

Family Participation in Therapeutic Foster Care:  
Multiple Perspectives

A Final Report on a Study of Families and Therapeutic Foster Parents as Partners

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## Executive Summary

Therapeutic foster care (TFC) offers a community-based treatment alternative for children with serious emotional disorders in the child welfare system, in which trained caregivers provide care in family settings. In the shift away from residential treatment for children with serious emotional disorders and toward family-centered, community-based treatment, TFC has emerged as a key component of the systems of care (Meadowcroft, Thomlison & Chamberlain, 1994; Stroul & Friedman, 1986; Stroul, 1989). The development of TFC homes may also be related to child welfare and mental health professionals' increasing awareness of the mental health needs of children in regular foster care (Blumberg, Landsverk, Ellis-McLeod, Ganger & Culver, 1996; Goerge, Wulczyn & Fanshel, 1994; Landsverk, Davis, Ganger, Newton & Johnson, 1996; Simms & Halfon, 1994).

Associated with the implementation of the Child and Adolescent Service System Program (CASSP) principles (Stroul & Friedman, 1986; 1988) and the development of the family advocacy movement (Bryant-Comstock, Huff & VanDenBerg, 1996) in the last fifteen years, there has been increasing emphasis on the participation of parents and other family members in the treatment of children with serious emotional disorders. In some children's mental health literature, family participation and family involvement are used almost interchangeably. In this monograph, the word "participation" will be used to indicate that families have a "level of influence beyond token involvement" (Simpson, Koroloff, Friesen & Gac, 1999, p.15) and that their participation connotes "an important role in decision making" (Simpson et al., 1999, p.15). This definition distinguishes family participation from family involvement as it has been used in the family therapy literature to indicate limited family roles in relation to the service system (Simpson et al., 1999).

To date, there has been only limited attention to family participation where children are in out-of-home placements, even though there is research evidence that parent-child contact is associated with more rapid family reunification. Family support and the promotion of family participation in children's treatment and care are believed to contribute to successful family reunification when children are placed in TFC. But TFC programs vary in the extent to which they involve parents. Some TFC programs report that working with families is one of the most difficult aspects of their work (Stroul, 1989).

This monograph presents the findings of a qualitative study of family participation in TFC. Thirty five semi-structured qualitative interviews of one and a half to two hours were conducted with three groups of respondents: parents of children placed in TFC; TFC providers; and child welfare/mental health professionals. The study examined family participation in TFC from the perspectives of ten parents who between them had fourteen children placed in TFC, twelve TFC providers who were caring for their children, and twelve child welfare (and in some cases mental health) professionals who were working with each child.

The interviews focused on the characteristics of children placed in TFC, challenges of caring for these children, and their responses to TFC. Aspects of family participation in TFC which were examined in the study included: parent-child contact; parent-professional communication and information sharing; parent participation in decision making; and relationships between parents, professionals, and TFC providers. Professionals' and TFC providers' values and attitudes toward family participation, barriers to participation, and strategies to enhance family participation were identified. Cultural and class issues in placement planning and ongoing care were examined, as well as patterns in services use before and during placement, and plans for follow-up care.

In the report that follows, a review of relevant literature on family participation in children's mental health, foster care, and therapeutic foster care is presented. The methodology of the study is described, findings are presented, and there is a discussion of the findings and their implications for further research. The fourteen children who were the focus of the interviews in this study were troubled children and each had multiple mental health diagnoses. There was considerable divergence of the understanding of parents, TFC providers, and professionals of the children's mental health conditions and appropriate treatment strategies. The children's behavioral difficulties presented many challenges to caregivers, but all except one child were responsive to the treatment they received in TFC and related services. At the time of the study, three children were in the process of transitioning home and there were plans for another three children to be reunified with parents. Adoption was planned for four children from two families and long-term foster care for three other children. The child who was unresponsive to TFC was in the process of transfer to a group home at the time of the study.

All the children who were the focus of the study, except two, had been placed in care because of allegations of abuse and/or neglect. The parents who were interviewed faced a number of challenges in their own lives, such as poverty, mental illness, substance abuse, or the effects of domestic violence. Findings indicate that this group of families received few services to help with their own difficulties or the challenges of raising a child with a serious emotional disorder prior to their children being placed in out-of-home care. After placement in TFC, a range of services were offered to the children and their families, which with a few exceptions were perceived as helpful. Parents whose children were in the process of reunification were anxious for supportive services to continue.

Parents interviewed in this study wanted to have contact with their children in TFC and to participate in planning and decision making related to treatment and care for their children. Generally, child welfare and mental health professionals stated in interviews that they believed in the value of family participation, but their actual practice varied. Some families were satisfied with their participation in TFC, for example they participated in decision making meetings and felt that they were treated with respect. Parents appreciated professionals who shared information with them, provided support, and facilitated contact with their children. Parents were appreciative of TFC providers who reached out to them to share information about their children and offer opportunities for contact.

Some parents were angry about having limits placed on their contact with their children and being excluded from decision making. In some cases, parents were critical of the professionals and TFC providers. Professionals identified organizational barriers to family participation, such as large caseloads which constrained child welfare workers' time to devote to families. Another challenge to family participation related to TFC providers' lack of training to work with parents. TFC providers offered a range of perspectives on their willingness to have contact with families and to support children in the retention of parent-child bonds.

This qualitative study is a case study in a local context, and therefore the exercise of caution is urged in generalizing from the findings. In the local context, there are implications for recruiting and training TFC providers to work with families and for organizational supports, such as small caseloads, to allow child welfare staff to have the time to work closely with families. Other purposes of the study were two-fold: to give voice to parents of children in TFC and front-line professionals and providers about their working relationships; and to contribute to the development of a research agenda to more fully understand the phenomenon of family involvement with children placed in out-of-home care and its long-term effects on child and family well-being.

Since this study is only the second research project that gives voice to the parents of children placed in TFC, a group considered disadvantaged by many standards (see also Barno, 1994), the perspectives of parents have been given expanded attention in this publication, compared to those of professionals and TFC providers. For clarity, the biological parents of children placed in TFC are referred to as parents and therapeutic foster care providers as TFC providers; where alternative terminology has been used in direct quotations, it is retained. Professionally qualified staff, whether child welfare caseworkers or mental health therapists, are referred to as professionals, caseworkers, or workers and their professional affiliation is noted where appropriate. Substantial portions of the findings related to the perspectives of the three groups of respondents (parents, child welfare/mental health professionals, and TFC providers) on family involvement in TFC are adapted from two articles (Jivanjee, in press a: b).



## **Literature Review**

### **The Emergence of Family Participation in Children's Mental Health**

Since the mid-1980s, the field of children's mental health has been revolutionized by the shift toward family-centered, community-based services for children with serious emotional disorders and their families (DeChillo, Koren & Schultze, 1994; Friesen & Huff, 1996; Koroloff, Friesen, Reilly & Rinkin, 1996). New approaches to professional practice emphasize family strengths (Saleebey, 1997) and the empowerment of families (Koren, DeChillo & Friesen, 1992; Lee, 1994). Increasingly, families are being welcomed as full partners in the planning and delivery of services (Friesen & Huff, 1996; Koroloff, Friesen, Reilly & Rinkin, 1996). New models of family-professional collaboration are characterized by professionals offering support and understanding to families, practical assistance, sharing information, and being open to modifying services in response to feedback from parents (DeChillo, Koren & Schultze, 1994).

### **Family Participation in Foster Care**

Attention to family strengths has emerged in some new models of child welfare practice (Bricker-Jenkins, 1997) and there is growing attention to family involvement in decision making through mechanisms such as the family group decision meeting (Keys, 1996; Merkel-Holguin, 1996). But traditional beliefs about protecting children from abusive and/or neglectful parents may limit the extent of parental involvement in foster care. In the 1970s, interest in parental participation in foster care emerged from research which examined "foster care drift," the phenomenon of children remaining in foster care for extended periods of time without plans for their long-term care (Lahti, Green, Emlen, Zendry, Clarkson, Kuehnel & Casciato, 1978).

Evidence of the importance of the attachment relationship between caregiver and child (Bowlby, 1969) drew attention to the potentially traumatic effects of parent-child separation when children are placed in foster care. Research findings that family reunification is associated with parental visiting (Fanshel, 1975; Maluccio & Sinanoglu, 1981; Sinanoglu & Maluccio, 1981) led to a new focus on parent involvement in "permanency planning" for children which was formalized by P.L. 96-272, the 1980 Adoption Assistance and Child Welfare Act (Fein, 1991).

In the 1980s and 1990s, several research studies confirmed the association between parent-child contact and family reunification (Benedict & White, 1991; Davis, Landsverk, Newton & Ganger, 1996; Tam & Ho, 1996). Whether the goal of foster care is family reunification, adoption, or other long-term out-of-home care, parent involvement helps to ensure family continuity and stability (Thomlison, 1991). Family ties are more likely to be preserved when parent-child relationships are nurtured (Colapinto, 1998), and successful family visiting occurs (Hess, 1987; 1988; Hess & Proch, 1988; Howard & Proch, 1986; Lee & Nisivoccia, 1989; Loar, 1998). By working closely with families, professionals can help to prepare them for the challenges of caring for children with serious emotional disorders after they leave foster care (Landsverk,

Davis, Ganger, Newton & Johnson, 1996). The sense of isolation and stigmatization that parents of children in foster care experience may be reduced by their participation in parent groups (Schneiderman, Connors, Fribourg, Gries & Gonzales, 1998).

In addition to parent-child contact, parent involvement (participation) in foster care is maintained in "activities, tasks, services, and decision making throughout the time the family is involved with the foster care process" (Blumenthal, 1984, p.2). This author proposes a "presumption of total parental involvement" unless continued parental involvement is judged to be detrimental to the child and parental rights are terminated (Blumenthal, 1984, pp.11-12). According to this author and her colleagues, parent involvement in foster care helps to achieve the following: maintain the parent-child relationship; enhance parents' self-esteem; give parents information about their child; allow foster parents to model appropriate behaviors; ease reunion; facilitate parents' use of resources; and aid parents in understanding children's needs and having appropriate expectations and management of the child (Blumenthal & Weinberg, 1984).

High levels of family participation are associated with enhanced roles for foster parents with families, including role model, mentor, confidante, parent aide, partner, and assistant in making changes required for children's return home (Hess, 1993). Child welfare experts recommend recruitment, training, and support designed to prepare foster parents to perform these roles with parents (Burton & Showell, 1997; Erera, 1997; Hess, 1993). Practical guides to planning, supporting and training child welfare staff and foster parents to promote and maintain parent participation have been developed (Family Rights Group, 1986; Hess & Proch, 1988; Lee & Nisivoccia, 1989; Pine, Warsh & Maluccio, 1993; Schatz & Bane, 1991; Warsh, Maluccio & Pine, 1994). Since activities to promote parent-child contact are time consuming and complex, experts recommend administrative arrangements to support child welfare staff in this work (Hess, 1988; Hubbell, 1981; Proch & Howard, 1986).

Despite awareness of the benefits of family involvement, there is evidence that families are often left out, or not made aware of the importance of maintaining regular contact with their children, and then blamed for their lack of participation (Family Rights Group, 1986). There are continuing calls for child welfare professionals and foster parents to involve families with their children in foster care (Brazier, 1996; Davis et al., 1996; Farmer, 1996; Palmer, 1992; Tiddy, 1986).

## **Families and Therapeutic Foster Care**

TFC models vary, but they share certain general characteristics:

- children are placed with families selected and trained to work with children with special needs who would otherwise be admitted to an institutional setting;
- typically, only one or two children are placed at one time;

- child welfare staff in TFC programs have small caseloads, so that they may work more effectively with each child and family;
- TFC providers are treated as members of the treatment team; and
- TFC providers receive a higher stipend than that paid to traditional foster parents (Bryant, 1981; Galaway, Nutter & Hudson, 1995; Hawkins, 1989; Hudson, Nutter & Galaway, 1994a; 1994b; Rivera & Kutash, 1994; Stroul, 1989).

As a result of TFC program variability, it is difficult to reach conclusions about its effectiveness (Rivera & Kutash, 1994), but several studies have demonstrated promising treatment outcomes, with children returning to less restrictive environments, often the parental home (Chamberlain & Reid, 1991; Hawkins, Meadowcroft, Trout & Luster, 1985; Horner, Smith, & Ray, 1990; Galaway, Nutter, & Hudson, 1992; Hudson, Nutter & Galaway, 1994b; Moore & Chamberlain, 1994).

Since a goal of many TFC placements is family reunification, Maluccio and Whittaker (1989) recommend that preserving family ties be a focus of intervention. As in regular foster care, where the permanency plan is for adoption or other long-term out-of-home care for children, continuing family contact is likely to assist in preserving children's attachment (Bowlby, 1969; Grigsby, 1994). Parent participation in TFC is considered to include several elements: regular, planned parent-child visits; participation with the treatment team in developing treatment and care plans and monitoring progress; support and assistance to resolve personal or family problems; and preparation for the child's return home (Bryant, 1981; Stroul, 1989, pp.25-26). Parents of children in TFC were found to want support and they identified the following key ingredients of support: validation of their parenting experiences; assistance with transportation; inclusion in their child's experiences; and supportive communication, characterized by accessibility, exchange of information, and opportunities for parental input (Barno, 1994).

In spite of growing awareness of the likely benefits of family participation in TFC, there is only limited attention to this aspect of practice in descriptions of TFC programs (Grealish, Hawkins, Meadowcroft, & Lynch, 1989; Hawkins & Breiling, 1989; Hudson, Nutter, & Galaway, 1994a; Snodgrass & Bryant, 1989). Some TFC models have evolved their treatment focus to incorporate family participation (Bryant & Snodgrass, 1992). But while there may be policies in place to encourage parent participation, in many agencies there are discrepancies between policy and actual practice (Hudson, Nutter, & Galaway, 1994a).



## **Method**

### **Purposes of the Study**

The purpose of this qualitative study was to examine family participation in therapeutic foster care from the perspectives of parents, child welfare and mental health professionals, and TFC providers. The following aspects of family participation were addressed in the study:

- parent-child contact;
- parents' access to information about their children's well-being and progress;
- parents' involvement in decision making about their children's daily care and long-term care planning; and
- the qualities of relationships between parents, professionals, and TFC providers.

Factors that enhanced and impeded family participation were examined, including values related to family participation and attitudes toward specific families. Cultural and social class issues in placement planning and ongoing care, barriers to family participation, and strategies to enhance family participation were identified. Parents' perspectives and professionals'/providers' perspectives on family participation are reported elsewhere (Jivanjee, 1998a; 1998b). The characteristics of children placed in TFC, the challenges of caring for them, their responses to TFC, patterns in services use before and during placement, and plans for continuing services were examined.

### **Study Context**

The study was carried out in the local context of four counties within a single state where TFC programs were developed and funded collaboratively by the state child welfare and mental health agencies. Each county in the study had 4-8 TFC slots for children with serious emotional disorders who required out-of-home placement. Program development in each county was guided by state administrative rules (OAR 412-24-400 to 412-24-480) which provided standards for recruitment, training, and support for TFC providers and the development of treatment teams composed of child welfare and mental health staff, TFC providers, and parents. In the program design, each county incorporated requirements for reduced caseloads for child welfare caseworkers, access to appropriate mental health services for children in TFC, and regular respite care for TFC providers.

According to program rules, families were to be consulted as to their preference for their child's placement with a specific TFC family (OAR 412-24-450). Professionals were required to facilitate regular parent-child contact and parental participation in treatment team meetings, plans, and decisions (OAR 412-24-430). Further, TFC providers were expected to assist each child to have contact with her/his family and to support and enhance parent-child relationships, unless contraindicated in the treatment plan (OAR 412-24-440). However, an earlier study

found

that training for TFC providers was mainly focused on increasing their knowledge of emotional and behavioral disorders and cognitive and behavioral approaches to treatment and there was little or no training in working with families (Jivanjee, 1994).

Families of children placed in TFC had a range of opportunities for potential participation in their children's care: visits with their children at their home, at the TFC home, or at a neutral site; other contacts with their children such as telephone calls and letters; contacts with child welfare staff and TFC providers; information about their children's activities and progress; and participation in decision making at child welfare/mental health treatment teams and citizens' review boards (CRBs). CRBs are bi-annual formal meetings with the goal of assuring the welfare of children in care. They are attended by citizen representatives, as well as treatment team members, attorneys, and court-appointed special advocates (CASAs). There are legal requirements that parents and older children be invited to attend and participate in CRB meetings.

## **Procedures**

The research team developed three parallel versions of a long semi-structured interview protocol for use with parents of children in TFC, child welfare/mental health professionals, and TFC providers. The interview protocols were pilot-tested and revised with feedback from members of a parent advocacy organization and the staff, foster parents, and parents of children in foster care at a private non-profit foster care agency.

Letters, telephone calls, and meetings with TFC teams were used to provide information about the study and to gather contextual information about the implementation of TFC programs. Child welfare staff in TFC programs agreed to distribute letters to parents of children in TFC who had involvement with their children. The letters described the purposes and expectations of the study and asked parents to initiate their participation in the research either by returning a signed reply note or making a telephone call to the researcher. Out of approximately 30 possible parent participants, ten parents and one grandmother replied to the letters and participated in interviews. With the agreement of each parent, the TFC provider and primary professional(s) working with the child and family were interviewed and their perspectives were compared.

Each respondent participated in one semi-structured in-depth interview lasting one and a half to two hours. Parents and TFC providers were paid \$25 for their time. Professionals were not paid, but saw their participation in the research as an opportunity to contribute to knowledge building.

Interviews were conducted by two second-year social work graduate students who had received training in child welfare and mental health issues, and skill training in qualitative interviewing. Questions for all three groups of respondents focused on aspects of family participation with the specific family of each child placed in TFC: the frequency and types of parent-child contact; parent-professional communication; information sharing about children's progress; and parents'

participation in decision making about their children's care. Information was also gained about the following topics: characteristics of the children, including their mental health diagnoses, the challenges of caring for them; their responses to TFC; the use of services by children and their families before and during placement; and plans for follow-up services after TFC. There were questions about cultural and social class issues related to placement planning and ongoing care. Barriers to family participation and strategies to enhance participation were also addressed.

Data from the in-depth interviews were tape recorded, then transcribed and analyzed with the assistance of The Ethnograph computer software program (Seidel, 1994). An inductive analytic process was used with the qualitative data which was guided by grounded theory methodology (Glaser & Strauss, 1967; Strauss & Corbin, 1994) and the naturalistic inquiry methodology of Lincoln and Guba (1985). Transcripts were read independently and coded by at least two members of the research team to ensure inter-rater reliability and to increase the trustworthiness of the findings (Lincoln & Guba, 1985). Where there was disagreement between team members about how a segment of data should be coded, a third reader reviewed the data and there were negotiations until agreement was reached. Trustworthiness was also enhanced by the triangulation of data sources (parent, professional(s), and TFC provider in each case), regular intensive de-briefing by the research team after all interviews, and the development of an audit trail (Lincoln & Guba, 1985). Major themes were identified as they emerged from the data in an inductive analysis process.



## Results

### Participants

Study participants were family members of fourteen children with serious emotional disorders who had been placed in TFC for at least three months, TFC providers to their children, and child welfare/mental health professionals. Ten parents participated in the study: eight mothers and two fathers. The grandmother of one child who had been his caregiver before placement was also interviewed. Some TFC providers and professionals had responsibility for children in TFC from more than one family, and therefore they participated in repeat interviews focused on each separate family. There were twelve interviews with ten TFC providers and twelve interviews with ten professionals. Of the interviews with professionals, ten were with child welfare staff and two with a mental health professional. With family involvement the focus of the study, cases were selected for inclusion when there was at least some family involvement. Therefore, the cases described here are not representative of all TFC cases.

All of the family members who participated in the study, except two, had their children removed from their care by the state because of findings of child abuse or neglect. The exceptions were a mother and grandmother who each requested placement because they were unable to manage their child's difficult behaviors. One of these placements continued to be voluntary, but in the other case, parental rights were assumed by the state because the grandmother did not want the child to return to her home. The children who were the focus of the study ranged in age from 3 to 16 years. All of the children had mental health diagnoses such as oppositional disorder, attention deficit-hyperactivity disorder (ADHD), post-traumatic stress disorder, and depression. Detailed diagnostic information about the children is provided in the discussion of the characteristics of children placed in TFC. In four families, children were placed in TFC directly from home because of their emotional or behavioral problems; in six cases, children were transferred to TFC from regular foster care because of their mental health needs. In some of these cases, children had experienced multiple foster home placements because the regular foster parents did not have the skills to manage their behaviors, and in a few cases there were allegations of further abuse in the foster home. For half the families, the long-term plan was family reunification, while for four families, the plan was adoption or long-term foster care because of parents' ongoing problems such as substance abuse or mental illness; in one case, the plan was still undecided.

All of the parents and professionals in the study except one professional were Caucasian. One professional was African American. One child (who was in a voluntary placement) was bi-racial and he was placed in a TFC home with a bi-racial couple. One TFC provider was Asian-American and the others were Caucasian. The duration of TFC placements ranged from three months (the minimum for inclusion in the study) to three years. Eight of the parents were single parents and two were couples. All of the parents were disadvantaged by poverty, and in some cases, inadequate housing. One mother had been homeless and was staying intermittently with relatives. In addition to their children's serious emotional disorders, many of these parents faced

significant challenges in their own lives such as domestic violence. Three parents had a serious mental illness and three had a history of substance abuse. Information about the characteristics of parents and the placement context are summarized in Table 1 below. Brief summaries of each family situation are provided on page 11 of this report, with names changed to protect the privacy of respondents.

**Table 1**  
Characteristics of TFC Parents and Families (N = 10)

<u>Gender of respondent:</u>	
Mothers:.....	8
Fathers: .....	2
<u>Children's route to TFC:</u>	
From family home .....	4
From regular foster care .....	6
<u>Family after-care plan:</u>	
Family reunification .....	5
Adoption .....	2
Long-term foster care .....	2
Undecided.....	1
<u>Primary factors affecting parents' capacity to care for children:</u>	
Children's mental health problems .....	10
Parents' mental illness .....	3
Parents' history of drug/alcohol abuse.....	3

Professionals and TFC providers who participated in the study were those who were working with the fourteen children placed in TFC. Child welfare caseworkers who participated in the study were experienced master's level social workers. The mental health therapist who participated in two interviews was a graduate-level professional with specialized training and experience in children's mental health. Of the ten TFC providers who were interviewed, seven were couples and there were three single parents. Most TFC providers had previous experience as regular foster parents and they had provided TFC for 1 to 12 years. TFC providers were required to have participated in a minimum of 20 hours of preliminary training and at least 10 hours per year of ongoing training, as well as weekly supervision/consultation with a mental health professional and/or team (the training requirements were substantially higher in some counties). Several TFC providers also had related job experience, such as nursing, alcohol and drug counseling, treatment of young offenders, and care of individuals with developmental disabilities. One TFC provider was a trained mental health therapist and a TFC couple had raised two of their own children with serious emotional problems: one child with attention deficit hyperactivity disorder and one child with depression.

Characteristics of the fourteen children placed in TFC. The fourteen children in TFC who were the focus of the study had mental health problems. Research participants were shown a list of possible child mental health diagnoses and they indicated which ones had been given to the children who were the focus of the interviews. This strategy allowed comparison of the responses of the three research participants related to each child. Some of the mental health conditions which were the focus of treatment were formally diagnosed, while others were speculative. The three groups of respondents, parents, professionals, and TFC providers were asked questions about their understanding of the child's mental health. Only in a few instances did all three respondents agree on the child's diagnosis. There was a lot of divergence in their understanding of the specific diagnoses given to each child. All children except one had at least two diagnoses and one child had eight different diagnoses. Since members of the research team were not in a position to verify the accuracy of diagnostic information, all diagnoses mentioned by research participants are included in the discussion.

Brief case summaries. Sam (age 7) was removed from his mother Karen's home because of neglect and her substance abuse. Sam has diagnoses of anxiety, oppositional-defiant disorder, conduct disorder, attention deficit hyperactivity disorder (ADHD), and post-traumatic stress disorder (PTSD). The TFC provider also reported that Sam demonstrated antisocial behavior and that he may have a developmental disorder and fetal alcohol syndrome, although these diagnoses were not confirmed. Because Karen successfully completed substance abuse treatment and developed a close relationship with the TFC providers, she was very involved in Sam's treatment and care. Sam recently returned home. The TFC providers continue to be supportive to Sam and Karen and to provide respite care.

Brenda is eleven years old and has ADHD, a developmental disorder, and a learning disability. The TFC provider also believes that she has PTSD, oppositional-defiant disorder, and an eating disorder. Brenda was removed from the care of her mother and stepfather because of physical abuse, the parents' substance abuse, and her mother's request to place her for adoption because she could not manage her behavior. After three years in TFC, Brenda is transitioning home. Throughout Brenda's treatment, her mother, Rhonda complied with treatment requirements and has been actively involved in decision making. She is concerned about meeting her daughter's needs for appropriate services after she returns home.

Danny aged six and Martin (9) were removed from their mother's home because of neglect and alleged sexual abuse. The younger boy has a history of fire-setting. Both children have been diagnosed with ADHD and PTSD. The after-care resource will be the boys' father, Ralph. Soon after placement in TFC, one of the children was moved to another TFC home because of sibling rivalry. While the child welfare caseworker has advocated for Ralph, the mental health therapist and TFC providers have negative attitudes toward him. He has, therefore, had little communication with the TFC providers and minimal involvement in treatment planning.

Albert (13) was placed in TFC because of ADHD and attachment disorder. Diagnoses of PTSD, oppositional-defiant disorder, and learning disability have also been given. Raised by his grandmother from age three to eleven, Albert's behavioral difficulties led her to ask the child welfare agency to assume responsibility for his care. Albert's social worker recently located his mother, Debbie who had no contact with her son for over ten years. The social worker has facilitated parent-child contact and the re-establishment of their relationship. At the time of the interview, Albert was in the process of transitioning to a group home near his mother's home. The treatment team has not yet decided who will provide Albert's after-care.

With her own history of mental illness, Donna was unable to cope with her children's difficult behaviors. At age nine, Nathan and his sister Andrea (3) have been in TFC for one year. Nathan has obsessive-compulsive disorder and the TFC provider thinks that he has oppositional-defiant disorder. Andrea is believed to have been sexually abused and the TFC provider has noticed signs of PTSD. There has been conflict between Donna and child welfare staff, but she has felt supported by the TFC providers. Currently, parental rights are being terminated and Nathan and his sister will be placed for adoption.

Five children were removed from their mother Tonya's care because of her substance abuse. The two eldest sons, Melvin (14) and Robert (12) were placed in TFC because of diagnoses of oppositional-defiant disorder and depression. Robert also has conduct disorder and ADHD. Melvin has demonstrated signs of PTSD and a learning disability. The care plan for the two boys is long-term foster care. Tonya has limited involvement in decision making because of her many relapses in substance abuse treatment. The caseworker has been supportive to this mother and she understands the constraints on her involvement.

A single father, Frank, is working to rebuild his relationship with his daughter, Laura (16), who was removed from her mother's home five years ago and placed in TFC because of depression. The TFC provider reports that Laura also exhibits oppositional-defiant disorder. Laura will remain in foster care until she is emancipated at 18. Frank is very involved in the decision making process, but he feels that his ideas are not taken seriously and that he is perceived as an obstacle in Laura's treatment.

Annette, a single mother, turned to the child welfare agency for help with her son Jamie (aged 8) who has ADHD, oppositional-defiant disorder, PTSD, and a learning disability. Jamie was exhibiting out-of-control behaviors and Annette felt unable to manage him. This bi-racial child was placed with a bi-racial TFC couple and after 18 months of treatment returned to live with his mother. Annette established a close working relationship with the TFC providers and still calls upon them occasionally for support. She was pleased with the treatment Jamie received and feels ready to parent him again.

When Frances' mental health deteriorated, she was unable to care for her four children. The two younger children, Susie (8) and Caroline (4) were placed in TFC because of their diagnoses of reactive attachment disorder, PTSD, and oppositional disorder. The TFC provider facilitated parent-child contact and has been supportive to Frances. Frances has relinquished custody to the state and the long-term plan is for an open adoption placement.

Stephen (8) was placed in TFC following a failed placement in regular foster care because the foster parents were unable to manage his behavior. Stephen has ADHD, attachment disorder, and a learning disability. His mother, Wanda was raised in foster care and has a long history of mental illness. She is divorced from Stephen's father, Stan, who lives in another county. Both parents have occasional contact with Stephen and participate in decision making meetings. Stephen responded well to TFC and recently moved to a regular foster home. The after-care plan is to reunify him with his father.

Perceptions of diagnostic information about the children in TFC. Diagnostic information about the children placed in TFC is summarized in Table 2 below:

**Table 2**  
Mental Health Diagnoses For Children Placed in TFC

Mental health diagnosis	Number of children with diagnosis
Anxiety disorder	1
Attachment disorder	4
Oppositional-defiant disorder	10
Conduct disorder	2
Attention deficit hyperactivity disorder	8
Developmental disorder	2
Eating disorder	1
Learning disability	5
Childhood depression	4
Post-traumatic stress disorder	10
Antisocial personality	1
Fetal alcohol syndrome	1?
Arsonist	1
Obsessive-compulsive disorder	1
Suspected sexual abuse	1?

All fourteen of the children were under psychiatric supervision and eight were taking medication for their mental health condition at the time of the study. However, the lack of agreement about the specific mental health problems is a cause for concern in light of the need for the significant adults in a child's life to treat her/him consistently. In particular, parents were unclear about their child's mental health problems and the kinds of daily management likely to be most helpful. From the parents' descriptions, it appeared that the professionals had not clearly explained the children's conditions to parents or they had failed to use language that parents could understand. For example, a parent said,

*He's had several diagnoses, but I'm not sure where it stands. I've talked with his therapist and he gave a diagnosis like ADHD and a few other ones I can't remember.*

In response to a question about what diagnoses on a list had been discussed with a parent, she said, "Most of them." In some cases, parents had not received a clear explanation of their child's condition, or disagreed with the diagnosis and therefore were unable to treat the child consistently in line with the work of the mental health team. For example, Ralph disagreed with diagnosis of attention-deficit hyperactivity disorder that had been given to his two sons:

*I don't really think they're that hyper. They're no more energetic than any other kids that I know.*

Another parent who disagreed with a child's diagnosis said,

*There's some listed here that the state says she has, but it's not correct... She was put on some medication, but I told her she didn't need it.*

Even TFC providers who participated as members of the mental health team were unsure of the child's diagnosis in some instances. A TFC provider described a conversation about a child's diagnosis:

*There was one listed at the meeting. It was dissociation and I don't know if he's been tested for that or not, but they sounded pretty sure that he had it. And attention-deficit disorder. That one has come up too. And post-traumatic stress disorder has come up. But these are just in conversation, so I don't know if they diagnosed him with them.*

These findings illustrate that this group of parents and TFC providers did not have adequate information to understand how to deal with the children consistently, and might have benefitted from clearer and fuller diagnostic information.

Strengths of children in TFC and challenges in caring for them. While the children in TFC had difficult emotional and behavioral problems to deal with, they also had many strengths that were recognized and appreciated by their parents and caregivers. A mother described her children as "loving and compassionate to other people." A TFC provider described a child as "friendly, outgoing, and social." Other words used to describe children in TFC were sharp, curious, independent, intelligent, funny, pretty, patient, and eager to learn.

The difficult behaviors associated with their multiple diagnoses and histories of abuse and neglect resulted in many challenges to caregivers of these children. Three children's difficult behaviors had led family members to seek their placement in out-of-home care in the first place. In other cases, challenging behaviors had led regular foster parents to request that the children be transferred because they could not manage the behaviors. Rhonda described her daughter, Brenda's behaviors:

*She has a hard time dealing with emotions. She has a tendency to lash out and get angry, instead of dealing with what's really there, like fear or sadness... She can't sit still long enough to learn anything. Brenda is a very difficult, very maneuvering, very deceitful, and when she wants to be, very trying child.*

The TFC provider described her perception of Brenda,

*Brenda is a person you can never give enough attention to. When she goes off on a tangent, yes, she makes my life a living hell...*

Karen described her son's tendency to be oppositional and to regress:

*... a lot of things are power plays with him. Like bedtime's a power play... getting him to mind, you know, or getting him to bed on time. Getting him not to whine because, like I said, he goes back to being a four or five year old.*

Typical behaviors described by TFC providers included aggressive outbursts, tantrums, lying, and withdrawn behaviors. Children were described as difficult, frustrating, time-consuming, demanding, deceitful, and trying. A TFC provider described the behaviors of two children in her care:

*Nightmares, feces smearing, encopresis, aggressiveness... biting. The main reason they were put with me is that they weren't doing well in (regular) foster care because of those behaviors. They also did food hoarding, night wandering, and food smearing.*

Referring to another child's behaviors, a TFC provider said:

*Once he decides that he's not going to do something, if you try to force him, he'll kick walls and show a basic lack of control. Its challenging for me.*

Another TFC provider referred to the unpredictability of a child in her care:

*Some days are so good with (the child) and he can just be so much fun and other days are really very difficult and you just think the day is never going to end. He gets into that negative mode and no matter what you do, nothing seems to work.*

A mental health therapist described the demands of caring for Albert:

*He is a very demanding child attention-wise. You need to give him one-on-one attention almost constantly. The other thing is that developmentally he is so delayed that his thinking is so egocentric. It's very difficult at times to get him to redirect himself and control himself.*

### **Use of Services by Children and their Families**

To address the severity of the children's emotional and behavioral problems, the TFC providers had access to a range of mental health and supportive services. Interview participants were shown a list of possible services that the child and family might receive and they indicated which services were received before and during placement in TFC. Parents and professionals indicated that before their child was placed in care, families had received few or no services to help them deal with their own difficulties, family stress, and the strains associated with caring for a child with a serious emotional disorder. Two families had received no services at all before their child was placed in care. Three families had received a combination of services including substance abuse treatment and supportive services such as family counseling, individual therapy, and material assistance. The other families had received one service, such as family therapy, short-term intensive family support from a Family Builders or HomeBuilders program, or parenting classes. Whatever their goal, these services had been insufficient to prevent placement of the children.

During placement in TFC, the children had access to a range of mental health and related services, including individual, group and family therapy, after-school and recreational programs, and special education. All TFC providers had access to regular respite care, and took advantage of this service on a regular basis. All families were invited to participate in individual, family, and/or group therapy, but not all did so. Some parents participated in drug and alcohol treatment and parent education, and a few families received intensive support and practical assistance. One family participated in a family unity meeting, an approach to decision making in child welfare that involves extended family members and formal and informal community support providers (Burford, Pennel, MacLeod & Campbell, 1996). Data about children's and families' use of services before and during placement are summarized below in Table 3:

**Table 3**  
Use of Services by Children and their Families Before and During TFC Placement

	Before placement	During placement
Family counseling	2	1
Case management	1	
Support group		1
Respite care		10
Emergency/crisis services		2
Mental health consultation		7
Medication		8
Substance abuse services	3	3
Ongoing individual therapy	5	9
Family therapy (with bio family)	2	7
Family therapy (with TFC provider)		2
Group counseling/therapy	1	6
Recreational therapy	1	6
Special education		9
After school program		3
Parenting classes	2	3
Intensive Family Services	1	1
Transportation	2	2
Housekeeping assistance	1	
Family Unity Meeting	1	
Payment for respite	1	
Family Builders	1	
Assistance with bills	1	
<b>Total no. of types of services provided</b>	<b>25</b>	<b>80</b>

The table indicates that in purely numerical terms, many more services were offered to the children and their families after they were placed in out-of-home care than before they were placed. Because of the time-limited nature of the study, it is impossible to say whether placement might have been avoided or delayed if more intensive services had been available to the families before placement. It is known that some parents had tried to get help in dealing with their child and/or their own problems before the child was placed. One parent described several attempts to get help from the child welfare agency before the crisis that precipitated her children's placement:

*... they were usually too short of funds, the problems weren't detrimental enough to my son's ability to function in society... I hadn't hurt him. He hadn't hurt anyone else. It wasn't a high enough risk factor.*

This parent was frustrated that she had not been able to get help and angry at the agency.

Parents' perceptions of services. Parents expressed a range of views of the helpfulness of the services that were offered to them. In some instances, parents failed to see the point of counseling or therapy because the goals had not been explained to them and they did not see how it helped them or their children. For example, a parent commented on family therapy sessions:

*... we don't talk about nothing that's got to do with the boys and with all their problems... We go in there and he asks me about how my visits were, what did we do, that's about it, and then the boys just sit and play the rest of the hour.*

Another parent had tried to get an explanation of his child's treatment from the mental health professional, but still did not understand:

*I talked with her several times and she tried to explain it to me and I'd go, "Huh? It ain't doing any good, so why are you doing it? You're going at it wrong."*

More frequently, parents reported that the services were helpful. After she had described assistance from a Family Builders program, a parent was asked in what ways the program had been helpful. She said,

*Because they teach you how to budget. They give you suggestions on how to cut costs. Being consistent with a chart for chores and appointments and stuff. That way the kids can see them as well... They were helpful. I wish they could step into my life today.*

A parent commented that the provision of transportation to visit her children and to attend mental health and counseling appointments helped her to have regular contact and be actively involved in her child's treatment.

The service that was most appreciated by parents who received it was parent education. Three of the parents who took part in the study participated in parent education and they described this service as extremely valuable. Some parents also said that informal teaching by TFC providers helped them to learn how to understand their children's development and to manage their children's behaviors.

A parent described how she learned a lot about child development at parenting classes:

*At first it was really hard for me to deal with and I thought because I was off the drugs that she should come to me instantly. The parenting classes helped me realize that I have to gain that trust. It's not something that comes automatically just because I'm a mom. It's something that I have to earn. I'm starting to earn that.*

Initially, Karen was unaware of what she would need to do to be reunified with her son. With support and teaching from the TFC providers, she learned how to provide consistent care and structure for her son:

*I figured as long as he got to counseling and things like that, that I was doing okay. But, it wasn't being a parent to him at all. By finding out things that he needed, as far as getting up at a certain time, going to bed at a certain time, eating at a certain time, it's hard to explain, you just sort of do it and you can tell a difference.*

Tonya began to understand the reasons her children were removed from her care and appreciated that they were helped by being in care:

*At first I blamed (the agency). I thought they're the worst people in the world. They took my kids and they didn't have any reason to take my kids. Now that I'm in recovery again, I can see why and I'm glad they took the kids.*

Some parents learned more effective parenting skills from observing the TFC providers interacting with their children and from their instruction. For example a mother said, "They really encouraged me to play with my kids." Where there was a high level of interaction with TFC providers, parents gained parenting skills from their teaching. For example, Karen described how she learned from the TFC providers:

*I learned it from... the treatment foster parents. They told me what works best with him and what they see as working well with him and I try to follow up with the same limitations that they have with him.*

A few parents did not perceive the services that were offered to them and their children as helpful. But most parents believed that the services were helpful to them and their children. Parents who were in the reunification process were anxious to ensure that they continued to have access to support and services and that TFC providers would continue to provide respite care for their child. Commenting on her son's involvement in therapeutic recreational activities, a parent said, "I think it was good for him. I've noticed a big difference." Rhonda was fearful that when her child returned home, she would lose access to the services that had been helpful:

*I hope they continue to be as supportive as they are right now. My concern is... that they are going to return her to me and say, "Here you go" and we're going to be left with no help... and we're going to be stranded, again, with a child that we don't know anything to do with.*

The overall experience of having her children placed in TFC, developing a relationship with the child welfare worker, and getting help for herself was an enlightening experience for one parent, who said:

*I'm glad (the agency) took my kids, because I wouldn't have got the help I needed if they hadn't... I think that's how I realized that I had a problem because my kids are the ones I hurt most... The child welfare worker's the one that got me to wake up and realize I wanted recovery.*

Parents' assessments of their children's responses to TFC. Despite the difficult challenges the

children posed to caregivers, all of the children included in the study were described as having made major progress in TFC, with one exception. Children's behaviors were described as improved and their emotional difficulties were alleviated by treatment. Parents, professionals, and TFC providers said that children benefitted from observing and participating in healthy, non-abusive relationships in TFC homes, from the love, structure, and consistency demonstrated by TFC providers, and from the time, attention, and teaching that they received. Only one parent was dissatisfied with the treatment and his children's responses to TFC.

All except one of the parents who were interviewed recognized the ways that TFC was benefitting their children and appreciated the qualities of the TFC providers. A TFC provider said that the placement was working well for one child because he received love, care, support, and normalcy to be a "regular" kid. Initially he had been very angry and aggressive, but now she described him as joyful, expressive, and honest. Donna, who had experienced several abusive relationships with men appreciated the loving relationships in the TFC home:

*He's seeing a man and a woman in a relationship that are not abusing each other. It's not verbally abusive, it's not physically abusive, there's no mental or psychological battering.*

Another mother whose children had been abused by her ex-husband and relatives in her family observed great changes in her children:

*There's such a significant difference in my kids. They're more trusting. They're more loving. They realize that people can care about you and discipline you without beating you to death.*

Parents also appreciated the affection, consistency, structure, and discipline provided by the TFC providers. When asked about her daughter's response to the TFC placement, Rhonda described the effects of the structured environment on her:

*She's got somebody she can rely on, even if she doesn't like what she hears. She knows that these people are going to take care of her. There's no abuse... they think the world of her. They always tell her that they love her. They tell her how beautiful she is.*

She was pleased with the TFC provider's work with Brenda:

*She's constantly on her and getting the help that she needs both emotionally and physically... She's constantly trying to find a way to help (the child) deal with the ADHD and her own personality. You know she's very patient and very stern. I think she's the best thing for Brenda right now. She seems to have everything that Brenda needs at this point.*

In some cases, the high level of family participation was believed to contribute to consistent treatment, and in turn lead to successful child outcomes. For example, a child welfare

professional described the effects on a child of the parent and TFC provider working closely together, "... she's able to see consistency from all the players that are involved in her life." Another mother recognized that the TFC placement offered her son an opportunity to deal with his problems that she was unable to provide:

*... they provided more for him than I was able to at the time. Plus it gave him a safe place to process whatever his emotions were and to have a sense of security. More security than I could offer at that time.*

Donna, who had agreed to relinquish her parental rights, recognized the skills that the TFC providers were teaching her children :

*She's giving my children tools that will help them throughout their lives... Reasoning tools, problem solving tools, coping skills that I don't think I could have done as effectively or as efficiently.*

Other parents noted improvements in their children's behavior as a result of their TFC placement. A mother commented that the TFC providers had helped her son deal with his anger and express his emotions. Another parent saw that her daughter was no longer having tantrums and her younger child whose speech was delayed started to talk. A mother saw her son change and she learned from the TFC providers how to maintain the progress he had made:

*It helped him in understanding that there's guidelines in life. He learned to trust, to listen, basically. And it was good because when I started meeting with them, they kind of passed it on to me, so it helped me work with him the way they were working with him.*

In one instance, a father, Ralph was unhappy about the way his children were being treated and said that the TFC provider had "weird ideas" about raising children, even though the TFC providers and professionals saw improvements in their behavior. He disagreed with the TFC provider's strategy to teach his sons less violent behaviors:

*I'd buy them a toy or something, like a little die-cast airplane or something and she'd take them away from them because they were too violent. And giving (a child) a bottle to go to bed with.*

He also believed that placing his two sons in separate TFC homes had a negative effect on them, "... it seems like they're just going back downhill now that they're apart." The professionals in this case did not clearly communicate to the father how they believed the treatment plan would help the children.

One child, Albert, appeared not to respond well to TFC and there were plans to move him to a group home at the time of the study. The child welfare worker described his deteriorating behaviors:

*He began doing some serious regressing. He began assaulting the foster mom a couple of times... He was minimizing. He was avoiding issues... out of retribution for her grounding him, he snuck out of his bedroom one night while they were sleeping and keyed their car. He caused a lot of damage... The child was kind of withdrawing.*

Because of these changes in the child, the treatment team decided that family care was not appropriate because "the emotional quality of a family was too close for him to handle at that point" and he was to be placed in a group home with special education closer to his mother's home where they could have more contact.

### **Family Participation in Therapeutic Foster Care**

The major focus of the study was on family participation in TFC and the three groups of respondents shared their perspectives on this topic. Separate reports of the findings on parents' perspectives and the perspectives of professionals and TFC providers are reported in detail elsewhere (Jivanjee, in press a; b) and much of the material in the following sections is drawn from these articles.

All parents expressed their wish for regular and frequent contact with their children, but many were constrained by requirements related to their own behaviors which were placed on them by child welfare professionals. There were also limitations placed by some TFC providers who did not want parents to know their telephone number or where they lived. Some family participation was constrained due to parents' lack of time and or access to transportation. Parents also wanted to have information about their children and to have a say in planning and making decisions about their care and treatment. Child welfare practice related to family participation in decision making varied greatly.

Professionals and TFC providers described their values and beliefs about working with families generally and their attitudes toward specific parents. Concrete examples of activities and behaviors that supported and impeded family participation were reported by parents, TFC providers, and professionals. In the analysis process, it appeared that relationships and practices with parents were shaped by professionals' values regarding family participation and their attitudes toward specific parents, and by TFC providers' willingness to communicate with parents and facilitate parent-child contact. Challenges to family participation identified by professionals related to system level barriers and TFC providers' lack of training and/or hesitation to work with parents. Parents also identified barriers to their participation, such as professionals' and TFC providers' negative attitudes toward them, professionals' lack of follow-through, and TFC providers' reluctance to have contact with them.

In the discussion that follows, findings related to family participation and the specific factors that enhance and constrain family participation in TFC are reported. Descriptions of professionals' and TFC providers' values related to family participation and cultural issues, attitudes toward parents, and practices and relationships that promoted or impeded family participation are

followed by discussions of organizational barriers to family participation. Strategies to enhance family participation are also reviewed.

Professionals' and TFC providers' values related to family participation. All of the parents interviewed in the study wanted to have a lot of parent-child contact and a high level of participation in planning and decision making in relation to their child's care. All professionals and some TFC providers expressed positive values toward family participation in TFC and one professional noted the original philosophy of the program:

*The criteria for the program (were) originally to have family involvement, with the goal being to return the child to his family. That's not always been able to be the case. That's our ideal.*

The predominant positive themes in favor of family participation were related to the practical goals of viewing parent-child contact and family participation in planning as ways to maintain parent-child bonds and achieve positive outcomes. Child welfare workers were supportive of keeping families together wherever possible and they expressed beliefs that family participation contributed to successful outcomes for children. For example, a child welfare professional said,

*... the family needs to be part of the case plan. None of us likes to be told that we're failures or that someone else is going to tell us what to do and how to do it better. And it doesn't work if we do that, so its got to be a partnership where they buy into what's going on and understand their participation in it and recognize and take responsibility when they fail to do what they've recognized they should do.*

Another child welfare worker commented:

*I realize that any effective work we've done with Laura has been through gaining the support and connection with her parents.*

Several child welfare caseworkers worked with parents to help them understand the goals and planning in the case, and to assure their commitment to the goals. Tonya's case worker explained his approach to developing partnerships with parents and gaining their cooperation:

*We want to be part of your team. We want to work with you... You may see us as an adversary, but we want you to understand that we are not your adversary, we have saved your child from what we thought was a serious problem. We want to work with you so you can correct what was happening that placed that child in the situation.*

Even where it was unlikely that the children would return home, there was a preference for maintaining attachment. With reference to Donna, a mother with mental illness who had agreed to relinquish her parental rights, the child welfare worker noted:

*Andrea needs to know who her mom is, good, bad, or indifferent... In time, everyone will understand each other. Not living with your mom isn't the worst thing in the world, but never seeing your mom could be.*

Information sharing was emphasized as an aspect of family participation by some workers and TFC providers. For example, a child welfare professional described his work to reestablish a relationship between Albert and his mother:

*I try to call her now and include her in what's going on in (his) life... I think that's been good for her. I think she's felt more involved that way.*

Another child welfare worker saw her work with parents as a valuable instrument for teaching and supporting parents with the goal of family reunification:

*... we are trying to bring the family back together and I think the treatment has to be focused on that and facilitate that. So the more the families can be involved in the treatment process, I think the more successful the family will be when they leave treatment. It's like doing push-ups. We get strong and get in condition when we practice. We practice being good parents, good families, good children and then after we practice it enough and it looks like it's working, then we say, "OK, go play the game." I think that's why involvement is important. We have to give them the tools to do that.*

Having described values in support of family participation, some child welfare staff mentioned constraints that they would impose if parents did not comply with the treatment plan. Referring to the relationship between a boy in TFC and his mother, a child welfare worker said,

*I think it's important for him to have involvement with his mother. He really needs that. However, if she regresses back to drug use or selling drugs, then he shouldn't have any involvement with her.*

Relationships were strained in situations where TFC providers did not value the families of children in their care. A few TFC providers did not think that it was their job to have contact with parents and they did not think parent-child contact was helpful to the children. One TFC provider said that she thought it would be a conflict of interest for her to work with parents. She did not want parents to have her address or telephone number and preferred the child welfare worker to pass on all communications. Another TFC provider said she did not interact with parents because,

*I think it is more important that the therapist does that kind of work with them. Sometimes it is real easy if you get involved with the parents to get caught in the middle and I just don't want to do that.*

Only one child welfare professional described a general preference to limit parental participation

in TFC. She favored family participation only in the later stages of care, believing that children need time to make progress in treatment before contact with parents is re-established.

Cultural and social class issues. The philosophy of the TFC program was described by one TFC provider as being to honor the values and beliefs of the children and their families. Taking culture, social class, values and beliefs into account in placement planning and respecting family values during placement were seen as important in the general sense, although this did not always happen in practice. In response to a question about the importance of considering culture and values in TFC placements, a child welfare professional said,

*I think that it's very important. If a child comes into a home that is totally foreign to them... the child is likely to be freaked out about being in a totally different environment. They need something that's familiar.*

Unfortunately, in planning placements, it was not usually possible to match children with TFC providers because of the limited availability of placements. In situations of limited TFC resources, variables such as child safety, keeping siblings together, having a two-parent foster family, or foster parent experience in dealing with specific kinds of behavioral difficulties were dominant. Therefore, there was little or no matching based on cultural issues or family beliefs. One child welfare professional stated her belief that matching culture and life style were ideal, but that providing safety and structure and meeting the child's emotional needs were more important. In response to a question about taking family culture and values into account in placement planning, a caseworker responded:

*If it was a perfect world, we'd consider those, but it isn't. It's far from it, and it's hard enough to find a good provider like (the TFC provider), let alone all the other things that may be helpful.*

Another child welfare worker affirmed the influence of practical considerations related to meeting the child's specific emotional and behavioral needs:

*I don't know if her beliefs were even considered. I think it's the expediency of looking for the best resource for the child taken into account. We did try to look for the best interest of the child, one that worked for the child. A combination of the behavioral problems and the personality of the foster home. The reality is that sometimes it is driven by the availability of resources.*

Generally, there seemed to be a preference among caseworkers for attention to basic "good" values, for example,

*I think the safest situation is that the children should be in a home where there are good values. Where there is love and where there is recognition, validation, appreciation.*

Parents varied in their responses to questions about the extent to which they believed that their beliefs and values had been taken into account in the placement process and how important this was to them. One parent was focused on the best care for her child, "I really don't care what their beliefs are as long as they take care of my daughter." Annette appreciated that her request for her bi-racial son to be placed in a bi-racial home was fulfilled, "I thought he'd be more comfortable in a home like that." In response to a question about the extent to which her beliefs and values were addressed in the placement decision, a mother said that she was not asked about values and beliefs but that she felt sure that they had been taken into account because of the qualities of the families that children were placed with. Another mother noted that she had been asked for "a little bit about my background, if I had a religious background or anything like that." Other parents said that there had been no attention to their values in placement planning.

For children in placement, most TFC providers said that they tried to honor the family's beliefs and values. But in several cases they actively worked to change children's behaviors that had been acceptable in their family home, but that the TFC providers did not value. For example, TFC providers taught children table manners and predictable daily routines and they limited children's access to television programs. One TFC provider commented, "I think that we accept their values except for the discipline part. They just have to go by our rules and the program's." In most cases, parents were satisfied because they received explanations and observed improvements in their children's behaviors. For example, a mother said, "That's their ethics and that's the way they run things and that's OK with me because (the child)'s calmed down so much and he's not so rowdy." Another mother commented, "It's the kind of home I wish I'd had when I was growing up."

In some cases, differences between parents and TFC providers in their beliefs about appropriate child-rearing practices contributed to conflict. For example, a TFC provider restricted a child's access to toys that his father had given him, because she believed that they contribute to his violent behaviors. Unfortunately, the treatment team did not include the father in treatment planning, even though the long-term plan was to return the child to the father's care. As a result he was angry and resentful. The child welfare caseworker in this case believed that the father needed support and education to understand his sons' mental health needs and to provide appropriate care. But there was conflict between child welfare and the mental health treatment team which she related to value differences:

*The dad's family is very conservative, redneck, anti-authority, down-to-earth, tell the truth, anti-establishment, anti-government. They're just hard working people who drink periodically and who live hard.*

The relationship difficulties between the professionals and this parent were exacerbated by the treatment team's efforts to change the values of the boys by criticizing the father. The child welfare worker was concerned that negative views of the father were being presented to the children. She feared that by not honoring the values of the family or supporting the family as a unit, more harm would be done in the long-term:

*I think they need to be teaching the boys to think and feel with the values of the family... But not try to change the boys' values. They will go back to their family and we've got history cases that you can go back on how many kids we've kept in foster care for years because their family has not been good enough, or safe enough to raise them and as soon as the kids are eighteen, they move back home and join their parents.*

Unfortunately, the mental health therapist was unwilling to be interviewed for this study, so the researchers are unable to give a fuller explanation for the treatment rationale in this case.

Social class difference was a consideration in the TFC providers' treatment of children and responses to parents. Some child welfare professionals were concerned about the effects of economic difference on children who would return home from an affluent TFC home. One child welfare worker thought that placement in an economically advantaged home was disrespectful to parents who did not have access to adequate resources. Another child welfare worker stated her preference for placing children in the same or a similar neighborhood to provide continuity, but given the treatment needs of these children, local placement was not feasible. One worker was particularly concerned about the attitudes of TFC providers toward the parents of children in their care:

*Typically, they are maybe in a different class, but if it is a lot different, then I think it makes treatment harder. I think if you get people who can't relate to the parents, who look down on the parents, then you're doomed.*

Professionals' and TFC providers' attitudes toward families. Professionals' and TFC providers' positive attitudes toward families contributed to the development of effective working relationships. Predominant positive attitudes were: empathy with parents' struggles; appreciation of their courage and strengths; and respect earned by parents who complied with treatment requirements.

Relationships with parents appeared to be stronger when professionals and TFC providers had respect for them and empathy with their struggles. A TFC provider had empathy with parents of children in TFC who had to comply with requirements:

*I wouldn't like to go through what any one of these moms has to go through because I like being in control of my life. I wouldn't want anybody saying I had to go to the parenting class, this drug and alcohol class, this group session. I mean those are a lot of hoops to jump through.*

A mental health therapist had an empathic attitude toward a mother:

*I have this compassion, this empathy for her because I see the work she has done to turn her life around.*

A child welfare worker described her feelings about Karen, a mother who had faced many challenges, but had met all the requirements of the agency:

*Boy, I have a lot of respect for her. She went through a lot and did everything that was asked of her. I feel sorry for her because she had a horrible upbringing and she knows it. And I can understand how she feels angry about it.*

Another caseworker described her respect for Annette, who had advocated for appropriate services for her son and demonstrated resourcefulness in gaining what she needed to help her to care for him:

*Of all the parents I have ever worked with, one of Annette's greatest assets is that she uses community resources better than anyone I have ever known... It's not just playing the system. She really knows how to use those resources for what they are meant to be.*

Some parents earned professionals' respect by complying with the treatment plan. For example, a child welfare worker, admitted that she had overcome her initial reservations about a mother and came to respect her:

*When I first read the case, before meeting (the mother), my immediate response was, "Oh, this is horrible, How could this person have ever done this? And we need to find this child an adoptive placement." And then I met her and I began to see the remarkable changes she'd made in her life and ... how she was now back in her life and accepting full responsibility.*

She added that she believed that this parent could be supportive to other parents in similar situations:

*She's very well respected because of the major turnaround that she's made and her insight and ability to take responsibility and comply with services. She's just done a marvelous job. I would say she's an excellent example for another parent following in her footsteps. In fact, that's been brought up, that she would be a good resource for other parents to talk with.*

Practice with parents was also shaped by negative attitudes on the part of some professionals and TFC providers. The most frequently encountered negative attitudes incorporated skepticism about parents' capacity to keep their word, dislike, and fear. A TFC provider reflected on how her experiences had made her cynical about a parent's capacity to comply with requirements:

*... you have to understand that people, after you have worked with them for a while, get a reputation for a certain type of behavior and you get to the point where you expect certain things from certain people. Where we would listen, a lot of it you just kind of take with a grain of salt.*

In one case, the mental health treatment team had a negative attitude toward a father whom they excluded from planning his children's care. Even though the children had been removed from his ex-wife's home and a judge had determined that he would be their after-care resource, the child welfare worker said that he was shut out of planning because the team disliked him.

*They don't like this parent and so they intentionally do not give him the services he needs in the way he needs to get the information.*

A TFC provider feared parental contact and avoided having parents visit at her home or taking children to their family home. Instead, she arranged to meet parents at an agreed place when a home visit was planned for the child in her care:

*Usually we try to stay out of going to their home... I feel more protected. Sometimes the parents feel bad about not having their kid and sometimes we become the target of the parent's feeling. So we try to shield that by maintaining somewhat of a distance.*

Parents' perspectives on their participation in TFC. Practices which facilitated or constrained family participation contributed to families' satisfaction with their children's treatment. Aspects of practice described by parents were: communication with parents; facilitation of parent-child contact and parent involvement in decision-making; and interventions to enhance parenting skills.

Parent-professional communication and information-sharing emerged as important themes in family participation in TFC. Some parents were regularly informed about their child's progress. For example, Tonya said, "They always make sure I know what's going on and why." In response to a question about her involvement in decision making, Rhonda said that she felt respected by the team:

*All the suggestions that I've had a chance to make have been accepted. If it's something that they think is appropriate then we find a compromise... They don't make me feel like I'm two inches tall or that I'm stupid, you know, or that I'm just looking out for myself. They realize that this is all really hard for me and I'm trying to do what's best for everybody and so they help a lot.*

Frances appreciated the TFC provider's willingness to give her information about her children:

*She'll call and tell me that they have a doctor's appointment and what for. She'll call and tell me what's going on. She's really good.*

In addition, this mother was pleased that the provider took time to learn about the family so that she could keep the children connected with relatives that they had not seen:

*She's asked me a lot about my family because they've asked a lot of questions. So she can tell them about their aunts and uncles. I was surprised, she called up and asked all their names and memorized them so she could talk about them. She says its important that they don't forget, so she talks to them, like two times a week, about my family besides me.*

Some parents appreciated child welfare workers' and TFC providers' efforts to facilitate their contact with their children. A mother described the increasing frequency of her contact with her son as she prepared to bring him home:

*He was able to call me every day. I was able to call him every day, if I needed to. There, for a while, I was going out there about once every other week during the week to see him for a couple of hours... Then weekends.*

Another parent commented on the TFC provider's support of her contact with her children:

*She (the TFC provider) seems to be the only one that wants me to be involved... She thinks it's important because my kids ask about me a lot.*

There were quarterly treatment team reviews of the cases of all children in TFC. Bi-annually, the progress of each child and family was examined by a citizens' review board (CRB), an oversight committee of local citizen representatives, professionals, legal representatives, and parents. At these meetings, decisions about children's future treatment and care were made. A mother offered her perspective on CRB meetings she had participated in:

*It's run in a formal way... they go over the service agreement for each of the children, how the foster parents see them coming along, how my interaction with the kids is going, how the counselors see the kids changing, and what problems they are still having. Then, of course, how (the agency) sees me and my interaction with the kids.*

In response to a question about the extent of their influence in decision-making, some parents, including those whose children were in the custody of the state, said that they had a lot of influence. In response to a question about her influence in decision-making, a mother said:

*Right now it's a group effort... As far as rules about how (the child) is being treated and what her treatment is going to be, I would say that the foster mother and the caseworker have more control over exactly what will happen, but we're given a say in it. If we say, "We don't feel this is right," then they'll say, "What do you think is?" and we'll give them our suggestions and we have a tendency to compromise.*

This parent described her initial nervousness about participating in a CRB meeting, and her relief

when she was not made to feel uncomfortable. When asked about her experience, she said,

*Actually it was pretty easy. They were all really nice. I expected a bunch of ogres in suits that didn't care about how I felt, you know. It was quite the opposite. They were very nice people, they were parents and grandparents and they were willing to listen to what I had to say. They were very fair. It wasn't nearly as bad as I thought.*

Debbie reported that she participated in decision making when plans were made to move her son from TFC to a group home. The child welfare worker explained the reasons for the move and it was agreed that Albert would benefit from being closer to her, so that they could have frequent parent-child contact. Tonya discovered that she had a right to participate in decision making when she learned at a CRB meeting that her son had been prescribed medication:

*I found out that (my son) was on Ritalin and they asked me if I had any questions and I said, "Yes. I would like to know why I don't have a right to know when my son is put on medication." The lady that was running it looked at my worker and said, "Why hasn't she been informed?" Her supervisor, too, looked at her and said, "I'd like to know that too."*

This discovery led to the mother overcoming her apprehension and becoming comfortable asking questions at meetings:

*With all these professionals in there, I got really nervous, but that helped me know that I can say stuff... Now I know that I can ask questions and I can also demand to know what's going on with my kids. I found out that's mandatory that they're supposed to let me know that stuff.*

The event was a turning point in the management of this case. Tonya commented,

*That helped make me feel more comfortable because I realized that my opinion did matter and that I was supposed to be informed. Since then, they've informed me when any of them was put on medication and what the medication is for.*

In contrast to these examples of efforts to involve parents in their children's care, there were situations where parents were allowed only limited contact with their children, received little information, and were left out of discussions. While the TFC standards require family participation in TFC placement decisions, only two parents reported that they were involved in any way in planning their child's placement. Annette requested a voluntary placement in a treatment home for her son because she was finding it impossible to manage his behaviors and Wanda asked specifically that her son be placed in a home with other children. Other parents complained that they were not allowed to have direct contact with their children. For example, a mother said,

*Right now I'm not allowed to know where they live. I'm not allowed to have their*

*address. I know what town they are in, but that's it... I would like to be able to call them once in a while.*

Another parent complained about not being allowed to have telephone contact with his children:

*I don't have their phone numbers... they're supposed to let them use the phone whenever they want... and (the child), he used to call me all the time and he doesn't call nobody now. I know they aren't letting them use the phone.*

A TFC provider described her own efforts to involve a mother in her children's lives, but said that the child welfare worker was reluctant to invite the mother to meetings:

*Social services is more not liking to involve everybody. It wouldn't have been the caseworker's choice to have her there... The caseworker didn't include her in the first (meetings).*

Some parents who felt left out of planning and decision making were extremely angry about being ignored. For example, a father was angry that he was not given information and that his questions were not taken seriously:

*They will not tell you everything. They make you feel like they are God. They don't listen to people. Every time you say something, they turn it around or they just block it out completely... I've been treated rotten. Like the bad guy.*

He attended review meetings, but did not feel that the team were open to hearing from him:

*I basically just sit there and listen... Because it doesn't matter what my opinion is. They're the treatment team. It's what they think is what they are going to do.*

The child welfare worker in this case was sympathetic to the father's feelings and felt that his anger was justified. In response to a question about how his comments were received by the treatment team at meetings, she replied, "As if he weren't there and as if he were a small child that they were giving direction to." Another parent was angry and resentful because he felt that he had little involvement in decision-making about his daughter's care and treatment. After several visits had been canceled, he described his plan to visit the agency's central office to demand more frequent visitations with his daughter.

Supports for family participation. It appeared that collaboration between parents and professionals was enhanced when professionals demonstrated honesty and appreciation of parents' strengths and their efforts to comply with requirements and fostered trust with parents. Parents appreciated child welfare workers who told the truth, shared information with them, involved them in decision making, and provided support and advocacy. Relationships between TFC providers and parents were more likely to develop when they demonstrated positive attitudes toward parents, shared information, and facilitated contact with children.

Positive relationships of parents with child welfare workers and TFC providers were characterized by a high level of trust. A child welfare worker described her approach to developing relationships with parents through honesty, support, and information sharing:

*(I say) "From today forward, I'm going to be honest with you. I expect you to be honest with me." And I give them all the power and control... I let everybody know what I know and everything I know as soon as I know it. And how to beat the system. And I give them the tools to do it.*

Rhonda was appreciative of the professionals' support of her child and honesty in their conversations:

*The caseworker is very supportive of Brenda, but yet she tells us the truth. She tells us what's going on. She doesn't play games. The mental health worker is very straightforward.*

Tonya described the child welfare worker's attention to sharing information with her and offering support:

*He's always explained everything to me in great detail... He's tried his best to be understanding of my situation. He always asks and makes sure I understand and that my voice is heard. If I have any questions, I can call him anytime I want. He's always there for me. If he's not in the office or able to take my call, he always gets back to me as soon as he can. He's always been real supportive and encouraging.*

This caseworker saw the importance of supporting Tonya to fulfill her parenting role to the fullest extent possible, even though her children were to remain in long-term foster care:

*I think its very important for a client to feel that their caseworker is an advocate and really trying to work for them... My job is to strengthen her and lift her up and help her to be a good mother.*

Tonya recognized and appreciated this effort:

*I have someone that's not only... on my side, but that can understand my side and will voice an opinion when I want to be heard. And when I say, "Hey, I don't understand this," will say, "OK, let me explain it this way."*

In a small number of cases, the child welfare and mental health professionals, TFC providers, and parents worked together in a collaborative way, exemplified by one situation described by the child welfare worker:

*Karen is involved in the decision making, involved in setting the structure and the boundaries and limitations for Sam, so that everybody is in sync. And what (the TFC provider) is doing in her home is the same as what Karen does when Sam visits and it's worked out really well.*

TFC providers were the major decision makers in relation to the amount of contact with parents. Their preferences for or against contact with parents appeared to be a result of their life experiences and preferences, rather than training. For example, a child welfare professional commented on one TFC couple's capacity to work with parents:

*I think that they have a lot of natural ability to accept parents for who they are and not accept them for who they think they should be. And I don't know how you can train somebody to have those kinds of values.*

Further, she believed that their experiences raising their own children had been influential:

*All of their children are grown and raised and they've been through this before and I think that has definitely had an impact on them and their ability to continue to provide care to these kids.*

The TFC provider explained that he was raised in foster care because of alcoholism and abuse in his family. His wife said that their ages (65 and 53) and experience raising their own child with attention deficit disorder prepared them to work effectively with children and parents.

One TFC couple were in recovery from alcohol abuse and they discussed the effects of their involvement in Alcoholics Anonymous in their work with a child and his family:

*We're recovering people. There's not a child we've worked with that doesn't have that in their backgrounds, so we use that as a treatment tool... We were able to talk to him about alcohol and drug addiction and how it affects his family in a realistic way.*

Other TFC providers mentioned their parenting experiences and work experiences in health, education, mental health, and developmental disabilities which prepared them for TFC.

Positive relationships between parents and TFC providers were related to providers' willingness to get to know parents, to discuss their goals and strategies for treatment, and to negotiate with

parents. One TFC couple talked about their work to build trust with the family of a child in their care:

*We have to earn trust with the family... The beginning starts with me making contact with them... I try to keep them apprised of what I have seen in (the child). And that just began to grow. Once I trusted that this was a safe family, then we began where they could call here, have the phone number, they could call (the child) when they chose to. Then they could come and pick him up or take him on visits.*

These TFC providers monitored the child's visits and saw their role as educating the parents about what would be helpful to the child:

*... we found out that all his siblings were there, which was not part of the treatment program. We wanted Jamie to feel special. We don't want the interference of the other kids... So we had to educate the parents along those lines.*

Parents gained positive perceptions when they observed the love and care given to their children. For example, a mother described the qualities she saw in the TFC providers and their behaviors that were helpful to her child:

*When I met them, I could see that they were real gentle people. They took the time too, even if they were busy, they took the time, and that's what he needed.*

Another parent observed the caring, structure, and consistency that her child gained from the TFC providers:

*There's so much love and nurturing there, that they know that if they disobey the rules that they're going to get disciplined. But its going to be in a positive way and yet they also know that if they do what they're told, they're going to get love and praise for it... They play with them and they love them and they let them know that they are loved and yet they set boundaries for them.*

A mother described the ways that the TFC provider had been able to bring about positive changes with her child:

*She's constantly trying to find a way to help (the child) deal with the ADHD and her own personality. You know, she's very patient and very stern. I think she's the best thing for (the child) right now.*

When asked how the TFC provider responded when she expressed concerns, a mother explained, "We'd sit down and I'd voice my opinion to them and they would listen and we'd talk about

things and kind of figure out a compromise." The child welfare worker attributed the positive relationship between this parent and TFC provider to their personal qualities:

*The foster mother is very laid back and very willing to listen. She's not one to pass judgment. She can set limits and she can hold her own. But she's just a good listener and does not come across as condescending or authoritarian... Rhonda has just really clicked with her and because Rhonda is in such a different position than she was in two years ago, she's also working very well with the foster parents.*

One couple provided TFC for children from three families who were included in the study. Two of the families worked toward reunification, while the children of the third parent were to be placed for adoption because of the mother's serious mental illness. The two child welfare workers who worked with this couple commented on their openness to communicate with parents, support parents, and facilitate parent-child contact, as well as provide a healthy therapeutic environment for the children. For example, the caseworker described the TFC provider's relationship with the mother who had agreed to relinquish custody of her children to the state:

*(The TFC provider) has a kind of open communication with Donna. So Donna is able to call her at least once a week and just kind of vent about what's going on and what she's frustrated about... Its just a really good situation because it allows Donna to talk to the kids. She can assure herself that they are safe. She can feel that she's a part of what's going on in their lives. She feels like she has some kind of connection to them through their foster mom... It's made a big impact on how Donna feels about the fact that her kids are in foster care.*

These TFC providers took on additional roles to prepare parents to care for their children. The TFC provider described her work with a mother and her daughter:

*... just starting slowly, letting her get the feel of being a mom, without saying, "Here's your kid." So now we're to where I take her one week and Rhonda takes her one week. And now when Rhonda is too tired and too stressed, then I'll just keep her home. I want this to work.*

Rhonda was fearful about her daughter returning home because she was unsure of how to manage her serious emotional and behavioral problems. But she was relieved that the TFC providers were committed to following through to ensure that the reunification was successful:

*Knowing that I have support... They've already told me that if there's any time I need a break, that they'd take her for a night or a weekend. So knowing that I have someone in my corner, they're not just going to turn her back over to me and say, "Here's your kid." There's no way I could handle that. So I'm needing all the help I'm getting right now.*

The TFC providers gave support and education to another parent who had not previously had opportunities to learn how to be a parent because of neglect in her own childhood. As well as providing a consistent, structured environment for the child, the TFC providers welcomed her into their home, and taught her how to provide structure and consistency for him. The caseworker commented:

*(The TFC provider) would prompt Karen on how to correct his behavior and so, you know, she did a lot of modeling and re-parenting of Karen, so that she could parent her son and it worked really well... I could see it as she got to know Karen and as that sort of fear and fantasy about what the birth mom is like went away and as she got a grasp on what she was really like.*

During visits, Karen appreciated their teaching and willingness to share parenting with her:

*As soon as I got there, Mom was the boss, instead of the foster parents being the boss. Which I didn't know anything about, being a parent. Nothing. So I'd ask them a lot of questions, "what time is his bedtime?" A lot of things I didn't know... So it was like learning to be a parent and trying to ask them what I should do.*

The TFC provider believed that her work with this mother contributed to the rapid and successful family reunification.

Where family participation was not valued by professionals or TFC providers and where there were negative attitudes toward parents, relationships were strained. In two cases, the TFC providers did not like the parents and did not want to have contact with them. By coincidence, in these two situations, fathers were the primary parents involved with their children. These fathers were distrustful of the professionals and the child welfare/mental health systems generally. A father no longer believed what the professionals told him: "They speak with forked tongue." Another father was excluded from treatment planning because of the mental health team's and TFC providers' negative attitudes toward him, even though the judge had determined that he would provide after-care for his children. He commented:

*They don't hear what I say. They only hear what they want and they can write down what they want and they can read anything the way they want to. And if they put that word, "treatment" in front of anything, bam, its necessary.*

He complained that he had been ignored when he expressed his opposition to the plan to separate his two sons and place them in different TFC homes:

*I told them how I felt about them splitting them up and stuff. I don't think its right for them to put them back together and then jerk them apart just because they fight with each other. They ain't never going to work on it if they aren't living together. It don't make any sense to me. But they did it anyway.*

The TFC provider restricted his son's access to some toys to teach him less violent behaviors, but the treatment team did not explain their rationale to this father. As a result he was angry and resentful:

*She's way too strict. They can't play with nothing. Everything is "too violent." They can't watch nothing on TV. They can't watch, you know, Teenage Mutant Ninja Turtles. They can't play with nothing, not even a little metal airplane.*

The father was aware of the negative attitudes toward him and was angry about the way he was treated:

*As far as I was concerned, they weren't going to let me have the kids at all. From day one, I was out of the picture just because of some charges that were filed against me a couple of years ago that were false.*

In response to a question about his relationships with the professionals and TFC providers, he said:

*We don't have a relationship, just "Hi!" and "Bye!" They don't like me... It doesn't matter what my opinion is. They're the treatment team. It's what they think is what they are going to do.*

The child welfare worker advocated for this father, but was unable to persuade the mental health team to teach him how to manage his children's behavioral difficulties. She complained that the mental health team were not doing what they had agreed to do:

*They have absolutely refused to provide him with any education or training having to do with the fire setting. They refuse to do it. They don't think it is their job to provide this parent any information about how to deal with a child who is a fire setter... They've refused. (The mental health therapist) stood up in court last week and told the judge, "We will not do that. It's not our job."*

A TFC provider was fearful of contact with parents of children placed with her. She described an early contact with the father of a child in her care:

*He was quite angry at the beginning and he used the meeting setting as a platform to complain about not being able to see his kid, all the things he feels (the agency) is doing to him and all that... After that he was more calm. But at the beginning I was concerned. I was scared of being around him.*

Barriers to family participation. Parents, professionals, and TFC providers identified different kinds of barriers to family participation and parent-child contact. Parents noted that the major barriers included their lack of access to transportation, inconvenient scheduling and location of meetings, and the limitations placed by professionals, while professionals focused on systemic barriers in the organization and parental behaviors. Wanda was unable to see her son as often as she would have liked:

*I have trouble getting transportation over to their offices... It's a little hard to get back and forth. It gets impossible to make all these meetings... There are times when I'm looking for work and I'm trying to do all this stuff.*

In response to a question about what would make it easier to have contact with her children, a mother said, "Phone numbers. Right now, I'm not allowed to know where they live... I would like to call them once in a while." Another parent thought that professionals were not in touch with what was going on in his life:

*Be more helpful. Just see the real world and come out of their bubble... Seems like they haven't been out of their office in a long time.*

A mother complained that the child welfare worker was unreliable and did not always keep her word:

*She'll set up meetings and not show up and not even call. And she'll say she's going to do something and she won't do it.*

She was thankful that the TFC provider placed a high priority on parent-child contact and was willing to advocate on her behalf:

*(The TFC provider) thinks that the kids should see me for more than an hour a week and she has to get that approved. And it took her forever to get that phone call approved. It took her three months to get that phone call approved. I think she should know what would be in my kids' best interest. And I think she should be able to make those kinds of decisions.*

Professionals identified a number of organizational barriers to family participation, which were related to bureaucratic constraints and lack of time, the program philosophy about working with parents and the intrusive nature of child protection work, negative attitudes toward parents, parents' discouragement, and lack of TFC provider training. In response to a question about barriers to working with parents, a child welfare professional said,

*Definitely large case loads. ...it seems that more and more paperwork is taking a precedence over family contact.*

One of the counties required staff to delegate work with the families of children in out-of-home care:

*We're not allowed much time or expected to work much with families ourselves. We're supposed to delegate that to the people at the group home, the therapist, or someone. Well, its a problem right now because there isn't anybody connected to this family.*

A mental health therapist described the cumbersome bureaucratic requirements for Albert and his mother, Debbie to renew their relationship:

*The fact that there is red tape. . . You have to do a home study, you have to go in, you have to meet both parents, you have to make some kind of service agreement which says what needs to happen. They need to do everything that someone who would be having this kid in their home would have to do. Pass criminal checks, be cleared for alcohol and drug issues, because they've had severe issues in the past, whatever their own treatment concerns would be. And they have to have that down on paper and signed.*

A child welfare worker noted that the child welfare agency should have tried sooner and more diligently to locate this mother:

*In retrospect, it was the agency's fault, quite frankly, for not trying to find out more about mom. Because we had an address for the lady. It wasn't like she lived in Timbuktu on a schooner or something. She lived in (city), for heaven's sake!*

One child welfare professional saw the involuntary nature of child welfare as a barrier to building relationships with families. In response to a question about the barriers to family participation, she expressed concern about the effects of child welfare professionals' interference in the lives of families:

*... the fact that you are pulling them out of the home. And how it feels to them if there is progress and what that means to them and what it means to have people looking at your family system and tinkering with it and maybe the impression that people are pointing their fingers at you. Those are probably the main barriers.*

Professionals' and TFC providers' lack of commitment to families was also mentioned as a barrier to family participation. For example, a child welfare worker said that the mental health team deliberately prevented a father from having much contact with his children:

*The treatment team. They're the barrier. I would have him have as much contact as possible and every weekend have visits. I want that to happen, but that's not going to happen partly because the foster parents have their own life and their own schedule and things. That's not what the treatment team wants and they can throw up a lot of road blocks.*

In that county, the child welfare professional said that the mental health agency was neglecting family participation in TFC, even though it was a primary focus in the program design:

*They don't, and to my knowledge, have not ever worked with families... My supervisor was one of the people who helped write the program and knew that it was part of the contract and was surprised to hear that there has not been any family work done for a couple of years.*

A child welfare worker pointed to parents' behaviors as a factor that constrained their participation, specifically their lack of cooperativeness and unwillingness to be truthful or to adhere to service agreements. In contrast, a mental health professional was empathic with parents' lack of energy which may act a barrier to family participation:

*It's no wonder that these parents are where they're at. They've given up, the majority of them, by the time we get these kids. They've really given up. And so, somehow, you have to get them back involved.*

Some child welfare workers lamented the lack of support services to help parents gain the skills and motivation to become involved with the care of their child.

In two counties, TFC providers' lack of training in working with parents emerged as a barrier to family participation. TFC providers in these counties could not recall receiving any initial training on working with parents. For example, a TFC provider said,

*... our main goal has always been the kids and you need to be able to get along with the parents, but if they're a stumbling block with you being able to work with the child, you're going to have to find a way around it because the child is always your first concern. I can't right off the top of my head think of a training where it was presented specifically, "this is what you do."*

Another TFC provider commented on the confusing guidance about dealing with parents that she received in her training:

*... there were two lines of behavior. One was encourage the birth parents, get them involved. The other was, don't have anything to do with them. It just came from different people telling their perspective. Because we had different people come in and give us lectures.*

This lack of training to prepare TFC providers to work with parents was highlighted by a child welfare worker:

*We've recognized that as a real need. It's an area that repeatedly seems to be a problem for parents... we're seeing this across the board that the relationships to the biological parent and how that works can manifest itself differently in different homes and some homes do a marvelous job with it and other homes seem to struggle. So I think (we need) a good training on it.*

Strategies to promote family participation in TFC. When parents were asked how family participation in TFC could be improved, their responses generally focused on ways that professionals could have been more helpful with their personal and family problems. Several parents wished that the agency could offer them individual counseling or a support group to help them deal with the loss of their children and the many other problems in their lives. Tonya, who had a history of drug abuse, wished that she had been offered support at a critical time:

*When they first took the kids, if they could have maybe suggested some counseling so I could deal with the loss, because it was right after that my parents died and it was just everything at once. It was real easy for me to turn back to drugs because I had so many things going on.*

A mother wanted the child welfare and mental health professionals to show more interest in her and to offer supportive services:

*At least ask me how I'm doing and how I'm coping instead of stacking more and more without even asking how I'm taking it so far and waiting until I crack and go "What happened?"*

One mother felt that the treatment team had not taken time to listen to her and to get to know her:

*If these people are going to sit there and make determinations about me, who I am, what I am, why I am, then they need to sit down and spend some time with me and get to know me as an individual.*

TFC providers' and professionals' responses to a question about how family participation in TFC could be improved mainly focused on ways that the agency could be more helpful. Reduced workloads were seen as offering enhanced opportunities to work closely with families. Supportive services were recommended for families, including transportation. Some TFC providers called for more resources for respite.

A caseworker noted that family participation may be neglected because child welfare staff are overworked and their primary responsibility is the children:

*I get the feeling, and this happens a lot, that (the agency) workers get really busy and*

*they have to prioritize and maybe that's not necessarily on their priority list.*

In cases where parental rights were being terminated, professionals regretted that the agency did not have the resources to pay for services to help parents with their own difficulties. There was concern about finding ways to help a mother to care for her daughter after she returned home because the agency would no longer be able to pay for services, and the child continued to exhibit serious emotional and behavioral problems. A child welfare professional emphasized the need for the mental health team to appreciate the strengths as well as the needs of a parent and his family:

*Recognizing the strengths of the family. Recognizing the needs of the family and providing for those needs and working with the boys to build a safety structure around themselves but to fit back in their family and within the family dynamics.*

Further, she pointed to the need to ensure that TFC team members follow through on their responsibilities:

*I hope that whatever comes out of this is a way to hold programs that contract to do services accountable for providing those services.*

Another child welfare worker described the challenge of mandated services and his recognition that parents who choose to make changes in their lives often find those changes to be more meaningful: "We have to mandate them or they won't do them but when we mandate them and they do them, it may not mean anything."

## Discussion and Implications for Practice

This study offers a unique opportunity to understand family participation in TFC from the perspectives of one group of parents of children placed in TFC, their child welfare and mental health professionals, and the TFC providers for their children. The research strategy of interviewing the parent, professional, and TFC provider focused on each child provided an opportunity to gain understanding of each respondent's perception of the story of family involvement as it played out in TFC. The researchers were able to compare the constructions and perspectives of each of the players, giving voice to all respondents. There was an effort to give additional weight to the voices of parents of children in TFC as they are considered a group whose perspectives have been neglected by researchers. It was possible to compare the perspectives of the respondents, gaining a richer understanding of situations seen from three points of view, and ideas from each respondent about "best practices" related to family involvement in TFC and strategies for improving practice.

All of the parents who were interviewed wanted regular contact with their children, information about their progress, and involvement in planning and decision making related to their care. While all of the families faced serious challenges related to poverty, family stress, and in some cases mental illness or substance abuse, the findings illustrate a number of examples of successful family participation. All of the children except two had been placed in out-of-home care following reports to child protective services of child abuse or neglect. Even with these troubled families, and regardless of whether the goal was family reunification, adoption, or long-term foster care for the children, the study provided evidence that child welfare professionals can facilitate family participation in TFC. When parents were helped to understand the best interests of their children, they participated in decision making toward their best interests, regardless of who the long-term caregiver would be. In cases where parents were excluded from decision making, they expressed resentment.

The children who were the focus of the interviews were troubled by serious emotional and behavioral disorders which manifested in the form of behaviors that were extremely challenging for caregivers to manage. The findings indicate there was a wide divergence of knowledge and understanding of the mental health conditions that affected the children. Multiple diagnoses were given for each child and there was a lack of correspondence among parents, professionals, and TFC providers about the exact diagnoses applied to the children. Parents particularly lacked accurate information about their children's mental health and were therefore less able to participate in consistent behavior management with their children. This finding points to the importance of mental health professionals making accurate diagnoses and communicating diagnostic information and strategies for treatment and behavior management clearly to all caregivers, with particular attention to using understandable language with parents and TFC providers who may not have sophisticated knowledge of mental illness.

The families who participated in the study received few services before their children were placed in out-of-home care, but they and their children had access to a range of mental health and supportive services after placement. It is notable that no children were reported as taking prescribed medications for their mental health condition before placement in TFC, but eight children were taking prescribed medication at the time of the study. These findings raise a question about whether the parents might have been better able to manage their children if they had been receiving medication while they were living at home. Data about the children's access to a complete mental health evaluation at an early stage were not collected in this study. A focus for further research might be whether the provision of more intensive services, particularly respite care which was available regularly for all TFC providers, might have helped to avert or delay the need for placement. Only one family had received respite care before the children were placed in care, but all of the TFC providers had access to regular respite care. In the cases of family reunification, a vital resource for the parents was the TFC providers' willingness to continue to provide informal respite care as needed. This issue needs to be further examined and taken into account in recruitment and training of TFC providers. Another cause for concern for parents who were being reunified with their children was their need for ongoing support and services after their children returned home. All of the families continued to face the challenges of poverty and lack of access to resources, such as affordable housing, health care, and reliable transportation.

While the TFC program rules required family participation in placement decisions, this rarely happened with this group of families. There was little attention to cultural and social class difference in placement decisions. While some TFC providers were respectful of parents with different beliefs and values than their own, in other cases social class and cultural differences contributed to TFC providers' efforts to change children's behaviors and unwillingness to have contact with parents.

The findings illustrate some of the ways that the participation of these families was shaped by professionals' and TFC providers' values related to families in general and their attitudes toward specific families. Child welfare and mental health professionals had varied perceptions of the extent to which they were required to support parent-child relationships and promote family participation with children in out-of-home care. There were many positive examples of family participation, even with families who faced serious challenges in their own lives. Some parents were actively involved in decision making meetings. These parents were comfortable expressing their views, felt that they were treated with respect, and said that their ideas were taken into consideration in decision making.

Parents appreciated professionals who communicated understanding of their difficulties, demonstrated respect, told the truth, and provided support. They were grateful when child welfare professionals advocated for them and their children. Parents approved of professionals who took time to explain complicated issues to them, facilitated contact with their children, and supported their effective participation in decision making meetings, a new and challenging

experience for most parents. Parents also expressed appreciation when TFC providers took the initiative in sharing information about their children, providing support, and offering opportunities for parent-child contact.

Not all parents had positive experiences with the child welfare and mental health systems and some parents were angry and resentful at professionals who excluded them from planning and decision making and limited their contact with children. Some parents were critical of professionals whom they perceived as deceptive, judgmental, and out of touch with reality. Professionals identified barriers to family participation, such as their lack of time due to large caseloads and organizational constraints, such as one county's requirement that work with families be delegated to another team. In another county, there was conflict between the child welfare and mental health agency in relation to the participation of a specific family.

In two counties, TFC providers had not received training to work with families and some child welfare staff noted that TFC providers did not have the willingness or skills to work with families. The lack of a family focus in the recruitment and training of TFC providers appeared to contribute to serious constraints on parent-child contact and parents' lack of information about their children's progress. The fact that the TFC programs examined in the study embraced principles of family involvement, but that some TFC providers were not trained to work with families is troubling. There is a need for research to examine the effects of recruitment and training strategies for TFC providers and foster parents which are specifically directed toward intensive support of families. There are some promising initiatives focused on shared parenting and partnership parenting (Barth, 1994; Burton & Showell, 1997; Lewis & Callaghan, 1993) which may provide some lessons for training TFC providers.

The researchers were unable to determine whether family participation was associated with more positive outcomes for children. This should be a focus of further study. However, there was evidence that higher levels of family participation were associated with more frequent parent-child contact and more harmonious relationships between parents, professionals, and TFC providers. This in turn appeared to be related to more rapid family reunification in some cases. But there is a need for further research to increase understanding of the effects of family involvement on children's well-being.

Since this qualitative study was small-scale and bound by the local context, the research team are unable to determine how pervasive the practices described here are. The research is grounded in the local context and findings are not generalizable to all settings. Yet, the findings offer an in-depth exploration of the perspectives of family members, professionals, and TFC providers on the dimensions of family involvement in TFC. The relevance of findings to other contexts should be determined by the reader based on the "thick description" (Lincoln & Guba, 1985, p. 214) provided in the detailed descriptions of cases and in-depth analysis of respondents' perspectives.

The selection of families to participate in the study resulted in a particular sample which is not representative of all parents of children in TFC. Child welfare staff were instrumental in contacting parents to elicit their participation in the study. This approach was selected as an ethical way to gain parents' active consent. However, the child welfare staff may have selected their most successful cases. Cases where there was no contact with parents were excluded from the study because the goal was to increase understanding of family participation. This may have resulted in a sample of situations where relationships between parents, professionals, and TFC providers were more positive than in other cases. The number of parents available for interview may have been limited by caseworkers' lack of time, and by their desire to protect parents from intrusive questioning.

Working with families of children in TFC is time-consuming and may be challenging. But there is growing awareness of the need to maintain children's attachments to their biological families. There is also increasing understanding of the benefits of family participation in decision making. This study has provided a case study of barriers to family participation and activities that contribute to participation, but further research is needed to more fully understand how parents, professionals, and TFC providers can work more collaboratively together in the interests of children's well-being. The study raises many questions for further research. We need longitudinal studies with larger samples to study the effects of family involvement on children's mental health, family relationships, and child and family outcomes in TFC.

Systems-level research is also needed to identify the administrative arrangements and organizational contexts that support family involvement. With the recent passing of P.L. 105-89, the Adoption and Safe Families Act of 1997, child welfare staff are required to pursue early termination of parental rights for children in foster care. New approaches to permanency planning incorporate concurrent planning (Katz & Robinson, 1991) and parents need to be aware of their rights and responsibilities in this process. Further research is needed to document the facilitation of family involvement to ensure appropriate and timely planning for children in out-of-home care and their families.

TFC is growing in importance as a key resource in community-based systems of care for the treatment of children with serious emotional disorders in the child welfare system. This exploratory study has provided a beginning understanding of family involvement from the perspectives of parents, professionals, and TFC providers. It has also raised many questions to guide further research. Greater understanding of the barriers to family participation in TFC and strategies to address them are needed. A specific focus of research should be the effects of recruitment and training of TFC providers to work closely with families. Finally, longitudinal research is needed to discover the effects of family participation on child and family well-being.

## References

- Barno, A. (1994). *Supports of and barriers to participation of parent with children in therapeutic foster care*. Unpublished MSW dissertation, Department of Social Work, College of St. Catherine and University of St. Thomas, St. Paul, MN.
- Barth, R.P. (1994). Shared family care: Child protection and family preservation. *Social Work, 39*(5), 515-524.
- Benedict, M.I. & White, R.B. (1991). Factors associated with foster care length of stay. *Child Welfare, LXX*, 45-58.
- Blumberg, E., Landsverk, J., Ellis-McLeod, E., Ganger, W. & Culver, S. (1996). Use of the public mental health system by children in foster care: Client characteristics and service use patterns. *Journal of Mental Health Administration, 23*(4), 389-405.
- Blumenthal, K. (1984). Involving parents: A rationale. In K. Blumenthal & A. Weinberg (Eds.), *Establishing parent involvement in foster care agencies*, (pp. 1-16). New York, NY: Child Welfare League of America.
- Blumenthal, K. & Weinberg, A. (1984). Involving parents: Administrative responsibility. In K. Blumenthal & A. Weinberg (Eds.), *Establishing parent involvement in foster care agencies* (pp. 17-71). New York, NY: Child Welfare League of America.
- Bowlby, J. (1969). *Attachment*, 2nd. ed. New York: Basic Books.
- Brazier, D.J. (Ed.). (1996). *Family-focused practice in out-of-home care: A handbook and resource directory*. Washington, DC: The Child Welfare League of America.
- Bricker-Jenkins, M. (1997). Hidden treasures: Unlocking strengths in the public social services. In D. Saleebey (Ed.), *The strengths perspective in social work practice*, 2nd edition, (pp. 133-150). New York: Longman Publishers.
- Bryant, B. (1981). Special foster care: A history and rationale. *Journal of Clinical Child Psychology, 10*(1), 8-20.
- Bryant, B. & Snodgrass, R.D. (1992). Foster family care applications with special populations: People Places, Inc. *Community Alternatives: International Journal of Family Care, 4*(2), 1-25.

- Bryant-Comstock, S., Huff, B. & VanDenBerg, J. (1996). The evolution of the family advocacy movement. In B.A. Stroul (Ed.), *Children's mental health: Creating systems of care in a changing society*, (pp. 359-374). Baltimore, MD: Paul H. Brookes Publishing Co.
- Burford, G., Pennel, J., MacLeod, S. & Campbell, S. (1996). Reunification as an extended family matter. *Community Alternatives: International Journal of Family Care*, 8(2), 33-55.
- Burton, D. & Showell, P.W. (1997). Partnership parenting in foster care. *Families in Society: The Journal of Contemporary Human Services*, 75, 520-521.
- Chamberlain, P. & Reid, J.B. (1991). Using a specialized foster care community treatment model for children and adolescents leaving the state mental hospital. *Journal of Community Psychology*, 19, 266-276.
- Colapinto, J. (1998). The patterns that disconnect: The foster care system is a classic catch-22. *Family Therapy Networker*, Nov./Dec., 43-44.
- Davis, I.P., Landsverk, J., Newton, R. & Ganger, W. (1996). Parental visiting and foster care reunification. *Children and Youth Service Review*, 18(4/5), 363-382.
- DeChillo, N., Koren, P.E. & Schultze, K.H. (1994). From paternalism to partnership: Family and professional collaboration in children's mental health. *American Journal of Orthopsychiatry*, 64(4), 564-576.
- Erera, P. (1997). Foster families attitudes toward birth parents and caseworkers: Implications for visitations. *Families in Society: The Journal of Contemporary Human Services*, 75, 511-519.
- Family Rights Group (1986). *Promoting links: Keeping children and families in touch*. London, England: Family Rights Group.
- Fanshel, D. (1975). Parental visiting of children in foster care: Key to discharge. *Social Service Review*, 7(1), 493-514.
- Farmer, E. (1996). Family reunification with high risk children: Lessons from research. *Children and Youth Services Review*, 18(4/5), 403-424.
- Fein, E. (1991). Issues in foster family care: Where do we stand? *American Journal of Orthopsychiatry*, 61(4), 578-583.
- Friesen, B.J. & Huff, B. (1996). Family perspectives of systems of care. In B.A. Stroul (Ed.), *Children's mental health: Creating systems of care in a changing society* (pp. 41-67). Baltimore: Brookes.

- Galaway, B., Nutter, R.W. & Hudson, J. (1992). Treatment foster care and the system of services for children. In A. Algarin & R.M. Friedman (Eds.), *Fourth Annual Research Conference Proceedings for a system of care in children's mental health* (pp. 223-232). Tampa FL: University of South Florida, Florida Mental Health Institute, Research and Training Center for Children's Mental Health.
- Galaway, B., Nutter, R.W. & Hudson, J. (1995). Relationship between discharge outcomes for treatment foster care clients and program characteristics. *Journal of Emotional and Behavioral Disorders*, 3(1), 46-54.
- Glaser, B.G. & Strauss, A.L. (1967). *The discovery of grounded theory*. Chicago: Aldine.
- Goerge, R., Wulczyn, F. & Fanshel, D. (1994). A foster care research agenda for the '90s. *Child Welfare*, LXXIII(5), 525-549.
- Grealish, E.M, Hawkins, R.P., Meadowcroft, P. & Lynch, P. (1989). Serving families of children in therapeutic foster care. In P. Meadowcroft & B. Trout (Eds.). *Troubled youths in treatment homes: A handbook of therapeutic foster care* (pp. 126-142). Washington, DC: The Child Welfare League of America.
- Grigsby, R.K. (1994). Maintaining attachment relationships among children in foster care. *Families in Society: The Journal of Contemporary Human Services*, 75(5), 269-276.
- Hawkins, R.P., Meadowcroft, P., Trout, B.A. & Luster, W.C. (1985). Foster family-based treatment. *Journal of Clinical Child Psychology*, 14(3), 220-228.
- Hawkins, R.P. (1989). The nature and potential of therapeutic foster family care programs. In R.P. Hawkins & J. Breiling (Eds.), *Therapeutic foster care: Critical issues* (pp. 5-35). Washington DC: Child Welfare League of America.
- Hawkins, R.P. & Breiling, J. (Eds.). (1989). *Therapeutic foster care: Critical issues*. Washington DC: Child Welfare League of America.
- Hess, P.M. (1987). Parental visiting of children in foster care: Current knowledge and research agenda. *Children and Youth Service Review*, 9(1), 29-50.
- Hess, P.M. (1988). Case and context: Determinants of planned visit frequency in foster family care. *Child Welfare*, 67(4), 311-326.
- Hess, P.M. (1993). Supporting foster families in their support of families. *Journal of Emotional and Behavioral Problems*, 2(1), 24-27.

- Hess, P.M. & Proch, K.O. (1988). *Family visiting in out-of-home care: A guide to practice*. Washington, DC: Child Welfare League of America.
- Horner, B., Smith, V. & Ray, J. (1990). Implementing a specialized foster care project: Problems, changes, recommendations. *Community Alternatives: International Journal of Family Care*, 2(1), 55-76.
- Howard, J.A. & Proch, K. (1986). Parental visiting in out-of-home care. *Social Work*, 31(3), 178-181.
- Hubbell, R. (1981). *Foster care and families: Conflicting values and philosophies*. Philadelphia, PA: Temple University Press.
- Hudson, J., Nutter, R.W. & Galaway, B. (1994a). Treatment foster family care: Development and current status. *Community Alternatives: International Journal of Family Care*, 6(2), 1-24.
- Hudson, J., Nutter, R.W. & Galaway, B. (1994b). Treatment foster care programs: A review of evaluation research and suggested directions. *Social Work Research*, 18(4), 198-210.
- Jivanjee, P.R. (1994). *Final report on the Oregon Treatment Foster Care Project*. Portland, OR: Portland State University, Regional Research Institute on Human Services.
- Jivanjee, P. (in press a). Family involvement in therapeutic foster care: Professional and provider perspectives. *Journal of Child and Family Studies*.
- Jivanjee, P. (in press b). Family involvement in therapeutic foster care: Parent perspectives. *Journal of Child and Family Studies*.
- Katz, L. & Robinson, C. (1991). Foster care drift: A risk assessment matrix. *Child Welfare*, LXX(3), 347-358.
- Keys, T. (1996). Family decision making in Oregon. *Protecting Children*, 12(3).
- Koren, P.E., DeChillo, N. & Friesen, B.J. (1992). Measuring empowerment in families whose children have emotional disabilities: A brief questionnaire. *Rehabilitation Psychology*, 37(4), 305-321.
- Koroloff, N.M., Friesen, B.J., Reilly, L. & Rinkin, J. (1996). The role of family members in systems of care. In B.A. Stroul (Ed.), *Children's mental health: Creating systems of care in a changing society* (pp. 409-426). Baltimore: Brookes.

- Koroloff, N.M., Friesen, B.J., Reilly, L. & Rinkin, J. (1996). The role of family members in systems of care. In B.A. Stroul (Ed.), *Children's mental health: Creating systems of care in a changing society* (pp. 409-426). Baltimore: Brookes.
- Lahti, J., Green, K., Emlen, A., Zendry, J., Clarkson, Q.D., Kuehnel, M. & Casciato, J. (1978). *A follow-up study of the Oregon Project*. Portland, OR: Regional Research Institute, Portland State University.
- Landsverk, J., Davis, I., Ganger, W., Newton, R. & Johnson, I. (1996). Impact of child psychosocial functioning on reunification from out-of-home placement. *Children and Youth Services Review, 18*, 447-462.
- Lee, J.A.B. & Nisivoccia, D. (1989). *Walk a mile in my shoes: A book about biological parents for foster parents and social workers*. Washington, DC: Child Welfare League of America.
- Lee, J.A.B. (1994). *The empowerment approach to social work practice*. New York: Columbia University Press.
- Lewis, R.E. & Callaghan, S.A. (1993). The Peer Parent Project: Compensating foster parents to facilitate reunification of children with their biological parents. *Community Alternatives: International Journal of Family Care, 5*(1), 43-65.
- Lincoln, Y.A. & Guba, E.G. (1985). *Naturalistic inquiry*. Beverly Hills, CA; Sage Publications.
- Loar, L. (1998). Making visits work. *Child Welfare, LXXVII*(1), 41-58.
- Maluccio, A.N. & Whittaker, J.K. (1989). Therapeutic foster care: Implications for parental involvement. In R.P. Hawkins & J. Breiling (Eds.), *Therapeutic foster care: Critical issues* (pp. 161-182). Washington DC: Child Welfare League of America.
- Maluccio, A. & Sinanoglu, P. (Eds.) (1981). *The challenge of partnership: Working with parents of children in foster care*. New York: The Child Welfare League of America.
- Meadowcroft, P., Thomlison, B. & Chamberlain, P. (1994). Treatment foster care services: A research agenda for child welfare. *Child Welfare, LXXIII*(5), 565-581.
- Merkel-Holguin, L. (1996). Putting families back into the child protection partnership: Family group decision making. *Protecting Children, 12*(3), 4-8.
- Moore, K.J. & Chamberlain, P. (1994). Treatment foster care: Toward development of community-based models for adolescents with severe emotional and behavioral disorders. *Journal of Emotional and Behavioral Disorders, 4*(1), 22-30.
- Oregon Administrative Rules 412-24-400 through 412-24-480. (1992). *Standards for Treatment*

*Foster Care.*

- Palmer, S.E. (1992). Including birth families in foster care: A Canadian-British comparison. *Children and Youth Services Review, 14*, 407-425.
- Pine, B.A., Warsh, R. & Maluccio, A.N. (1993). *Together again: Family reunification in foster care*. Washington, DC: The Child Welfare League of America.
- Proch, K. & Howard, J. (1986). Parental visiting of children in foster care: A study of casework practice. *Social Work, 31*(3), 178-181.
- Rivera, V.R. & Kutash, K. (1994). Therapeutic foster care. In V.R. Rivera & K. Kutash, *Components of a system of care: What does the research say?* (pp. 81-100). Tampa FL: University of South Florida, Florida Mental Health Institute, Research and Training Center for Children's Mental Health.
- Saleebey, D. (1997). (Ed.). *The strengths perspective in social work practice*, 2nd edition. New York: Longman Publishing.
- Schatz, M.S. & Bane, W. (1991). Empowering the parents of children in substitute care: A training model. *Child Welfare, LXX*, 665-678.
- Schneiderman, M., Connors, M.M., Fribourg, A., Gries, L. & Gonzales, M. (1998). Mental health services for children in out-of-home care. *Child Welfare, LXXVII*(1), 29-40.
- Seidel, J.V. (1994). *The Ethnograph, version 4.0* (computer program). Littlejohn, CO: Qualis Research Associates.
- Simms, M.D. & Halfon, N. (1994). The health care needs of children in foster care: A research agenda. *Child Welfare, LXXIII*(5), 505-524.
- Simpson, J.S., Koroloff, N., Friesen, B.F. & Gac, J. (1999). *Promising practices in family-provider collaboration*. Systems of Care: Promising Practices in Children's Mental Health, 1998 Series, Volume II. Washington, D.C.: Center for Effective Collaboration and Practice, American Institutes for Research.
- Sinanoglu, P.A. & Maluccio, A.N. (1981). *Parents of children in placement: Perspectives and programs*. New York: Child Welfare League of America.
- Snodgrass, R.D. & Bryant, B. (1989). Therapeutic foster care: A national program survey. In R.P. Hawkins & J. Breiling (Eds.), *Therapeutic foster care: Critical issues*, (pp. 37-76). Washington DC: Child Welfare League of America.
- Strauss, A. & Corbin, J. (1994). Grounded theory methodology: An overview. In N.K. Denzin & Y.A. Lincoln (Eds.), *Handbook of qualitative research* (pp. 273-285). Thousand Oaks,

CA: Sage Publications.

Stroul, B.A. & Friedman, R.M. (1986). *A system of care for severely emotionally disturbed children and youth*. Washington, DC: Georgetown University, CASSP Technical Assistance Center.

Stroul, B.A. & Friedman, R.M. (1988). Principles for a system of care. *Children Today*, 17, 11-17.

Stroul, B.A. (Ed.) (1989). *Series on community-based services for children and adolescents who are emotionally disturbed. Volume III: Therapeutic foster care*. Washington, DC: Georgetown University, CASSP Technical Assistance Center.

Tam, T.S. & Ho, M.K.W. (1996). Factors influencing the prospect of children returning to their parents from out-of-home care. *Child Welfare*, LXXV(3), 253-268.

Thomlison, B. (1991). Family continuity and stability of care: Critical elements in treatment foster care programs. *Community Alternatives: International Journal of Family Care*, 3(2), 1-18.

Tiddy, S.G. (1986). Creative cooperation: Involving biological parents in long-term foster care. *Child Welfare*, 65(1), 53-62.

Warsh, R., Maluccio, A.N. & Pine, B.A. (1994). *Teaching family reunification: A sourcebook*. Washington, DC: The Child Welfare League of America.

