

Achieving Placement Stability

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Placement stability as an outcome goal in child welfare performance measurement is grounded in the importance of providing stability for children as they are developing attachments and relationships to caregivers. Research shows that many children are vulnerable to placement instability, especially those who have been in long term foster care. This literature review provides an overview of the federal placement stability measure. It then summarizes the diverse set of factors has been found to be associated with placement instability, including characteristics of the child and family of origin, placement type and quality, and the child welfare system and services. Promising practices aimed at promoting placement stability are summarized, followed by questions designed to foster discussion about the relationship of the evidence to child welfare practice.

Keywords: Child welfare, placement stability, outcome, policy

INTRODUCTION TO PLACEMENT STABILITY

Placement stability as an outcome goal in child welfare performance measurement is grounded in the importance of providing stability for children as they are developing attachments and relationships to caregivers (UC Davis Extension Center for Human Services, 2008). This is a key concept in child welfare because of the research showing that placement stability is linked to a number of positive outcomes for children, including fewer school transitions, decreased stress, and fewer behavioral, mental health, and academic achievement problems associated with changing placements (UC Davis Extension Center for Human Services, 2008). Conversely, placement instability (characterized by a greater number of placements) is associated with an increased prevalence of attachment disorders and behavior problems; these factors, in turn, have a negative influence on the success of future placements, leading to even further risk of instability (Strijker, Knorth, & Knot-Dickscheit, 2008). Multiple placement changes can exacerbate existing problem behaviors in children and lead to behavior problems in children who did not previously exhibit these behaviors (Newton, Litrownik, & Landsverk, 2000; Rubin, O'Reilly, Luan, & Localio, 2007). Research shows that many children are vulnerable to placement instability, especially those who have been in long-term foster care (Webster, Barth, & Needell, 2000).

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COMPOSITE MEASURE OF PLACEMENT STABILITY

Because of the demonstrated importance of placement stability to foster child well-being and permanency, the federal Children and Families Service Review (CFSR) includes a composite measure for placement stability. The placement stability composite is the fourth of four measures under the outcome goal of permanency. Like the other measures under the permanency goal (reunification, adoption timeliness, and exits from long term care), the placement stability composite contains multiple individual indicators that are weighted and aggregated to form a single scaled score for the overall measure of stability. Unlike the other three permanency composites, however, the placement stability measure does not have multiple conceptual components; the three individual indicators capture placement stability for subgroups of children with varying lengths of stay in care, defined as follows:

- **C4.1:** Of all children who were served in foster care during the 12-month target period, and who were in foster care *for at least 8 days but less than 12 months*, what percent had *two or fewer placement settings*?
- **C4.2:** Of all children who were served in foster care during the 12-month target period, and who were in foster care *for at least 12 months but less than 24 months*, what percent had *two or fewer placement settings*?
- **C4.3:** Of all children who were served in foster care during the 12-month target period, and who were in foster care *for at least 24 months*, what percent had *two or fewer placement settings*?

In contrast to the other composite measures under the permanency outcome goal, the individual indicators comprising the placement stability measure are assigned roughly the same weights in the calculation of the composite score as follows:

- C4.1 comprises 33% of the total placement stability composite.
- C4.2 comprises 34% of the total placement stability composite.
- C4.3 comprises 33% of the total placement stability composite.

There are some important features of this measure that should be noted in order to understand how the measure is defined. First, as reflected in the individual data indicators that make up the composite, the national standard expects that children have two or fewer placements, regardless of their length of stay in foster care. This aspect has been criticized by many child welfare stakeholders for not being a realistic goal for all children, especially older children, those who have been in foster care long term, or those who might experience placement changes for positive reasons (e.g., moving to a foster home closer to the child's birth family; U.S. DHHS-ACF, 2007). The ACF has responded to these criticisms by reinforcing the necessity of ensuring placement stability for all children regardless of age or length of time in care; the ACF also notes that the evaluation and scoring for this measure does not require 100% compliance with the expectation of two or fewer placements (U.S. DHHS-ACF, 2007).

In addition, placement stability is measured with reference to a single tenure in foster care, despite the fact that children may have several stays in care due to recurrence of maltreatment and other circumstances (U.S. DHHS, 2005). It is also important to note that the CFPSR definition of placements encompassed by this measure does not include temporary stays in hospitals, camps, respite care, or institutional placements (U.S. DHHS, 2005). Like the reunification composite, the placement stability composite also excludes children in foster care for less than eight days, as it is believed that children in very short term foster care reflect a different constellation of needs and experiences compared to those in foster care for longer periods (U.S. DHHS-ACF, 2007).

In the following sections we provide an overview of the factors associated with placement instability and summarize information about promising practices that are used by child welfare agencies to promote placement stability.

FACTORS ASSOCIATED WITH PLACEMENT STABILITY

A diverse set of factors has been found to be associated with placement instability, including characteristics of the child and family of origin, placement type and quality, and the child welfare system and services.

Child and Family of Origin Characteristics

Individual child characteristics. In several studies researchers have focused on the age of the children, gender, race, and behavioral problems. Focusing first on gender, there is mixed evidence regarding whether males or females are at greater risk for instability. While a recent review summarizing research on placement stability concluded that females are at greater risk for instability (UC Davis Extension Center for Human Services, 2008), at least one study has found that males are at greater risk for instability (Webster et al., 2000). Considering age, children who are older are at greater risk for placement moves than infants are (Pardeck, 1984; Webster et al., 2000). Similarly, there is some evidence that White adolescents have increased instability (Pardeck, 1984; Webster et al., 2000). Finally, children have an increased risk of placement moves when there is a health or mental health diagnosis (Eggertsen, 2008), delinquency (Eggertsen, 2008) or other behavioral problems (Gilbertson & Barber, 2003; Newton et al., 2000; Strijker et al., 2008).

Family of origin characteristics. Researchers examining types of abuse have found that children who are removed due to sexual abuse and physical abuse in their family of origin are at greater risk for placement moves in foster care than children who enter foster care due to neglect (Webster et al., 2000). Children whose birth parents did not have mental health problems were stabilized in their placements earlier than others, possibly because they entered care with fewer problems (Rubin et al., 2007). Finally, children who have siblings in foster care have been shown to be at greater risk for changing foster care placements (Osterling, D'Andrade & Hines, 2009).

Characteristics of Placement

A more substantial body of research has identified particular placement characteristics that may contribute to either multiple placement moves or stability. Researchers in this area have focused on: (1) the role of foster parents, (2) kin versus non-kin placements, (3) the number of child welfare referrals, and (4) the number and timing of previous placement moves.

Role of foster parents. Children placed in foster homes with emotionally involved and stable foster parents have been found to experience greater placement stability (Walsh & Walsh, 1990). Children in homes where foster parents are supported, prepared, and trained to cope with special needs children also experience increased stability (Redding, Fried, & Britner, 2000). In addition, the effective matching of foster families with foster children in terms of child temperament, parent temperament, and parental expectations has been linked to stability (Redding et al., 2000).

Kin versus non-kin placements. Kinship care may be defined as any living arrangement in which a child is placed in the care of an adult to whom they are related other than their parents of origin; some states include adults other than blood relatives in their definition of “kin,” including: godparents, family friends, or anyone else with a strong emotional tie with the child (Geen, 2004). The living arrangement might be privately arranged or publicly initiated as a result of involvement from the child welfare system (Geen, 2004).

The stability of kin and non-kin placements have received significant attention from researchers. In one study researchers found that children in non-kin placements experienced increased risk for placement moves when first placed out of the home, and overall, experienced more placement moves than those in kinship care (Webster et al., 2000). In contrast, other researchers have found that the increased level of placement stability for those initially placed with kin dissipates for children in care for longer than one year (Testa, 2008).

In addition, a number of researchers have found that being placed in kinship care is associated with longer stays in care (Benedict & White, 1991; Berrick, Barth, & Needell, 1994; Courtney & Park, 1996; Smith, Rudolph & Swords, 2002; Vogel, 1999; Wulczyn & Goerge, 1992), and longer stays in foster care have been associated with increased placement instability (Webster et al., 2000).

Investigation into reasons why children placed with kin remained in care longer revealed that while kinship care providers were less likely to adopt the child in their care, they often reported being willing to care for the child until they were “of age” and since they were already family to the child, felt it was similar to adoption (Berrick et al., 1994). Extrapolating from these findings, kinship care appears to provide increased stability for children who are initially placed with kin, provided they achieve permanency quickly. Strategies to quickly move kin placements toward permanent placements may increase the likelihood of prolonged stability for these children.

Finally, a child’s personal experiences within the child welfare system have shown to be associated with placement stability. Children with a history of sibling placements who are then placed alone often experience an increase in the number of placement moves (Leathers, 2005). Children without prior child welfare involvement have been shown to be more likely to experience stability early in their care (Rubin et al., 2007). In addition, moving children more than once during their first year in care is associated with increased instability later in care (Webster et al., 2000).

System Factors

Factors in the broader child welfare system have also been studied in terms of their relationship to placement stability. In one study researchers found that 70% of placement moves resulted from system or policy mandates (e.g., moves to short or long-term facilities, relative/sibling placements, or funding problems) rather than being based on the needs of the child (James, 2004). Caseworker turnover has also been linked to placement instability (Pardeck, 1984; Ryan, Garnier, Zyphur, & Zhai, 2006). Factors associated with high turnover include lack of supervisory support, low salary, high caseloads, administrative burdens, and low levels of training (General Accounting Office, 2003 as cited in Ryan, Garnier, Zyphur, & Zhai, 2006).

In contrast, factors promoting placement stability include the provision of subsidies for guardianship and adoption placements (Berry & Barth, 1990; Testa, 2002) and the use of caseworkers with graduate-level training (Ryan et al., 2006).

PROMISING PRACTICES FOR ACHIEVING PLACEMENT STABILITY

As child welfare agencies implement practices to improve performance on the placement stability outcome measure, a common strategy is to target risk factors associated with poor outcomes

(Osterling, D'Andrade, & Hines, 2009). By eliminating or mitigating risk factors (e.g., inadequate foster parent training or behavioral problems on the part of the child) it may be possible to improve stability. However, the research evidence does not conclusively identify one particular strategy or set of strategies that improve placement stability. A lack of evidence does not necessarily mean that the practice does not have an impact on placement stability or other outcomes, but rather that potential impact cannot be determined with the evidence available. Some of the practices and research discussed here are also reviewed at length in the following resources:

- UC Davis Extension Center for Human Services (2008). A literature review of placement stability in child welfare services: Issues, concerns, outcomes and future directions.
- University of Kansas training modules at <http://www.rom.ku.edu>
- Osterling, K. L., D'Andrade, A., and Hines, A. (2009). *Child Welfare Outcomes in California: Improving performance on foster care reentry and placement stability.*

Multidimensional Treatment Foster Care and Early Intervention Foster Care

Multidimensional treatment foster care (MTFC) is a practice model based on social learning theory, originally developed in 1983 in Oregon to treat serious and chronic juvenile offenders (TFC Consultants, Inc., 2009). Since then, the model has been adapted in numerous ways to treat populations with various needs and characteristics including: adolescents, preschoolers, children and youth with mental health issues, children and youth in foster care, and female- or male-specific needs. Specifically, MTFC is a multi-faceted therapeutic intervention that is designed to simultaneously decrease problem behaviors while increasing appropriate normative and positive social behavior in children and adolescents (TFC Consultants, Inc., 2009). MTFC is used especially with children and youth who are in need of out-of-home care, including juvenile justice, foster care, and mental health settings.

Key program elements of MTFC include:

- Close supervision,
- Fair and consistent boundaries,
- Predictable consequences for behavior,
- Supportive adult mentoring relationship(s), and
- Reduced exposure to peers with similar behavior problems.

Clinical and treatment components involve:

- Behavioral parent training and support for MTFC foster parents,
- Family therapy or other aftercare resources for biological parents,
- Skills training for youth,
- School-based intervention and support, and
- Psychiatric consultation and medication management as needed.

There are three identified versions of the model including: MTFC-A (for adolescents), MTFC-C (for middle-school aged children), and MTFC-P (for preschoolers; TFC Consultants, Inc., 2009). The different models are similar in treatment components and implementation, but are tailored to address key developmental and socio-emotional needs of the particular age groups. MTFC-P may also be referred to as the Early Intervention Foster Care program (EIFC; Fisher, Burraston, & Pears, 2005).

Effectiveness. MTFC has been repeatedly evaluated, including the use of randomized clinical trials (RCTs), producing compelling evidence supporting the effectiveness and utility of the model with different populations (Chamberlain, 2003; TFC Consultants, Inc., 2009). MTFC has been shown to decrease placement disruption in the second 6 months of the program (Smith, Stormshak, Chamberlain, & Bridges Whaley, 2001). This result may be achieved because MTFC serves youth with delinquency and emotional and behavioral problems (Chamberlain, 2003), factors that are associated with placement instability. In addition, children with mental health diagnoses (an important risk factor for placement instability) maintained better in the community once they left a hospital setting than those involved in traditional care (Chamberlain & Reid, 1991). MTFC has also been shown to decrease criminal referrals for youth involved in the program (Chamberlain & Reid, 1998), and prevent delinquency in girls (Chamberlain, Leve, & DeGarmo, 2007).

Two evaluations in which researchers compared child welfare outcomes for pre-school age children in foster care who received MTFC-P with children who received traditional foster care services found that MTFC-P had a positive impact (Fisher et al., 2005; Fisher, Kim, & Pears, 2009). One study focused on successful permanent placement rates (Fisher et al., 2009) while the other examined failed placement rates and moves (Fisher et al., 2005). The favorable findings in these studies indicated that children who received MTFC-P had a significantly higher number of successful placements and a significantly lower number of placement moves.

Implementation. TFC Consultants, Inc. (2009) provides comprehensive consultation, training, and support services for implementing MTFC. In order to start a 10-bed program the following staff resources are often necessary:

- 1 full-time program supervisor,
- 1 half-time individual therapist,
- 1 half-time family therapist,
- Half-time skills trainer(s),
- 1.75 FTE foster parent recruiter, trainer, and PDR caller,
- 1 foster family for each placement, and
- Psychiatric services on an hourly fee basis.

The full start-up process takes approximately one year and begins with a site visit from TFC Consultants, Inc. to describe MTFC, identify possible staff and participants, and develop an implementation plan and timeline. This is followed with a four-day staff training session at the model site in Oregon. Participating foster parents attend a two-day training session at the site where the program is being implemented. On-going consultation and support are provided as well. For more information, contact TFC Consultants, Inc., <http://www.mtfc.com/index.html>.

Keeping Foster and Kin Parents Supported and Trained

Keeping Foster and Kin Parents Supported and Trained (KEEP) is a program based on MTFC that aims to train foster caregivers to cope with challenging behavioral problems that foster children may exhibit (California Evidence-Based Clearinghouse, 2009b). The program emphasizes the active role of caregivers in shaping the child's behavior and is designed to give caregivers tools to assist children to decrease problem behaviors by setting appropriate limits and encouraging positive behaviors. The essential activities of KEEP include the following (California Evidence-Based Clearinghouse, 2009b):

- Foster/kinship family attends weekly parent support and training group sessions.
- Foster/kinship family groups are conducted by a trained facilitator and co-facilitator.

- Foster/kinship family receives supervision in behavior management methods.
- Foster/kinship family group sessions are structured so that the curriculum content is integrated into group discussions.
- Foster/kinship family receives weekly Parent Daily Report Checklist calls by either the facilitator or co-facilitator to trouble shoot problems the foster parent was having in implementing the assignment, and to collect data on the child's problem behaviors during the past day.
- If foster/kinship family misses a parent-training session, the material from the missed session is delivered during a home visit at a time convenient for the foster parent.

These activities are completed over a 16-week period, with in-person sessions lasting 90 minutes and one 10 minute phone call per week (California Evidence-Based Clearinghouse, 2009b).

Effectiveness. An early study of the efficacy of KEEP found that the program decreased child behavior problems and placement changes (Chamberlain, Moreland, & Reid, 1992). Subsequent studies also confirmed these results, finding that the program decreased behavior problems (Chamberlain et al., 2008) and increased stability (Price et al., 2008).

Implementation. The program requires a video camera to record sessions, a television to view instructional tapes, and use of agency space to conduct sessions. The official training for caseworkers lasts 5 days, followed by weekly telephone supervision for 12 months. Once a staff member is trained, they can train other staff at the agency (California Evidence-Based Clearinghouse, 2009b). Additional information is available from: Patricia Chamberlain, PhD, Oregon Social Learning Center, pattic@osl.org.

The Incredible Years

The Incredible Years is a program providing child, parent, and teacher training designed to prevent and reduce conduct and behavior problems in young children, increase emotional and social competence, and promote positive parenting practices. While the program does not directly attempt to increase placement stability, it aims to prevent factors that may contribute to instability. The Incredible Years is used primarily in outpatient clinics, community agencies, and schools (California Evidence-Based Clearinghouse, 2009a). Incredible Years parenting programs focus on improving parenting skills and increasing school involvement for parents of children ages 0–12 (The Incredible Years, 2009). Training occurs in a series of weekly two-hour sessions (9–20 sessions, depending on the program). The BASIC program contains a home visiting component for parents mandated to enroll in the program due to child abuse or neglect (The Incredible Years, 2009). The California Evidence-Based Clearinghouse (2009a) provides the following description of competencies for the parent components:

The Incredible Years BASIC Parent Training Program:

- How to build strong relationships with children through child-directed play interactions
- How to be a social, emotional and academic coach for children
- How to provide praise and incentives to build social and academic competency
- How to set limits and establish household rules
- How to handle misbehavior

The Incredible Years ADVANCE Parent Training Program:

- How to handle stress, anger and depression management issues

- How to problem solve between adults
- How to help children learn to problem solve
- How to provide and receive support

The child training components include guides for facilitating small group therapy and for teachers in the classroom seeking to “strengthen children’s emotional, social, and academic competencies” (The Incredible Years, 2009: <http://www.incredibleyears.com/program/child.asp>). Small group therapy is conducted in two hour sessions over the course of 20–22 weeks. Program materials include a therapist manual, DVDs, workbooks for home activities, problem solving books, and case vignettes (The Incredible Years, 2009). Facilitators may also purchase extra program materials (e.g., puppets and magnets; The Incredible Years, 2009). Ideally, the therapeutic version is facilitated in conjunction with the parent component. The California Evidence-Based Clearinghouse (2009a) provides the following description of the competencies for the child components (The Incredible Years, 2009):

Emotion Management:

- How to talk about feelings
- How to understand and detect feelings in others
- How to self-regulate and manage upsetting feelings

Social Skills:

- How to talk to and make friends
- How to work in teams
- How to cooperate and help others
- How to effectively communicate
- How to follow rules
- How to play with others and enter groups

Classroom Behavior:

- How to listen
- How to follow school rules
- How to stop-look-think-check

Problem Solving:

- How to deal with anger
- How to solve problems step-by-step
- How to be friendly

Effectiveness. The Incredible Years program is one of the few child welfare interventions evaluated in multiple randomized control trials (Baydar, Reid, & Stratton-Webster, 2003; Reid, Webster-Stratton, & Baydar, 2004; Reid, Webster-Stratton, & Beauchaine, 2001; Webster-Stratton, Reid, & Hammond, 2001, 2004). It has been found to improve positive parenting and decrease child conduct problems at home and school (Baydar, Reid, & Stratton-Webster, 2003; Webster-Stratton, Reid, & Hammond 2001, 2004). Effectiveness has been shown to: (1) increase as program engagement increases (Baydar, Reid, & Stratton-Webster, 2003; Reid, Webster-Stratton, & Baydar, 2004), and (2) hold for one year after the intervention both in an ethnically diverse sample (Webster-Stratton & Beauchaine, 2001) and in low-income families (Reid, Webster-Stratton, & Baydar, 2004).

Implementation. The Incredible Years can range in cost from \$1,300 for the school age parent training program to \$4,795 for the entire program package (Baby/Toddler + Preschool Basic + Advance + School Age Programs). Although the Incredible Years recommends that group leaders get certified, it is not required; however, an agency must purchase the program materials. For more information, contact Lisa St. George, Administrative Director at incredibleyears@incredibleyears.com.

Parent Child Interaction Therapy

Parent Child Interaction Therapy (PCIT) is a parent training program based on attachment and social learning theory (Herschell, Calzada, Eyberg, & McNeil, 2002; Chaffin et al., 2004). It is designed for families who experience problems with young children (2–6 years old) exhibiting emotional and behavioral problems (Herschell et al., 2002). PCIT aims to teach parents “specific skills to establish a nurturing and secure relationship with their child while increasing their child’s prosocial behavior and decreasing negative behavior” (PCIT.org), impart skills in effective non-violent discipline with their children, and improve parent–child interactions (Chaffin et al., 2004). PCIT provides a manual that guides coaches in the training of individual parent–child dyads (Herschell et al., 2002). Although most families complete PCIT in 10–16 one-hour weekly sessions, PCIT is assessment driven and therefore has no predetermined time limit (Herschell et al., 2002).

PCIT takes place in two successive phases: (1) Child-Directed Interaction (CDI) and (2) Parent-Directed Interaction (PDI). When playing with their child during the CDI phase, parents are taught to frequently use the PRIDE skills (Praise, Reflection, Imitation, Descriptions, and Enthusiasm) and to avoid questions, commands, and criticism (Herschell et al., 2002). Children choose their own toy and parents must follow their child’s lead. Parents are continuously assessed during CDI, and begin PDI when they are determined to be ready. PDI helps parents to acquire skills in issuing commands appropriately, as well as providing consistent consequences for both compliant and noncompliant behavior. Treatment is completed when parents have attained the necessary skills and children achieve behavioral goals (Herschell et al., 2002).

At the beginning of each phase, the therapist explains the skills involved in the interaction and why they are used. After the initial explanation, therapists model specific interactions so that parents and children can role-play the skills and practice what they have learned. Parents and children then attend weekly coaching sessions in which the therapist uses a one-way mirror to observe parent–child interactions and speaks to parents using a radio earpiece to inform them how to “implement specific behavioral skills with their children” (Chaffin et al., 2004, p. 501).

Effectiveness. PCIT is considered to be an evidence-based, empirically supported program (Chaffin et al., 2004; Herschell et al., 2002; California Evidence-Based Clearinghouse, 2009c). In a meta-analysis of PCIT studies, Thomas & Zimmer-Gemlock (2007) found that PCIT was effective in reducing child behavior problems and improving parenting outcomes. Chaffin et al., (2004) report that PCIT reduced recurrence of maltreatment among a population of physically abusive parents. Other studies have suggested that PCIT can reduce child conduct problems (Nixon, Sweeney, Erickson, & Touyz, 2004), mothers’ stress (Nixon et al., 2004; Bagner & Eyberg, 2007), and coercive discipline techniques (Nixon et al., 2004). Thomas & Zimmer-Gemlock (2007) report however, that findings cannot necessarily be generalized to those with low socio-economic status or those in high risk groups.

Implementation. Resources needed to implement PCIT include: (1) Two connected rooms with a one-way mirror on the adjoining wall; (2) Wireless communications set consisting of

a head set with microphone and an ear receiver; (3) VCR and television monitor to tape record sessions for supervision, training, and research (California Evidence-Based Clearinghouse, 2009c). PCIT requires a comprehensive training program; the cost of a 5 day workshop is \$3,000, which includes: (1) 40-hours of face-to-face contact with a PCIT trainer; (2) Advanced live training; (3) Case Experience; and (4) Skill review. For additional information, contact: Sheila M. Eyberg, Ph.D., at pcit@phhp.ufl.edu.

Neighbor to Neighbor

Neighbor to Neighbor was developed by the Jane Addams Hull House Association and is aimed at keeping sibling groups of four or more children together in the foster care system (California Evidence-Based Clearinghouse, 2009d). The program utilizes a community-based team approach that may include foster and birth parents, in order to keep the children together while working on permanency planning. Neighbor to Neighbor seeks to professionalize the role of foster parents by providing training, support, salaries, and benefits to families. In addition, the program provides birth families and children with comprehensive case management and clinical services as needed. The program includes the following components (California Evidence-Based Clearinghouse, 2009d):

- Uses licensing representatives to recruit and develop professional foster parents,
- Hires foster caregivers as salaried employees,
- Uses a community-based and strength-based team (foster caregiver, birth parent, and association employee) approach,
- Assigns one case manager and advocate per family,
- Places one sibling group per foster family,
- Provides foster family & birth family case management services,
- Provides comprehensive in-house clinical services, including evaluations and medication management by a contracted pediatric psychiatrist and services by a substance abuse treatment provider,
- Utilizes a Phases of Sibling Foster Care approach that provides a clear description of interventions utilized from intake through aftercare,
- Provides 24-hour staff availability and support,
- Offers respite care for foster caregivers,
- Emphasizes reunification and alternate permanency planning for sibling groups,
- Provides aftercare for up to one year following reunification,
- Uses outside clinical consultants for parenting capacity assessments, consultation for treatment planning or critical decision making, and
- Provides an education liaison to support staff and foster parents and to be the resident expert on special education laws and advocacy within the school system.

Effectiveness. In a study using administrative data researchers found that children involved in Neighbor to Neighbor experienced greater stability, increased placements with siblings, and fewer moves to more restrictive care than children in non-kin or specialized foster placements (Testa & Rolock, 1999). However, permanency planning was more difficult for Neighbor to Neighbor involved children (Testa & Rolock, 1999). Less rigorous program evaluations have also found positive outcomes for Neighbor to Neighbor (Rolock & Testa, 1997; Rolock & Testa, 2003). Studies suggesting that professional foster care services improve outcomes for children provide support for these findings (Ainsworth & Maluccio, 2003; Hutchison, Asquith, & Simmonds, 2003; Holland, Faulkner, & Perez-del-Aguila, 2005).

Implementation. In order to implement Neighbor to Neighbor, the following participants may be needed: foster caregivers, case managers, therapists, family advocates, licensing representatives, educational liaison, supervisors, and director(s), psychiatrist, substance abuse treatment provider, and clinical consultants (California Evidence-Based Clearinghouse, 2009d). In addition, the following supplies may be needed: computers, assessment tools, therapeutic games, educational toys, books, video tapes, DVDs, CDs, VCR, DVD player, video camera, digital camera, art supplies, writing material, staff offices, family visiting rooms, therapy rooms, and conference rooms (California Evidence-Based Clearinghouse, 2009d). There is a manual and training for Neighbor to Neighbor, and more information can be found by contacting Vanessa Lankford, MSW, at: Vlankford@hullhouse.org or at: <http://www.cachildwelfareclearinghouse.org/program/64/detailed#relevant-research>.

Attachment and Biobehavioral Catch-Up

Attachment and Biobehavioral Catch-Up (ABC) is a program designed to assist foster and adoptive caregivers with difficult behaviors that children are exhibiting due to early maltreatment (California Evidence-Based Clearinghouse, 2009e). Often these children have developed behaviors that do not elicit a caring, nurturing response. ABC is designed to teach caregivers how to nurture children and provide safe, stable environments, based upon the following principles (California Evidence-Based Clearinghouse, 2009e):

- When a child behaves in ways that pushes the caregiver away, the caregiver can learn to respond with nurturance.
- Although some caregivers may not be “naturally” nurturing, they can learn to provide nurturance.
- When a child is dysregulated at behavioral and biological levels, a caregiver can learn to provide an environment that helps child develop regulatory capabilities.

Effectiveness. In one study, children in ABC showed lowered stress levels, measured by salivary cortisol level, as compared to another targeted intervention group, (Dozier et al., 2006).

Implementation The process of caregiver learning occurs over a 10-week period, in weekly one hour sessions with homework to be completed between sessions (California Evidence-Based Clearinghouse, 2009e). Significant staff time, training, and supervision are required in addition to a laptop computer, video camera, and web cam. The initial training is five days followed by one year of supervision. There is a manual that describes how to implement this program. For more information contact Mary Dozier, Ph.D., at mdozier@psych.udel.edu, or see: <http://www.cachildwelfareclearinghouse.org/program/108/detailed#references>.

Wraparound

Wraparound services were specifically designed to meet the needs of children with behavioral problems, mental health problems, and delinquency who are involved in multiple systems of care (California Evidence-Based Clearinghouse, 2009f). Wraparound services are also referred to as individualized care (Evans, Armstrong, & Kuppinger, 1996). The program engages family members, service providers, community supports, and other important adults in the child’s life in order to collaborate on an individualized plan of care (California Evidence-Based Clearinghouse, 2009f). Wraparound expands on existing positive assets of the family, the child, and the community, in order to build relationships, strengthen natural support systems, keep the child in a stable community placement, and avoid institutional care. The values embedded in the Wraparound framework

require that services are “individualized, family-driven, culturally competent and community-based.” The program includes the following four phases: (1) engagement and team preparation, (2) initial plan development, (3) implementation, and (4) transition (California Evidence-Based Clearinghouse, 2009f).

Effectiveness. There are a variety of wraparound service programs implemented in practice (Clarke & Clarke, 1996) and efforts to define the service for the purpose of research and evaluation are still underway (Ferguson, 2006). However, the programs evaluated in the studies described here adhere to the basic program principles.

The Wraparound model has been associated with increased placement stability in two studies (Clark et al., 1996; Clark, Lee, Prange, & McDonald, 1996). In other studies researchers have shown that the Wraparound model improved mental health outcomes and increased placements in less restrictive environments (Bruns, Rast, Peterson, Walker, & Bosworth, 2006), and improved functioning and reduced symptoms in emotionally disturbed children (Evans, Armstrong, & Kuppinger, 1996; Myaard, Crawford, Jackson, & Alessi, 2000). Similarly, wraparound services were shown to improve outcomes in the adjustment of at-risk youth entering or exiting specialized treatment centers (Hyde, Burchard & Woodworth, 1996). In contrast, researchers in one study found no difference in functioning, symptoms, life satisfaction, or positive functioning between wraparound and traditional mental health service groups and found wraparound to be more expensive (Bickman, Smith, Lambert, & Andrade, 2003). Other studies have shown that alternative services (e.g., multisystemic therapy) demonstrated more improvement in the clinical symptoms of an emotionally disturbed population than wraparound services (Stambaugh et al., 2007).

Implementation. The costs to implement this program include staff time and training, hiring of parent advocates, and possibly a committee that coordinates care among participating agencies (California Evidence-Based Clearinghouse, 2008f). For more information, contact Janet S. Walker, Ph.D., janetw@pdx.edu, or see <http://www.rtc.pdx.edu/nwi/>.

Family Group Decision Making

Family Group Decision Making (FGDM) is a general term describing multiple group-based decision-making models that involve the family (Berzin, Cohen, Thomas & Dawson, 2008). FGDM was designed for families in which a child is in danger or at risk of out of home placement (California Evidence-Based Clearinghouse, 2009g). An FGDM meeting is a discussion between an interdisciplinary team and a family regarding the reasons the child is in danger, the strengths already existing in the family, and the steps that need to be taken to ensure child safety (Berzin et al., 2008), FGDM allows the family to lead the decision-making process about the care of their children, including placement and placement moves (California Evidence-Based Clearinghouse, 2009g).

There are four phases involved in FGDM: (1) referral, (2) preparation and planning, (3) the FGDM meeting, and (4) follow-up planning and events (Merkel-Holguin, 1996 cited in Berzin et al., 2008, p. 37). Implementation of these phases typically involves: (1) independent non-case carrying coordinators, (2) 20–25 hours of preparation by the therapist for an average 3.5 hour session, (3) private time when family group meets independent of service providers to develop a plan, and (4) agreement by the public agency to carry out the plan and provide the necessary resources (California Evidence-Based Clearinghouse, 2009g).

Effectiveness. A number of early studies found positive effects for FGDM: decreasing maltreatment events (Pennell & Burford, 2000), decreasing CPS reports and actions (Pennell &

Burford, 2000; Gunderson, Cahn, & Wirth, 2003), increasing stability and number of placements with parents (Gunderson et al., 2003), and decreasing number of court hearings, case times, and court ordered placement (Walker, 2005). FGDM has also been reported to have a high level of family satisfaction (Litchfield, Gatowski, & Dobbin, 2003) and may increase family acceptance of placement decisions (Gill, Higginson, & Napier, 2003). However, these studies relied on self-report data and non-matched comparison groups or non-random assignment, weakening their ability to make claims about FGDM's effectiveness.

More recently, the efficacy of FGDM has been called into question by several studies. A 2006 study found that FGDM had no impact on placement stability (Berzin, 2006). A recently published randomized control trial indicated that FGDM was no more effective than usual treatment in improving outcomes related to child safety, placement stability, and permanence (Berzin et al., 2008). It has been suggested that some components of FGDM are not consistently implemented, and this may lead to difficulties in achieving the desired outcomes (Berzin, Thomas, & Cohen, 2007).

Implementation. Costs to implement the program include staff time, meeting place, food/materials, and funds to ensure plans can be implemented (California Evidence-Based Clearinghouse, 2009g). There is a manual and training available for the program and more information can be found by contacting Lisa Merkel-Holguin at lisa@americanhumane.org, or at: <http://www.cachildwelfareclearinghouse.org/program/130/detailed#relevant-research>.

Family to Family

Family to Family (F2F) is an initiative of the Annie E. Casey Foundation aimed at encouraging states to redesign their foster care systems (O'Connor, 1997). It seeks to improve outcomes for children and their families by linking their experience in the system to their individual and familial needs, based upon the following four principles (Rideout, Usher, & Wildfire, 2005; Annie E. Casey Foundation, 2009):

- A child's safety is paramount.
- Children belong in families.
- Families need strong communities.
- Public child welfare systems need partnerships with the community and with other systems to achieve strong outcomes for children.

The core activities include (California Evidence-Based Clearinghouse, 2009h):

- Team decision making.
- Recruitment, development, and support of resource families
- Building community partnerships.
- Self-evaluation.

The first core activity in Family to Family is Team Decision Making (TDM). TDM is a form of Family Group Decision Making where parents, sometimes children, a neutral facilitator, community members, and family supports come together to discuss placement decisions in a structured way (California Evidence-Based Clearinghouse, 2009h). Recruitment, development, and support of resource families and building community partnerships are long term components of the intervention (California Evidence-Based Clearinghouse, 2009h).

Effectiveness. In one study that used non-matched comparison groups researchers found that Family to Family participants experienced fewer out of home placements and faster reunification,

although this difference between the groups declined over time (Usher, Wildfire & Gibbs, 1999). There is some indication that TDM (one activity within the Family to Family program) is difficult to implement, but has been implemented consistently in counties that adhere carefully to the guidelines (Crampton, Crea, Abramson-Madden, & Usher, 2008; Crea, Usher, & Wildfire, 2009). The Annie E. Casey Foundation completed its own evaluation of a program in Los Angeles, reporting that 75% of the children involved in Family to Family who were at risk for placement moves were able to remain in their current placement (Annie E. Casey Foundation, 2009).

Implementation. The resources needed to implement the program include staff time, food and material costs, paid facilitator positions for TDM, steering committee, and possible costs associated with community linkages and contracts (California Evidence-Based Clearinghouse, 2009h). There is a manual and training available for this program and more information can be found at the Annie E. Casey Foundation, <http://www.f2f.ca.gov>.

Court Appointed Special Advocates

Court Appointed Special Advocates (CASA) is an organization consisting of volunteers who act as third-party advocates on behalf of children involved with the child welfare system (National CASA Association, 2006). A CASA volunteer is sometimes referred to as a Guardian Ad Litem and becomes involved with a child welfare case when a judge determines that the involvement of a CASA volunteer is necessary, typically in difficult and complex cases (National CASA Association 2006; Youngclarke, Ramos, & Granger-Merkle, 2004). The role of the volunteer is to provide constant and consistent support to the child as well as to ensure that the child's voice is heard in court hearings and proceedings (Berliner, 1998; National CASA Association, 2006). CASA volunteers generally handle only a few cases at a time in order to provide concentrated, in-depth support and advocacy for children (Youngclarke et al., 2004). CASA volunteers maintain regular contact with the child, biological family, foster family, and child welfare caseworker in order to provide information to the courts and help facilitate well-informed decisions on behalf of children in care (National CASA Association, 2006). Specific CASA volunteer goals include: advocating for appropriate placement for the child, promoting placement stability and safety, and achieving permanency in a timely manner (Calkins & Millar, 1999).

Effectiveness. Evaluations of CASA programs generally provide evidence of a positive impact of CASA volunteers in child welfare cases. However, it is difficult to specify how CASA involvement affects child welfare outcomes because CASA volunteers are not involved in all child welfare cases, are assigned at various points-in-time of the case, and are not randomly assigned to cases when they do get involved, making comparisons of CASA involvement to non-involvement difficult. In one study researchers found that children with CASA involvement had significantly fewer placements while in care and spent a significantly shorter average length of time in care (Calkins & Millar, 1999). Children with a CASA volunteer had approximately one-third fewer placements and spent an average of eight fewer months in care than children without an assigned CASA volunteer (Calkins & Millar, 1999). Another study also found similar results regarding placement stability and length of stay in out-of-home care, though this study did not examine the statistical significance of the findings (Leung, 1996).

There is conflicting evidence suggesting that CASA involvement may not have a positive impact on child welfare outcomes. For example, a study in Kansas compared the outcomes of children in foster care with CASA volunteers to children without CASA volunteers and, overall, did not find significant differences in outcomes between the two groups (Litzelfelner, 2000).

A significant exception relates to placement stability, where children with CASA involvement experienced significantly fewer placement changes while in care compared to children without CASA involvement (Litzelfelner, 2000).

Implementation. The CASA organization bears all costs for training, providing volunteers and necessary resources. More information is available at the California CASA Association: <http://www.californiacasa.org/index.htm>.

CONCLUSION

In this review we have discussed the issue of placement stability, one of the outcome indicators used in the CFSR evaluation process to measure child welfare agency performance. The review provided an overview of the CFSR data indicator for placement stability, followed by a summary of the research literature on factors associated with placement instability, and promising practices for improving agency performance on this measure. The following questions are intended to promote reflection and discussion as a way to support the translation of research into actions to improve outcomes:

- Are foster parents receiving all available resources and support to increase their ability to be stable caregivers without disruption?
- Is permanency for children in kinship placements being pursued as robustly as permanency for children in foster placements?
- Are children who exhibit behavior problems being given all available interventions and resources to decrease the likelihood of placement disruptions?
- Is CASA being utilized to the fullest extent to improve stability outcomes?

While the available research is admittedly unclear on precise steps to improve performance on placement stability, promoting practitioner dialogue is an entry point to translating research into practice. Further advances in improving this outcome will require not only further research, but continuing discourse among practitioners to identify effective paths forward in the application of the research.

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