facilitation of services for others connected to a child.

Chamberlain (1990) compared treatment foster care programs that relied on adults to provide supervision and discipline with the peer culture model and found that treatment foster care resulted in greater time spent with a supervising adult and more consistent discipline, which

led to greater improvements in child functioning. However, Evans and her colleagues (1994) found that a child's biological parents could care as effectively as treatment parents when sufficient support was provided. It is unclear at this time whether treatment foster care improves social competence and problem solving skills (Chamberlain & Reid, 1991), self-concept (Evans et al., 1994), or intellectual functioning (Rubenstein, Armentrout, Levin, & Herald, 1978).

Conditions at Discharge

Literature reviews by Bates et al. (1997) and Reddy and Pfeiffer (1997) have indicated that, compared to institutional care, treatment foster care improves children's ability to be maintained in less-restrictive environments and achieve permanency at discharge. Fanshel, Finch, and Grundy (1990) reported that 55% of the children in their study left treatment foster care through emancipation at age 17, and Thomlison's work (1991) suggested that 10%–34% return to their biological parents after leaving treatment foster care. Overall, studies indicate that 60%–80% of youth are discharged to settings that are less restrictive than treatment foster care (Chamberlain, 1990; Colton, 1990; Farmer et al., 2003; Hawkins, Meadowcroft, Trout, & Luster, 1985; Hudson et al., 1990; Jones, 1990; Meadowcroft et al., 1994; Stroul, 1989; Thomlison, 1992; Timbers, 1990).

Some studies have found differences in outcomes between treatment foster care and other programs sustained over time. This research indicates that by at least seven months post discharge, children served in treatment foster care programs were more likely than those from residential treatment settings to be living in minimally restrictive settings (Hawkins, Almeida, & Samet, et al., 1989; Chamberlain, 1990; Fanshel et al., 1990; Meadowcroft et al., 1994). It is unclear, however, if these children were comparable on other measures.

In contrast, a 1995 study by Gallaway, Nutter, and Hudson found no meaningful association between program characteristics and type of discharge (planned/unplanned) or restrictiveness of post-discharge living arrangement. Differences were found only between extremes, with planned discharge more likely to occur from a high-cost, low-caseload program than from a low-cost, high-caseload program.

Multidimensional Treatment Foster Care

One approach that has been shown to be an effective treatment family foster care model is the multidimensional treatment foster care (MTFC) model, developed by Chamberlain and her colleagues in the early 1990s as an alternative to residential placement for serious juvenile offenders. MTFC is one of the few mental health interventions for children and youth that has been accorded the imprimatur "evidence-based treatment" (Hoagwood, Burns, Kiser, Ringeisen &

Schoenwald, 2001) based on criteria established by the Task Force on Psychological Intervention Guidelines of the American Psychological Association in 1995 (Chambless & Hollon, 1998). One theory behind the development of MTFC is that group settings such as detention facilities and juvenile training schools actually increase antisocial or delinquent behavior by reinforcing negative behaviors (Fisher & Chamberlain, 2000).

The MTFC model uses parents as the primary treatment agent, with the youth's own biological family helping to shape treatment plans and participate in family therapy and home visits (Chamberlain, 1990, 1994; Chamberlain & Mihalic, 1998; Fisher & Chamberlain, 2000). Parents are believed to have the ability to reinforce their child's behavior in both positive and negative ways, positively by minimizing access to other delinquent adolescents and negatively by ignoring or failing to confront their child's association with antisocial peers. This model trains foster parents to provide corrective or therapeutic parenting for antisocial adolescents. It draws on social learning theory and cognitive-behavioral approaches so that treatment parents are taught how to provide the youth in their care with clear and consistent limits and expectations and how to reinforce positive youth behavior.

As in other behaviorally-based treatments, the MTFC model uses the point-and-level system. Youth earn points for positive behaviors such as getting up on time, attending school regularly, behaving appropriately in the classroom and at home, following directions, and having a good attitude. Treatment foster parents exchange points for privileges that increase as the youth advances in the program (Chamberlain & Smith, 2003). Privileges are removed for violations of clearly established rules and for misbehavior. If necessary, a youth can be returned briefly to a detention facility if he or she becomes violent, aggressive, or a danger to self or others.

In order to implement this highly prescribed form of treatment, MTFC foster parents receive 20 hours of pre-service training, as well as close ongoing support and supervision. Foster parents are contacted by program staff daily by telephone and data are collected on a youth's behavior over the previous 24 hours, using the Parent Daily Report (PDR) Checklist (Chamberlain & Smith, 2003). At that time, problems are also discussed and plans are reviewed with the case manager. They attend weekly support meetings with program staff and other foster parents. There is also weekly family therapy and parent training for the biological parents, individual treatment for the youth, and weekly supervision for the foster parents (Chamberlain & Mihalic, 1998).

This model utilizes a treatment team as well, which is comprised of therapists, psychiatrists, case managers, and daily callers (Chamberlain, 1998). Individualized daily programs are developed for each participant in MTFC, specifying a schedule of activities and behavioral expectations. The

PDR on each child is reviewed by a program supervisor daily and treatment plans are adjusted accordingly. There are three levels of supervision and a child must earn the right to move to a less-restrictive level (Chamberlain, 1998).

Caseloads are small (10 to 12) in this model and although MTFC is expensive, it has been shown to save \$5,815 per year per child because of criminal justice costs and an additional \$11,760 through reduced crime victims' costs (Fisher & Chamberlain, 2000). Further, the effectiveness of this model has been rigorously studied in several randomized trials. In one randomized study in which youth were assigned to MTFC or group care, those in MTFC had significantly fewer arrests, fewer self-reported delinquent activities, less frequent runaways and less time spent in incarceration than youth in group care (Chamberlain & Reid, 1998).

Although MTFC was initially developed for adolescents in the juvenile justice system, it has been modified for, and piloted among, children in the foster care system. Early intervention treatment foster care (EITC) serves children aged 3 to 7 with serious emotional disturbances who have been removed from their birth families by the state (Fisher, Gunnar, Chamberlain, & Reid, 2000). The behavioral management techniques have been modified from the original MTFC program to be more developmentally appropriate for this age group. While most service delivery occurs in the treatment foster home, all participants attend a weekly play group to learn social skills (Fisher et al., 2000).

When compared to children who were placed in regular foster care or who remained with their biological parents, children in the EITC program had better outcomes. Regular foster parents had lower parenting scores than the other two groups and behavioral problems among children in regular foster care increased more than those in the other types of care. Further, children in EITC exhibited changes in stress hormone levels similar to non-maltreated children, whereas hormone levels of children in regular foster care remained consistent with those of children currently experiencing extreme stress or maltreatment (Fisher et al., 2000).

This model has also been shown to have low disruption rates, compared to other treatment foster care programs. The likelihood of disruption in EITC was found to be twice as high in the first six months (17.8%) than the second six months (9.2%), with older girls at the highest risk for disruption. Other studies have shown the disruption rate in other treatment foster care programs to range from 38% to 70% (Berrick, Needell, Barth, & Jonson-Reid, 1998; Staff and Fein, 1995; Stone & Stone, 1983; Smith, Stormshak, Chamberlain, & Whaley, 2001).

Conclusion

Despite the generally agreed-upon program components of treatment foster care established by the Foster Family-Based Treatment Association, very little is known about its

effectiveness. A well-specified model such as that of multi-dimensional treatment foster care is essential to increase consistency across workers and situations and reduce the ambiguities that can lead to poor results in terms of child functioning, safety, and stability. It is important that a program have a well-defined clinical and program model, and a set of procedures consistent with its underlying theoretical base, along with measurable goals and methods for evaluation and improvement (Redding et al., 2000).

Even when well-specified models do exist, treatment foster care programs have not clearly documented how such models are being applied in the field. Without the ability to describe actual practice, it is not possible to evaluate a treatment foster care model's effectiveness. Further, past research has not consistently utilized control—or at the very least, comparison groups—without which outcomes cannot be attributed to the effectiveness of a program. When comparison groups have been used, descriptions of those groups and the interventions they have received have been insufficient, again limiting the usefulness of these analyses.

Nevertheless, past research has indicated that treatment foster care may be effective at stabilizing children and reducing the restrictiveness of post-treatment placements, particularly as compared to institutional care. Data on the behavioral or social effects of treatment foster care have been less clear when comparing this model to both regular foster care and institutional care. One exception to this ambiguity has been information that has come from the rigorous research that has been done on MTFC and EITC. This work shows positive outcomes from one highly intensive treatment family foster care model and can serve as a touchstone for future effectiveness research on other models of treatment foster care, an essential element of the system of care in children's mental health services (Pumariega, Winters, & Huffine, 2003).

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Author's note. The authors wish to thank Casey Family Services, Inc., for supporting the research for this article.

Manuscript received: August 28, 2005

Revised: July 21, 2006

Accepted: July 25, 2006