Appendices A-F: What does the Research Tell us about Services for Children in Therapeutic/ Treatment Foster Care with Behavioral Health Issues?

Report of the SAMHSA, CMS and ACYF
Technical Expert Panel, September 27-28, 2012

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Appendix A: Technical Expert Panel Meeting Agenda

What Does the Research Tell Us About Services for Children in Therapeutic/Treatment Foster Care With Behavioral Health Issues?

Technical Expert Panel

Centers for Medicare & Medicaid Services

Baltimore, MD

September 27-28, 2012

Agenda

September 27, 2012

I. What Do We Know About Therapeutic/Treatment Foster Care?

9:00 a.m. Welcome

Carol Spigner, M.S.W., D.S.W.
Facilitator

Barbara C. Edwards, M.P.P.
Group Director
Centers for Medicare & Medicaid Services
CMS/CMCS/Disabled and Elderly Health Programs Group

Larke Huang, Ph.D.
Senior Advisor on Children
Lead, Trauma and Justice Strategic Initiative
Administrator's Office of Policy Planning and Innovation
Substance Abuse and Mental Health Services Administration

Clare Anderson, M.S.W., L.I.C.S.W.
Deputy Commissioner
Administration on Children, Youth and Families

9:30 a.m. Consensus Process

Doreen Cavanaugh, Ph.D.

Research Professor
Health Policy Institute
Georgetown University

II. What Do We Know About Identifying Youth Appropriate for Therapeutic/Treatment Foster Care?

9:45 a.m. What Does the Research Tell Us About Children in Therapeutic/Treatment Foster Care?

Bryan Samuels, M.P.P.
Commissioner, Administration on Children, Youth and Families
Administration for Children and Families
U.S. Department of Health and Human Services

10:30 a.m. Break

10:45 a.m. What is the Current State of the Research Base for Therapeutic/Treatment Foster Care for Youth?

Johna Hughes Bruton, M.S.W.
Clinical Assistant Professor
School of Social Work
University of North Carolina

11:00 a.m. Discussion

11:30 a.m. Screening, Assessment, and Level-of-Care Placement Criteria for Therapeutic/Treatment Foster Care

Ann Doucette, Ph.D.
Research Professor of Evaluation and Health Policy
Director, Midge Smith Center for Evaluation Effectiveness
Director, The Evaluators' Institute
The George Washington University

11:55 a.m. Discussion

12:30 p.m. Lunch

III. What Do We Know About the Essential Elements of Therapeutic/Treatment Foster Care?

1:45 p.m. What is the Evidence Base for Essential Elements of Therapeutic/ Treatment Foster Care for Youth?

John Landsverk, Ph.D.
Director, Child & Adolescent Services Research Center
Rady Children's Hospital

2:05 p.m. Discussion

2:45 p.m. Break

IV. What Do We Know About the Psychosocial Treatment of Youth in Therapeutic/Treatment Foster Care?

3:00 p.m. What Does the Research Tell Us About Mental Health and Other Service Use by Youth in Therapeutic/Treatment Foster Care?

J. Curtis McMillen, Ph.D.
Professor
School of Social Service Administration
University of Chicago

3:20 p.m. Discussion

4:00 p.m. Adjournment

What Does the Research Tell Us About Services for Children in Therapeutic/Treatment Foster Care With Behavioral Health Issues?

Technical Expert Panel

Centers for Medicare & Medicaid Services

Baltimore, MD

September 27-28, 2012

Agenda

September 28, 2012

9:00 a.m. Welcome

Carol Spigner, M.S.W., D.S.W.
Facilitator

10:00 a.m. Discussion

10:40 a.m. Break

I. What Do We Know about Outcomes for Youth in Therapeutic/Treatment Foster Care?

9:15 a.m. What Does the Research Tell Us About Juvenile Justice and Mental Health Outcomes for Youth in Therapeutic/Treatment Foster Care?

Leslie D. Leve, Ph.D.

Senior Scientist
Oregon Social Learning Center

Substance Use Disorder and Child Welfare Outcomes for Youth in Therapeutic/Treatment Foster Care

Johna Hughes Bruton, M.S.W.
Clinical Assistant Professor
School of Social Work
University of North Carolina

Long-Term Mental Health Outcomes for Ethnically Diverse Adults Placed in Family Foster Care as Children

Susy Villegas, Ph.D., L.C.S.W.
Assistant Professor
School of Social Work
University of Oklahoma

II. What Do We Know about Organizational Issues in Therapeutic/Treatment Foster Care?

10:55 a.m. What Does the Research Tell Us About Organizational Issues Related to the Provision of Therapeutic/Treatment Foster Care?

Elizabeth M.Z. Farmer, Ph.D.
Professor
School of Social Work
Virginia Commonwealth University

11:15 a.m. Discussion

12:00 p.m. Adjourn

Appendix B: Technical Expert Panel Participant List

What Does the Research Tell Us About Services for Children in Therapeutic/Treatment Foster Care With Behavioral Health Issues?

Technical Expert Panel

September 27-28, 2012 • Centers for Medicare & Medicaid Services • Baltimore, Maryland

PARTICIPANT LIST

Richard Barth, Ph.D.
Dean of the School of Social Work and
Professor, University of Maryland
School of Social Work
525 West Redwood Street
Baltimore, Maryland 21201
Room: 5E14
Phone: (410) 706-7794
Fax: (410) 706-0273
Email: rbarth@ssw.umaryland.edu

Alfiee M. Breland-Noble, Ph.D., M.H.Sc.
Director, The AAKOMA Project,
Assistant Professor Department of Psychiatry
Georgetown University Medical Center
2115 Wisconsin Avenue, NW
Suite 120
Washington, DC 20007
Phone: (202) 687-2392
Alternate Phone: (202) 944-5400
Fax: (202) 687-0694
Email: ab2892@georgetown.edu

Martha Morrison Dore, Ph.D., M.S.W.
Director of Research and Evaluation, Division of Child and Family Services
The Guidance Center/Riverside Community Care
5 Sacramento Street
Cambridge, MA 02138
Phone: (617) 354-2275 ext. 130
Fax: (617) 547-4356
Email: marthamdore@aol.com

Ann Doucette, Ph.D.
Research Professor of Evaluation and Health Policy
Director, Midge Smith Center for Evaluation Effectiveness
Director, The Evaluators' Institute
The George Washington University
2147 F Street NW
Washington, DC 20052
Phone: (202) 994-8112
Fax: (202) 315-3304
Email: doucette@gwu.edu

Elizabeth M. Z. Farmer, Ph.D.
Professor, MSW Program
Virginia Commonwealth University
School of Social Work
1001 West Franklin Street
P.O. Box 842027
Richmond, Virginia 23284-2027
Phone: (804) 828-1030
Fax: (804) 828-0716
Email: efarmer4@vcu.edu

John D. Fluke, Ph.D.
Associate Director for Systems Research and Evaluation, Department of Pediatrics
Kempe Center for the Prevention and Treatment of Child Abuse & Neglect
University of Colorado School of Medicine
The Gary Pavilion at Children's Hospital Colorado
Anschutz Medical Campus
13123 East 16th Avenue, B390
Aurora, CO 80045
Cell Phone: (303) 810-1934
Alternate Phone: (303) 864-5219
Fax: (303) 864-5367
Email: john.fluke@ucdenver.edu

Gene Griffin, Ph.D., J.D.
Assistant Professor
Northwestern University Department of Psychiatry and Behavioral Sciences
710 N. Lake Shore Drive Room 902
Chicago, IL 60611
Phone: (312) 503-1375
Email: e-griffin@northwestern.edu

Kay Hodges, Ph.D.
Professor, Department of Psychology
Institute for the Study of Children, Families, and Communities
Eastern Michigan University
Ypsilanti, MI 48105
hodges3600@gmail.com
*Phone:*734 330 0216
Email: hodges3600@gmail.com

Johna Hughes Bruton, M.S.W.
Clinical Assistant Professor
School of Social Work
University of North Carolina
325 Pittsboro St CB #3550
Chapel Hill, NC 27599-3550
Phone: (919) 962-6431
Cell Phone: (919) 606-4044
Fax: (919) 962-6562
Email: johnahughesbruton@gmail.com

John Landsverk, Ph.D.
Director, Child & Adolescent Services Research Center
Rady Children's Hospital
3020 Children's Way, MC 5033
San Diego, CA 92123
Phone: (858) 966-7703 ext. 3755
Alternate Phone: (541) 726-4859
Fax: (858) 966-7704
Email: jlandsverk@aol.com

Leslie D. Leve, Ph.D.
Senior Scientist
Oregon Social Learning Center
10 Shelton McMurphey Blvd.
Eugene, OR 97401
Phone: (541) 485-2711
Fax: (541) 485-7087
Email: lesliel@oslc.org

John S. Lyons, Ph.D.
Professor
School of Psychology
University of Ottawa
Children's Hospital of Eastern Ontario
401 Smyth Road, R1118
Ottawa, ON
Phone: (613) 562-5800 ext. 8701
Fax: (613) 562-5147
Email: john.lyons@uottawa.ca
Alternate Email: johnslyonsphd@yahoo.com

J. Curtis McMillen, Ph.D.
Professor
School of Social Service Administration
The University of Chicago
969 E. 60th Street
Chicago, IL 60637
Phone: (773) 702-1250
Email: cmcmillen@uchicago.edu

Maureen E. Murray, L.C.S.W.
Assistant Professor of Psychiatry and
Behavioral Sciences
Duke University School of Medicine
Box 3454 DUMC
Durham, NC 27710
Phone: (919) 687-4686 ext. 302
Fax: (919) 687-4737
Email: murra024@mc.duke.edu

Kristine Piescher, Ph.D.
Director of Research and Evaluation
Center for Advanced Studies in Child Welfare
University of Minnesota
Room 212 Peters Hall
1404 Gortner Avenue
Saint Paul, Minnesota 55108
Phone: (612) 625-8169
Email: kpiesche@umn.edu

Mary E. Rauktis, Ph.D.
Research Assistant Professor
School of Social Work
University of Pittsburgh
2332 Cathedral of Learning
4200 Fifth Avenue
Pittsburgh, PA 15260
Phone: (412) 648-1225
Fax: (412) 624-1159
Email: mar104@pitt.edu

Susy Villegas, Ph.D., L.C.S.W.
Assistant Professor
School of Social Work
University of Oklahoma
700 Elm Avenue
Zarrow Hall Room 304
Norman, OK 73019
Phone: (405) 475-9282
Office Phone: (405) 325-1400
Email: susy.villegas@ou.edu

FACILITATOR

Carol Spigner, M.S.W., D.S.W.
Associate Professor/ Clinician Educator
2406 Valley Road
Harrisburg, PA 17104-1443
Phone: (717) 439-1136
Fax: (717) 234-0105
Email: spignerdsw@aol.com

FEDERAL PARTNERS

Administration for Children, Youth & Families

Clare Anderson, M.S.W., L.I.C.S.W.
Deputy Commissioner
Administration for Children, Youth & Families
US Department of Health & Human Services
1250 Maryland Avenue, SW
Washington, DC
Phone: (202) 205-8347
Email: Clare.Anderson@acf.hhs.gov

Caryn Blitz, Ph.D.
Policy Advisor, Office of the Commissioner
Administration on Children, Youth & Families
US Department of Health & Human Services
1250 Maryland Avenue, SW
Washington, DC
Phone: (202) 401-9225
Email: Caryn.Blitz@acf.hhs.gov

Bryan Samuels, M.P.P.
Commissioner,
Administration on Children, Youth & Families
Administration for Children and Families
U.S. Department of Health and Human Services
1250 Maryland Avenue, SW
Washington, DC
Phone: (202) 205-8347
Fax: (202) 205-9721
Email: Bryan.Samuels@acf.hhs.gov

Nadia Sexton, Ph.D.
Senior Fellow
Casey Family Programs
Administration for Children, Youth and Families
1250 Maryland Avenue, SW
Washington, DC
Phone: (201) 565-7676
Email: Nadia.Sexton@acf.hhs.gov

Kate Stepleton, M.S.W.
Program Specialist
Administration for Children, Youth and Families
1250 Maryland Avenue, SW
Washington, DC
Phone: (202) 205-8586
Email: kate.stepleton@acf.hhs.gov

HHS Office of the Assistant Secretary for Planning and Evaluation

David DeVoursney, M.P.P.
Analyst
Division of Behavioral Health and Intellectual Disabilities Policy
200 Independence Ave., SW
424E.15
Washington, DC 20201
Phone: (202) 401-7123
Email: David.DeVoursney@hhs.gov

Centers for Medicare & Medicaid Services

Jean K. Close, M.A.
Technical Director
Division of Benefits & Coverage
Mail Stop S2-14-26
Disabled & Elderly Health Programs Group
Center for Medicaid and CHIP
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850
Phone: (410) 786-2804
Email: jean.close@cms.hhs.gov

Barbara C. Edwards, M.P.P.
Group Director, CMS/CMCS/Disabled and Elderly Health Programs Group
7500 Security Blvd
S2-14-17
Baltimore, MD 21244
Phone: (410) 786-7089
Email: Barbara.Edwards@cms.hhs.gov

Kara C. Ker, M.S.W., L.C.S.W-C.
CMS Health Insurance Specialist
Center for Medicaid and CHIP
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244 -1850
Phone: (410) 786-0467
Email: Kara.Ker@cms.hhs.gov

John O'Brien, M.A.
Senior Policy Advisor
CMS/CMCS/Disabled and Elderly Health Programs Group
Center for Medicaid and CHIP
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850
Phone: (410) 786-5529
Email: john.obrien3@hhs.gov

Substance Abuse and Mental Health Services Administration

Suzanne Fields, M.S.W., L.I.C.S.W.
Special Expert
Office of Policy Planning and Innovation
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road #8-1021
Rockville, MD 20857
Phone: (240) 276-1838
Email: Suzanne.Fields@samhsa.hhs.gov

Rebecca Flatow, J.D., M.S.S.W.
Public Health Analyst
Office of Policy Planning and Innovation
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road
Rockville, MD 20857
Phone: (240) 276-2329
Email: Rebecca.Flatow@samhsa.hhs.gov

Larke Huang, Ph.D.
Senior Advisor on Children
Lead, Trauma and Justice Strategic Initiative
Administrator's Office of Policy Planning and Innovation
Director, Office of Behavioral Health Equity
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road
Rockville, MD 20857
Phone: (240) 276-2014
Email: Larke.Huang@samhsa.hhs.gov

Kelley Smith, Ph.D., M.S.W.
Social Science Analyst
Office of Policy Planning and Innovation
Center for Behavioral Health Statistics and Quality
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road #8-1004
Rockville, MD 20857
Phone: (240) 276-1276
Email: Kelley.smith@samhsa.hhs.gov

GEORGETOWN UNIVERSITY

Doreen Cavanaugh, Ph.D.
Research Professor
Health Policy Institute
Georgetown University
3300 Whitehaven Street, NW, Suite 5000
Washington, District of Columbia 20057
Phone: (202) 687-0634
Email: dacemail2@aol.com

Allison Johnson, M.A.
Graduate Student Research Assistant
Health Policy Institute
Georgetown University
3300 Whitehaven Street, NW, Suite 5000
Washington, District of Columbia 20057
Phone: (202) 687-1565
Email: aj328@georgetown.edu

Greg Entwhistle
Graduate Student Research Assistant
Health Policy Institute
Georgetown University
3300 Whitehaven Street, NW, Suite 5000
Washington, District of Columbia 20057
Email: ge46@georgetown.edu

Divya Goel
Graduate Student Research Assistant
Health Policy Institute
Georgetown University
3300 Whitehaven Street, NW, Suite 5000
Washington, District of Columbia 20057
Email: dg378@georgetown.edu

Arielle Kane
Graduate Student Research Assistant
Health Policy Institute
Georgetown University
3300 Whitehaven Street, NW, Suite 5000
Washington, District of Columbia 20057
Email: arielleskane@gmail.com

TRUVEN HEALTH ANALYTICS

John Easterday, Ph.D.
Senior Project Manager
Center for Financing Reforms and Innovation
Truven Health Analytics
4301 Connecticut Avenue, Suite 330
Washington, District of Columbia 20008
Phone: (202) 719-7830
Email: john.easterday@truven.com

Tami Mark, Ph.D., M.B.A.
Senior Director
Truven Health Analytics
4301 Connecticut Avenue, NW
Washington, D.C. 20008
Phone: (301) 214-2211
Email: tami.mark@truvenhealth.com

Sam Schildhaus, Ph.D.
Senior Research Leader
Center for Financing Reforms and Innovation
Truven Health Analytics
4301 Connecticut Avenue, NW
Washington, D.C. 20008
Phone: 202-719-7845
Email: sam.schildhaus@truvenhealth.com

CRP CORP

Renee Palmer
CRP, Inc.
1110 Bonifant Street Suite 400
Silver Spring, MD 20910
http://www.facebook.com/pages/CRP-Incorporated/125656000833938
Phone: (240) 247-2142
Fax: (240) 247-2143
Email: rpalmer@crpcorp.com

Appendix C: Consensus Process

A Delphi process of successive approximation was used to achieve consensus. At the technical expert panel meeting, presenters and panel members submitted candidate consensus statements in the six agenda topic areas. The candidate consensus statements addressed three questions within each topic area:

1. What Does the Research Tell Us About Therapeutic/Treatment Foster Care?

2. What Are Recommendations for the Implementation of What We Know?

3. What Are Recommendations for Advancing the Knowledge Base?

Following the meeting, Truven Health and Georgetown University (GU) staff conducted qualitative data analyses and developed a final draft of candidate consensus statements for balloting. The revised statements were sent to Technical Expert Panel member volunteers who reviewed the statements for accuracy, clarity, and inclusiveness. Georgetown University staff then collated the candidate consensus statements and prepared the electronic consensus ballot.

Technical Expert Panel members were asked to respond to each statement on the ballot using a 4-point Likert scale (Disagree [1], Somewhat Disagree [2], Agree [3] or Strongly Agree [4]). Panel members also had the option to abstain on any statement(s) that they did not feel qualified to address. All panel members were asked to rate the statements and return the electronic ballot to designated Georgetown University staff, who collated the responses and computed a mean and standard deviation for each statement. There was a 100 percent response rate in Round 1.

Statements with a mean from 1.00 to 1.99 were considered as reaching a consensus of disagreement and were eliminated from further consideration. Statements with a mean from 2.00 to 2.99 were considered a middle group with neither agreement nor disagreement. Statements with a mean from 3.00 to 4.00 were considered as reaching a consensus of agreement.

GU staff collated the middle group of statements with a mean from 2.00 to 2.99 and developed a second-round ballot. In that round, Technical Expert Panel members used a dichotomous scale (Disagree [1] or Agree [2]) along with the option to abstain. There was a 94 percent response rate in Round 2. Statements that received a mean of 1.5 or higher in the second round were considered as reaching a consensus of agreement and were added to the Round 1 consensus statements. The final voting tallies from Rounds 1 and 2 were sent to the Technical Expert Panel members.

Statements reaching consensus in Rounds 1 and 2 are included in the consensus synthesis. Consensus statement tables in appendix D indicate the strength of agreement for each consensus statement.

Appendix D: Consensus Statement Tables

What Does the Research Tell Us About Services for Children in Therapeutic/Treatment Foster Care With Behavioral Health Issues?

Technical Expert Panel Consensus Process Results Question 1, Round 1

Question 1. What Does the Research Tell Us About Therapeutic/Treatment Foster Care?

N=16

1. What Do We Know About Therapeutic/Treatment Foster Care?

MEAN	Standard Deviation	n	Comment
3.88	0.342	16	Many youth need more structure and services than is provided through regular foster care.

[1]Blue shading designates statements that did not reach consensus of agreement or disagreement in Round 1. Per the consensus process, these statements were sent to the Technical Expert Panel participants for a second round of voting.

[2]Red shading denotes that the statement reached a consensus of disagreement and, per the consensus process, was eliminated from further consideration.

3.88	0.342	16	Relationships matter in the lives of youth.
3.88	0.342	16	Many models of TFC have not been tested.
3.81	0.403	16	There is no standard implementation of TFC across states.
3.81	0.403	16	There is no standard implementation of TFC across child-serving systems.
3.81	0.403	16	There is evidence that at least some models of TFC can be effective.
3.81	0.403	16	Existing TFC research is not sufficient to provide full understanding of the TFC elements which contribute to outcomes.
3.81	0.403	16	Experiencing multiple placements may compound a youth's problems.
3.80	0.414	15	Youth in TFC have significant social, emotional and mental health problems.
3.73	0.458	15	Other factors in addition to therapeutic alliance may be important predictors of change in outcomes experienced by TFC youth.

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[2]Red shading denotes that the statement reached a consensus of disagreement and, per the consensus process, was eliminated from further consideration.

3.71	0.469	14	MTFC has been implemented in juvenile justice settings.
3.69	0.480	13	States license TFC in different systems for different purposes.
3.69	0.479	16	Youth in TFC are a high service-need group.
3.69	0.479	16	TFC is promising for youth with complex emotional, psychological and behavioral needs.
3.69	0.479	16	Addressing behavioral health needs of youth can successfully reduce their risk of adverse child welfare outcomes.
3.67	0.617	15	It is important to have a range of treatment models to address youth with diverse mental health needs.
3.63	0.619	16	The research on the MTFC and Together Facing the Challenge models, while well-specified and tested, is not sufficient to provide a full understanding of what is needed/for whom/under what conditions with what outcomes.
3.63	0.619	16	TFC serves youth with a wide range of presenting problems.
3.63	0.619	16	Addressing trauma/stress symptoms and other behavioral health needs of youth can successfully reduce their risk of adverse

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			child welfare outcomes.
3.60	0.507	15	MTFC has shown effectiveness in producing positive outcomes for youth.
3.60	0.632	15	Behavioral health problems in youth may improve through TFC.
3.60	0.507	15	TFC programs vary in cost.
3.56	0.629	16	TFC programs vary in implementation readiness.
3.56	0.512	16	Many youth come into TFC after experiencing multiple out-of-home placements.
3.54	0.519	13	There is widespread variation in TFC programs' conformity to Foster Family-Based Treatment Association (FFTA) Standards.
3.50	0.519	14	The research on TFC has concentrated primarily on two models, MTFC and Together Facing the Challenge.
3.50	0.730	16	Most of the research on MTFC and Together Facing the Challenge has been conducted by the developers of the models.

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3.50	0.632	16	It is important to provide trauma-informed services for youth in TFC.
3.47	0.743	15	It is important to clarify the distinction between a TFC practice and a TFC model.
3.47	0.640	15	MTFC was shown to result in improvements in youth well-being in randomized controlled trials.
3.47	0.516	15	Youth with serious problems have a better than chance likelihood of improving with MTFC.
3.44	0.512	16	Transition-age youth and young adults are at a high risk for mental health problems.
3.44	0.814	16	It is important to discriminate between traumatic responses to maltreatment, and other mental health conditions affecting youth in TFC.
3.43	0.646	14	Children with serious problems have a better than chance likelihood of improving with MTFC-pre.
3.40	0.632	15	There is no standard set of enrollment criteria for TFC.
3.40	0.910	15	A goal is to move from providing generic interventions to different youth to matching specific interventions to specific youth.

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[2]Red shading denotes that the statement reached a consensus of disagreement and, per the consensus process, was eliminated from further consideration.

3.40	0.507	15	There is evidence of the efficacy of TFC for youth in the short term.
3.38	0.650	13	MTFC was shown to result in improvements in permanency in randomized controlled trials.
3.38	0.500	16	TFC programs vary in duration.
3.36	0.497	14	Research indicates that the older the age of youth at entrance into foster care, the higher the number of out-of-home placements experienced.
3.27	0.799	15	A least two TFC models are well-specified in the existing research.
3.25	0.622	12	Many TFC agencies are incorporating key components of the FFTA Standards.
3.21	0.579	14	MTFC has been implemented in mental health settings.
3.18	0.751	11	Youth with serious problems have a better than chance likelihood of improving with Together Facing the Challenge.
3.14	0.770	14	MTFC has been implemented in child welfare settings.

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[2]Red shading denotes that the statement reached a consensus of disagreement and, per the consensus process, was eliminated from further consideration.

3.13	0.719	16	TFC as widely implemented in the United States does not follow established evidence-based practices.
3.08	0.515	12	Together Facing the Challenge was shown to result in improvements in youth well-being in randomized controlled trials.
3.07	0.730	14	Therapeutic alliance is an important predictor of change in TFC youth outcomes.
3.07	1.033	15	Pilot studies should be conducted before widespread funding and utilization of TFC.
3.00	1.069	8	Together Facing the Challenge was shown to result in improvements in permanency in randomized controlled trials.
*2.94	0.574	16	Together Facing the Challenge has shown effectiveness in producing positive outcomes for youth.
2.86	1.167	14	A modified MTFC model was developed because it is difficult to implement MTFC in real settings.
2.80	1.014	15	The dissemination of the MTFC model is quite limited.
2.77	1.092	13	MTFC has been shown to be a cost-effective TFC model.

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[2]Red shading denotes that the statement reached a consensus of disagreement and, per the consensus process, was eliminated from further consideration.

2.73	1.100	15	Together Facing the Challenge is a modified version of MTFC.
2.60	0.910	15	There is evidence of the efficacy of TFC for youth in the long term.
2.40	1.056	15	The research base is too limited to encourage widespread funding and utilization of TFC.
2.38	1.258	16	The field should recognize all foster care as therapeutic.
2.33	1.234	15	Multidimensional Treatment Foster Care (MTFC) is the original Therapeutic/Treatment Foster Care model.
2.33	0.866	9	Length of stay for child welfare-supervised youth in TFC is considerably longer than for similar youth in regular foster care.
*1.91	0.539	11	TFC has not demonstrated any improvement in permanency for youth.

2. What Do We Know About Identifying Youth Appropriate for Therapeutic/Treatment Foster Care?

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MEAN	Standard Deviation	n	Comment
3.79	0.426	14	Measures must be developmentally appropriate.
3.73	0.458	15	Youth well-being should be considered at intake into the child welfare system.
3.69	0.480	13	There is a need for actionable data on TFC youth outcomes.
3.67	0.488	15	More research is needed on the quality of TFC fidelity measures.
3.60	0.828	15	A comprehensive functional assessment (i.e. assessment of youth's day-to-day functioning across TFC domains) is important for determining the appropriate level of care.
3.60	0.507	15	Screening instruments, assessment requirements and level of care criteria vary widely in practice.
3.60	0.507	15	TFC is promising for youth at risk for more intensive placements.

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3.57	0.646	14	No one measure meets all needs.
3.53	0.834	15	A comprehensive functional assessment (i.e. assessment of youth's day-to-day functioning across TFC domains) is important for determining service needs.
3.53	0.640	15	It is important to assess issues that precipitated TFC placement (e.g. emotional and psychological health, interpersonal functioning, behavior problems, education, physical health care status and time in treatment).
3.53	0.743	15	Assessment of psychological, emotional and substance abuse status is essential in determining need for placement in TFC.
3.53	0.516	15	TFC serves a range of youth at risk of poor life outcomes.
3.53	0.640	15	Youth may be in TFC for medical, behavioral, developmental or justice-related reasons.
3.47	0.915	15	Youth entering foster care should receive a functional assessment to determine need for TFC or other intensive intervention.
3.47	0.640	15	Understanding the limitations of measures used to assess the mental health status of children and youth is important.

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3.47	0.743	15	It is critical to evaluate the sensitivity of measures used in making decisions about treatment intensity.
3.47	0.516	15	It is important to assess TFC youth outcomes in terms of real life activities or life skills which optimize the transition to adulthood.
3.40	0.910	15	A comprehensive functional assessment (i.e. assessment of youth's day-to-day functioning across TFC domains) is important for monitoring the youth's progress while receiving services.
3.40	0.632	15	Assessment measures for youth have limitations.
3.40	0.632	15	Screening instruments, assessment requirements and level of care criteria vary widely in published research.
3.33	0.724	15	There is a need to improve measures used to assess key youth and family domains.
3.27	0.647	11	Measures used to assess TFC youth outcomes vary in terms of dimensionality.
3.27	0.884	15	Rather than using a "one size fits all" assessment for youth in foster care, systems serving youth receiving child welfare services should employ an array of assessment tools.

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3.25	0.622	12	Measures used to assess TFC youth outcomes vary in terms of sensitivity.
3.23	0.725	13	Measures used to assess TFC youth outcomes vary in terms of validity.
3.15	0.689	13	Measures used to assess TFC youth outcomes vary in terms of reliability.
3.13	0.990	15	Employing an array of assessment tools allows systems to appropriately evaluate functioning across age groups.
3.07	1.100	15	Employing an array of assessment tools allows systems to appropriately evaluate the domains of social-emotional well-being for youth.
3.00	0.877	14	In practice, the placement of some youth in TFC may be a business decision rather than a clinical decision.
3.00	0.845	15	The TFC model must fit the youth's diagnostic profile and needs.
2.91	0.831	11	MTFC, a model focused on changing behavior, is most appropriate for youth with conduct disorder.
2.87	0.915	15	Length of stay in TFC will vary by youth's diagnostic profile.

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2.87	1.187	15	Standardized measures do not capture the nuances of a youth's psychological status.
2.86	0.864	14	Standardized measures are available for assessing the appropriate level of care.
2.75	0.866	12	Little attention has been given to the psychometric qualities of the measures used in TFC.
2.64	1.027	11	Young children with attachment problems need a longer-term TFC model.
2.27	0.905	11	MTFC is not appropriate for youth with anxiety disorders or post-traumatic stress disorder.

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3. What Do We Know About the Essential Elements of Therapeutic/Treatment Foster Care?

MEAN	Standard Deviation	n	Comment
3.88	0.342	16	The TFC agency's ability to support treatment foster parents is crucial to achieving positive youth outcomes.
3.87	0.352	15	Including TFC parents as members of the treatment team is an essential TFC element.
3.81	0.403	16	Assuring reduced caseloads for staff supporting TFC parents is an essential TFC element.
3.81	0.403	16	Investment in TFC parents is essential.
3.81	0.403	16	The TFC agency's ability to supervise treatment foster parents is crucial to achieving positive youth outcomes.
3.75	0.447	16	Providing specialized training to TFC parents is an essential TFC element.

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3.75	0.447	16	Monitoring the behavior of TFC youth is an essential TFC element.
3.75	0.447	16	The establishment of a therapeutic alliance between TFC foster parents and the youth in their care is essential.
3.73	0.594	15	Providing 24/7 support/coaching to treatment foster parents is an essential TFC element.
3.71	0.469	14	Providing appropriate aftercare resources for youth is an essential TFC element.
3.69	0.479	16	It is important to identify the essential elements of Therapeutic/Treatment Foster Care (TFC).
3.69	0.602	16	Providing older youth in TFC with preparation and training for adulthood is an essential TFC element.
3.69	0.704	16	Coordinating services for everyone involved in the TFC treatment plan is an essential TFC element.
3.69	0.602	16	Monitoring the use of psychotropic medication for TFC youth is an essential TFC element.
3.69	0.479	16	Assuring that treatment foster parents are able to meet the psychosocial needs of youth in their care is an essential TFC element.

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3.69	0.602	16	Supporting and engaging the family to whom the TFC youth will go following TFC is an essential element.
3.69	0.479	16	The definition of an aftercare resource may vary depending on the TFC youth's permanency plan (i.e. adoption, reunification, independent living, emancipation).
3.60	0.632	15	Providing individual mental health treatment for TFC youth is an essential TFC element.
3.57	0.646	14	Few agencies are implementing evidence-based TFC models.
3.56	0.814	16	Many variations of TFC models exist.
3.53	0.640	15	Allowing some youth to remain in TFC into early adulthood is essential to achieve lasting treatment outcomes.
3.50	0.730	16	Child trauma is an underlying issue for many of the youth who may benefit from TFC.
3.47	0.640	15	Providing academic support for TFC youth is an essential TFC element.
3.47	0.834	15	Providing social skills training for youth in TFC is an essential TFC element.

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3.44	0.727	16	If there is not a match between youth needs and treatment foster parent ability, placements may fail.
3.44	0.727	16	There is a need to assure that therapists working with TFC youth are competent in therapeutic modalities (i.e., individual therapy, family therapy etc.).
3.43	0.852	14	Providing 24/7 supervision to treatment foster parents is an essential TFC element.
3.40	0.632	15	Currently the purpose of TFC varies depending on how it is used in the continuum of out-of-home care.
3.40	0.507	15	Some TFC models employ some but not all of the TFC essential elements.
3.40	0.507	15	Fidelity to evidence-based treatment models leads to improved outcomes for youth.
3.38	0.619	16	There is a need to adhere to TFC practice standards.
3.38	0.619	16	There is a need to identify the credentialing requirements and professional expertise of mental health professionals who work in TFC.

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3.38	0.500	16	There is a need for more information on TFC model fidelity.
3.33	0.900	15	Treatment foster homes with professional treatment parents are an essential element of TFC.
3.33	0.617	15	Length of stay in TFC may be driven by the TFC model's theory of change.
3.31	0.602	16	There are some essential elements in TFC that need to be consistent across models.
3.31	0.873	16	There is a need to assure that therapists working with TFC youth are competent in trauma-informed treatment.
3.27	1.100	15	Involving birth or biological parent(s) in treatment planning and implementation is an essential TFC element.
3.27	0.704	15	Intergenerational trauma is an issue for many of the biological families who may benefit from TFC.
3.25	0.683	16	The field is currently limited in its knowledge of the relationship between race, ethnicity and culture and the essential elements of TFC.
3.21	0.699	14	There is a need for widespread implementation of evidence-based TFC models.

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3.14	0.663	14	Typical TFC practice does not adhere to the principles of the essential elements in MTFC.
3.13	0.743	15	TFC models generally treat seriously emotionally disturbed youth who have a high likelihood of needing more restrictive long-term residential treatment.
3.07	0.594	15	It is essential to provide higher reimbursement rates for TFC parents.
3.00	0.775	11	Many funded TFC programs do not have limits on length of stay.
3.00	0.816	16	The essential elements of TFC have not been identified through randomized controlled trials (RCTs).
3.00	1.195	15	TFC is a treatment setting.
3.00	1.000	11	Research has only studied bundled TFC models.
3.00	0.655	15	The field does not know the cost-effectiveness of TFC services.
3.00	0.679	14	Bundling of services is an essential element of TFC.

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2.93	0.917	14	Assuring that TFC homes have only one TFC youth except in the case of kinship groups is an essential TFC element.
2.93	0.997	14	Therapists working with TFC youth should also be compensated for delivering care management services.
2.81	0.655	16	TFC may be a long-term placement option.
2.73	0.961	15	Higher education institutions must prepare behavioral health students to work in TFC programs.
2.71	0.825	14	The field does not know the cost of TFC services.
2.69	1.014	16	It is essential that TFC models estimate the intended length of stay from the outset.
2.53	0.834	15	Given the state of research knowledge on TFC, it is premature to consider any list of essential elements as the standard for funding a TFC program.
2.50	0.535	8	Youth tend to stay in TFC longer than regular foster care.
2.30	0.949	10	The essential elements of the Multidimensional Treatment Foster Care (MTFC) model are so costly that few youth are able to

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			benefit from that model.
2.27	1.163	15	TFC is not a singular methodological therapeutic approach that can be manualized.

4. What Do We Know About the Psychosocial Treatment of Youth in Therapeutic/Treatment Foster Care?

MEAN	Standard Deviation	n	Comment
3.64	0.633	14	Psychosocial treatment of TFC youth should also include the biological parents when they are available.
3.56	0.629	16	Therapeutic/Treatment Foster Care (TFC) is a community-based, less restrictive alternative to more restrictive settings (e.g., group care, psychiatric residential treatment facilities, long-term residential programs, etc.).
3.56	0.629	16	Service coordination alone is unlikely to generate improved youth behavior.
3.47	0.516	15	Youth in TFC need access to an array of high quality services from the child serving agencies.

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3.44	0.629	16	Youth in TFC have high mental health service utilization.
3.44	0.814	16	Clinicians must be trained in appropriate evidence-based practices.
3.43	0.514	14	TFC may be used as a step down resource for youth leaving residential treatment.
3.36	0.497	14	Youth in regular foster care have high mental health service utilization.
3.36	0.745	14	The placement histories of TFC youth are dictated by the systems (mental health, juvenile justice, child welfare) in which they are served.
3.33	0.724	15	TFC youth receive services from a wide range of providers.
3.31	0.479	16	TFC plays a different role in states' systems of care depending upon its location in the system (child welfare, juvenile justice, mental health, etc.).
3.29	0.611	14	There is little research on trauma-focused TFC.

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3.27	0.594	15	TFC may lend itself to blending funding across two or more child serving agencies.
3.19	0.655	16	The design of TFC programs administered by child welfare agencies may differ significantly from the design of TFC programs administered by mental health agencies.
2.94	0.854	16	The field currently knows very little about mental health outcomes for youth currently served by TFC.
2.86	0.770	14	There is little information about psychosocial treatment of children (age 8 and younger) in TFC.
2.73	1.163	15	MTFC is the only TFC program that has demonstrated efficacy over a range of important outcomes.
2.47	0.915	15	The field only knows about the psychosocial treatment of youth in one model of foster care, Multidimensional Treatment Foster Care (MTFC).

5. What Do We Know About Outcomes for Youth in Therapeutic/Treatment Foster Care?

MEAN	Standard Deviation	n	Comment

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3.60	0.507	15	Some youth can benefit from regular foster care kinship placements.
3.53	0.516	15	For many youth, mental health concerns persist until adulthood.
3.47	0.516	15	TFC needs to be available for youth who need that level of care as an initial placement.
3.46	0.519	13	The majority of research focuses on youth who have had multiple placements prior to TFC.
3.40	0.507	15	There is a need to identify the main causes of TFC placement disruption.
3.40	0.632	15	There is a need to clarify how trauma-informed treatment affects the developmental trajectory of youth.
3.36	0.842	14	RCTs of MTFC have demonstrated improved juvenile justice outcomes for TFC youth.
3.33	0.488	15	TFC can be effective for improving mental health outcomes.
3.29	0.825	14	Short-term outcomes are consistently improved in the efficacy trials for the clearly articulated TFC models for populations tested thus far.

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3.27	0.647	11	RCTs of Together Facing the Challenge have demonstrated improved mental health outcomes for TFC youth.
3.27	0.458	15	Existing studies demonstrate positive TFC outcomes.
3.23	0.832	13	MTFC reduces recidivism in males in the juvenile justice system.
3.22	0.972	9	MTFC-pre has evidence of changing children's cortisol levels.
3.22	0.972	9	MTFC-pre has evidence of changing children's executive functioning.
3.20	0.632	10	TFC reduces recidivism in females in the juvenile justice system outcomes.
3.20	0.561	15	TFC programs vary in effect sizes for outcomes.
3.20	0.632	10	There is some evidence of fewer placement disruptions for TFC youth versus regular foster care youth.
3.15	0.801	13	Youth with severe behavioral problems have better outcomes from MTFC than from regular foster care.

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3.14	0.864	14	TFC components need to be manualized to assure treatment fidelity.
3.13	0.719	16	Placement disruption is a common event in foster care.
3.10	0.568	10	Youth enter MTFC because of behavioral problems or involvement in juvenile justice rather than for internalizing problems typically addressed by informed trauma treatment.
3.07	0.616	14	TFC has the potential to significantly reduce juvenile justice involvement.
3.07	0.704	15	MTFC-pre provides strong evidence for improving children's behavior.
3.00	0.816	13	Randomized controlled trials (RCTs) of MTFC have demonstrated improved mental health outcomes for TFC youth.
3.00	0.707	13	RCTs of MTFC have demonstrated improved substance abuse outcomes for TFC youth.
3.00	1.000	11	MTFC reduces recidivism in females in the juvenile justice system.
3.00	0.866	9	At least one study showed that MTFC youth had significantly lower levels of marijuana or other drug use than group care

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			youth.
3.00	0.877	14	MTFC is an effective model for preventing placement disruptions.
2.91	1.044	11	MTFC is most effective for youth with the most severe behavioral problems.
2.89	0.601	9	There is very little research on substance abuse outcomes in TFC.
2.83	0.718	12	TFC produces short-term gains in youth outcomes that are not necessarily sustained long term.
2.75	1.055	12	RCTs of MTFC have demonstrated improved child welfare outcomes for TFC youth.
2.73	1.191	11	RCTs of MTFC have demonstrated improved outcomes for "crossover" youth (youth who are involved in both the child welfare and the juvenile justice systems).
2.50	1.378	6	TFC shows greater improvements than regular foster care over time for girls.
2.20	1.135	10	RCTs of Together Facing the Challenge have demonstrated improved juvenile justice outcomes for TFC youth.

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2.13	0.835	8	Placement disruption is more common for girls.

6. What Do We Know About Organizational Issues in Therapeutic/Treatment Foster Care?

MEAN	Standard Deviation	n	Comment
3.73	0.458	15	There is a need to provide on-going training for treatment foster parents after the initial implementation of the TFC model.
3.56	0.512	16	The field needs to attend to how TFC is operationalized in practice.
3.47	0.516	15	Variability in adherence to TFC service type standards affects the identity of TFC in the field.
3.47	0.640	15	TFC agency organizational factors are important in shaping outcomes of youth in TFC.
3.47	0.516	15	Reimbursement levels and designs should be informed by level of care criteria.
3.40	0.632	15	The field has a limited understanding of TFC organizational issues due to a limited empirical base.

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3.38	0.619	16	The supervision of treatment foster parents needs to address the youth's needs.
3.33	0.724	15	There is a need to differentiate regular foster care from TFC in practice standards.
3.31	0.602	16	The field needs to develop level of care criteria for clinical decision making.
3.31	0.602	16	Variability in adherence to existing TFC standards affects TFC youth outcomes.
3.29	0.469	14	The field must define the selection criteria for TFC parents/families.
3.27	0.594	15	Currently the number of children in a TFC home is variable.
3.20	0.862	15	Unevaluated models of TFC may have data that could inform the question of TFC efficacy.
3.20	0.862	15	There is a need for uniform TFC standards nationwide.
3.00	0.816	10	Currently reimbursement for TFC is insufficient to provide essential services.

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2.79	0.579	14	TFC parents see themselves as substitute parents.
2.43	1.016	14	The field must avoid licensing a foster home for both regular foster care and TFC to preserve the integrity of the TFC model of treatment.
2.15	0.689	13	TFC parents do not see themselves as treatment professionals.

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What Does the Research Tell Us About Services for Children in Therapeutic/Treatment Foster Care With Behavioral Health Issues?
Technical Expert Panel Consensus Process Results Question 2, Round 1

Question 2. What are Recommendations for the Implementation of What We Know?

N = 16

1. What Do We Know About Therapeutic/Treatment Foster Care?

MEAN	Standard Deviation	n	Comment
3.81	0.403	16	Placement of a youth should be based on needs.
3.80	0.414	15	It is important to connect TFC youth to supportive, caring adults.

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3.75	0.447	16	The field needs to identify the target population who benefit from TFC treatment modality.
3.75	0.447	16	In current practice, youth with a wide range of mental health needs may be placed in either regular foster care or TFC, not depending on needs but on the availability of foster care placement slots.
3.69	0.602	16	TFC needs to consider and prepare for the youth's transition out of child welfare services.
3.69	0.479	16	TFC requires multifaceted interventions.
3.63	0.719	16	There is a need for a clear distinction between TFC standards of care and TFC model components.
3.63	0.500	16	It is critical to match the needs of TFC families with appropriate services.
3.63	0.619	16	Funding restrictions greatly influence the decisions about which youth will have access to evidence-based TFC.
3.60	0.507	15	There is a need to expand the use of best practices in TFC.
3.60	0.632	15	It is beneficial to assess alternative permanency supports for TFC youth in case planning.

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3.60	0.507	15	There is a need for flexible funding options that promote both youth treatment and youth well-being.
3.57	0.514	14	Providing ongoing/step-down services to maintain treatment gains is beneficial to TFC youth.
3.50	0.650	14	The Administration for Children, Youth and Families (ACYF) considers child well-being as important as safety and permanence.
3.50	0.516	16	The field needs to determine the services that comprise TFC.
3.50	0.516	16	MTFC is not available for the vast majority of youth who could benefit from it.
3.47	0.743	15	TFC placement decisions should be based on a functional assessment of the youth.
3.47	0.640	15	The field needs to clarify the criteria for admission of young children into TFC.
3.47	0.743	15	The field needs to maintain cultural humility when implementing TFC in a community.
3.44	0.727	16	The field must consider youth attachment to providers in the transition from TFC.

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3.44	0.727	16	The TFC treatment plan must be individualized and address the specific needs of each youth.
3.44	0.512	16	Many states need standardized criteria for TFC enrollment and services.
3.44	0.629	16	There is a need for clear standards of practice for TFC.
3.44	0.512	16	There is a need for a clear process to measure adherence to TFC standards of care.
3.40	0.507	15	The field needs greater uptake of evidence-based TFC programs.
3.38	0.619	16	There is a need for a clear operational definition of TFC.
3.38	0.619	16	Information from existing regular foster care and TFC practices needs to be analyzed to identify differences.
3.33	0.724	15	TFC needs to follow clear manuals and protocols.
3.33	0.900	15	TFC families should be reimbursed at higher rates than regular foster care families.

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3.31	0.602	16	The field needs to clarify the developmental treatment trajectory that youth in TFC are likely follow.
3.31	0.704	16	TFC interventions require fidelity to a model in order to be successfully implemented.
3.31	0.602	16	Juvenile justice systems would save money through greater implementation of evidence-based TFC programs.
3.29	0.825	14	The field needs federal regulations that encourage fidelity to basic standards of TFC.
3.27	0.704	15	The field needs state regulations that encourage fidelity to basic standards of TFC.
3.19	0.655	16	It is essential to correct fidelity drift from a TFC model using a continuous quality improvement process.
3.17	1.030	12	TFC caseworkers' caseloads should be limited to 10 to 15 youth.
3.13	0.806	16	Child welfare systems would save money through greater implementation of evidence-based TFC programs.
3.07	0.884	15	TFC needs to be available to youth as a treatment option for as long as it is needed.

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2.92	0.862	13	Medicaid reimbursement is based on medical necessity.
2.80	0.775	15	Higher education training programs for mental health professionals must include education in TFC.
2.45	0.934	11	The federal definition of medical necessity does not require a DSM diagnosis.

2. What Do We Know About Identifying Youth Appropriate for Therapeutic/Treatment Foster Care?

MEAN	Standard Deviation	n	Comment
3.79	0.426	14	The field needs assessment measures that are sensitive to change in youth over time.

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3.67	0.488	15	Measures that inform practice have greater utility.
3.67	0.488	15	Functional assessments and psycho-diagnostic evaluations of youth in TFC should be reimbursable.
3.67	0.488	15	There is a need for cost-effectiveness approaches and models for TFC.
3.60	0.632	15	Assignment to TFC must be based on youth's needs independent of referral source.
3.60	0.507	15	Measures of youth functioning and symptomatology are one component of the decision process in determining whether a youth may benefit from TFC.
3.54	0.519	13	The field needs measures that are sensitive to racially, ethnically and culturally diverse youth populations.
3.53	0.640	15	There is a need to assess both youth functioning and needs.
3.53	0.834	15	Placement and treatment decisions would be improved by having a documented connection between screening and assessment tools and treatment needs.

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3.50	0.855	14	Funders should require at least one functional assessment as part of determining level of care for TFC.
3.50	0.650	14	Items in a measure must be reviewed in terms of cultural sensitivity.
3.47	0.516	15	It is important to operationally define what is meant by functional assessment in TFC.
3.47	0.834	15	A validated assessment tool and regular re-assessments must inform the development and updating of the youth's TFC treatment plan.
3.47	0.640	15	It is important to sort out the influence of the business component vs. the youth's needs when conducting assessments for placement in TFC.
3.47	0.640	15	Cost is a component that should be included in evaluating the quality of TFC.
3.46	0.660	13	Both assessment measure sub-scores and total scores can be useful in placement planning.
3.40	0.828	15	Measures developed for assessing appropriate level of care at intake should not be assumed to be adequate measures of outcomes.

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3.40	0.828	15	Measurement items must encompass a range from mild to serious impairment so that the youth's treatment needs can be accurately identified.
3.40	0.828	15	There is a need for measures that assess real world functioning of youth as well as symptomatology.
3.40	0.737	15	Funding should not drive the decision to adopt specific measurement instruments.
3.33	0.617	15	Collaborative partnerships need to be developed between researchers and practitioners across TFC models to better understand the TFC theory of change.
3.33	1.047	15	Staff consensus is not a substitute for sound empirical measurement.
3.33	0.816	15	Changes in placement should be empirically informed by sound measurement.
3.31	0.751	13	There is a need for knowledgeable clinicians to interpret standardized assessment data.
3.29	0.469	14	Strengths based assessments may overlook important considerations in assessing improvement.

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3.29	0.611	14	The field should not employ measures simply because they are included in existing management information systems (MIS).
3.20	1.014	15	TFC youth assessment must include measures of trauma symptoms and experiences.
3.07	1.072	14	In setting standards for funders, it is important to distinguish case level measures versus program evaluation measures.
3.07	0.917	14	The limitations of measures and tools should be considered in determining the level of care for TFC
3.00	0.913	13	Child and Family Services Reviews (CFSRs) and other evaluative tools should be adapted to better reflect the needs of sub-populations of youth, especially those youth (such as TFC youth) with high-service needs.
2.71	1.069	14	The field knows very little about the quality of measures for specific populations.
2.71	0.994	14	The field needs different measures to determine placement for different youth populations.

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3. What Do We Know About the Essential Elements of Therapeutic/Treatment Foster Care?

MEAN	Standard Deviation	n	Comment
3.64	0.497	14	TFC providers should work with supportive aftercare resources to connect the youth to the community.
3.63	0.500	16	The TFC model should include genuine engagement of the TFC parents and the youth.
3.57	0.646	14	TFC parents should work with supportive aftercare resources to connect the youth to the community.
3.56	0.629	16	Service planning for youth in TFC is essential.
3.56	0.512	16	It is important to keep youth in the community in as normal a setting as possible.
3.54	0.519	13	The Parent Daily Report should capture information on TFC youth's problematic behaviors.

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3.50	0.632	16	Reimbursement rates need to reflect the additional requirements of TFC.
3.46	0.519	13	There is a need for a more widespread uptake of TFC programs that contain the identified essential elements.
3.44	0.629	16	There is a need for further research on the use of technology in TFC to improve cost-effectiveness.
3.38	0.768	13	Eligibility for TFC should not be based on having pre-determined post-discharge caregivers.
3.38	0.806	16	Regularly scheduled clinical supervision for TFC staff is essential to assure their effective working relationship with TFC parents.
3.38	0.619	16	TFC agency management needs to provide support and coaching sessions to assist staff in effectively working with TFC foster parents.
3.31	0.873	16	TFC should link with a youth's biological family or other designated post-discharge caregiver.
3.29	0.825	14	It is crucial to sort out how to integrate the TFC resource demands within the context of financial redesign and privatization models that are being developed in various states.

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3.15	0.987	13	The Parent Daily Report should capture what is being done to reinforce pro-social behaviors in TFC youth.
3.14	0.949	14	There is a need for further research on the use of technology to improve TFC fidelity monitoring.
3.13	1.125	15	Funding must support evidence-based, trauma-informed TFC.
3.13	0.885	16	TFC needs to be designed to serve youth, regardless of custody status.
2.93	0.884	15	The child welfare system should have input into the essential elements of TFC and the approval of any exceptions.
2.92	1.038	13	TFC parents should be reimbursed at a rate that enables one parent to be in the home at all times.
2.85	1.281	13	The Parent Daily Report should capture what is going well for the TFC youth.
2.81	0.834	16	The clinical judgment of the treatment team should determine the appropriateness of length of placement in TFC for youth.
2.75	0.931	16	TFC should not mix TFC youth with regular foster care youth within the same home.

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2.75	0.866	12	The Parent Daily Report is a validated assessment tool that can monitor youth well-being.
2.45	0.820	11	Two levels of TFC are needed to address specific assessed needs of youth.
2.33	1.323	9	The Parent Daily Report is a validated assessment tool that can monitor caregiver well-being.
1.94	0.680	16	The clinical judgment of case managers should determine the appropriateness of length of placement in TFC for youth.

4. What Do We Know About the Psychosocial Treatment of Youth in Therapeutic/Treatment Foster Care?

MEAN	Standard Deviation	n	Comment

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3.73	0.458	15	It is essential that mental health services be coordinated with other TFC treatment services.
3.71	0.469	14	Ancillary services for youth in TFC should be coordinated by well-trained, informed staff.
3.69	0.479	16	Carefully designed TFC has the opportunity for cost-effectiveness.
3.63	0.500	16	Decisions regarding re-placement following a placement disruption should reflect the youth's psychosocial needs.
3.60	0.737	15	Developing the human capital resources of TFC parents is an important priority.
3.56	0.512	16	It is critical to provide mental health services that are tailored to the treatment goals of each TFC youth.
3.53	0.516	15	Developing the human capital resources of TFC program staff is an important priority.
3.53	0.516	15	There is a need to identify the TFC components billable to health insurance.
3.50	0.730	16	The TFC treatment team must have a coordinator who has skill in coaching treatment foster parents to help improve TFC youth's behavior.

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3.40	0.828	15	Mental health therapy should be included as part of any TFC model.
3.38	0.506	13	Mental health therapy should be embedded in the TFC model rather than referring youth out for mental health treatment.
3.38	0.806	16	Behavioral health care for youth in TFC should be evidence-based.
3.36	0.745	14	Reimbursement approaches need to support the range of auxiliary services that TFC youth need.
3.33	0.724	15	TFC must be youth-centered to meet the individual needs of each youth.
3.33	0.816	15	Mental health therapists embedded within the TFC team should be funded at the same mental health reimbursement rates as comparable mental health practitioners.
3.20	0.775	15	In TFC, one staff member on each youth's team should be in charge of coordinating the care of all other providers.
3.15	0.801	13	TFC care workers need to coordinate care.
3.00	0.775	11	TFC should be reimbursed as a bundled service.

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2.46	0.776	13	TFC therapists need to coordinate care.
2.09	0.701	11	TFC youth are as likely to go to more intensive placement as a less-intensive placement or to return home following TFC.
1.50	0.527	10	Over their foster care careers, youth tend to need services in increasingly restrictive levels of care.

5. What Do We Know About Outcomes for Youth in Therapeutic/Treatment Foster Care?

MEAN	Standard Deviation	n	
3.73	0.458	15	There is a need for more cost-effectiveness research on TFC especially for non-juvenile justice populations.
3.64	0.497	14	The field needs to focus on services that improve outcomes for transition aged youth in TFC.
3.63	0.500	16	Youth behavioral health functioning should be measured as a TFC outcome.

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3.63	0.518	8	MTFC is more cost-effective than group care.
3.60	0.632	15	TFC should be designed to address the needs of youth across the developmental range.
3.56	0.629	16	The field needs to collect data on a relevant range of outcomes for youth in TFC.
3.44	0.629	16	Research has studied TFC outcomes for only a small number of the sub-populations of youth in TFC.
3.40	0.632	15	Developing strategies for holding TFC providers accountable to youth-level outcomes is an important priority.
3.31	0.793	16	When a foster home placement fails, the youth's mental health needs should be reevaluated.
3.27	0.704	15	Variations in child-rearing practices among racial, ethnic and cultural subgroups may have significant effects on the TFC practice model and outcomes for subgroups of youth (i.e., Hmong, Native American, etc.).
3.19	0.655	16	The field should be cautious when implementing TFC for youth under-represented in research studies.
3.19	0.834	16	Outcomes for youth in the juvenile justice system would improve with greater implementation of evidence-based TFC

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			programs.
3.14	0.864	14	Interaction with community leaders is essential to developing TFC for racially, ethnically and culturally diverse youth.
3.14	0.864	14	Outcomes for youth in child welfare systems would improve with greater implementation of evidence-based TFC programs.
3.08	0.900	12	Given its strong evidence base, certification process and manualization, MTFC is an excellent candidate for bundled reimbursement.
2.47	0.990	15	TFC programs that operate without an evidence-based, manualized program should not be eligible for Medicaid reimbursement.

6. What Do We Know About Organizational Issues in Therapeutic/Treatment Foster Care?

MEAN	Standard Deviation	n	Comment

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3.60	0.507	15	There is a need for systematic training for TFC supervisors.
3.60	0.507	15	Without adequate funding, it is impossible to fully implement evidence-based practices.
3.56	0.629	16	The field needs to monitor youth well-being on a regular basis following TFC placement.
3.50	0.516	16	Implementation of TFC may be affected by personnel issues.
3.47	0.516	15	TFC regulations on training need to reflect the current state of the knowledge base.
3.44	0.512	16	TFC implementation may be affected by policy decisions.
3.43	0.514	14	Regulations regarding number of youth per TFC home need to reflect current state of the knowledge base.
3.40	0.737	15	TFC parents should be considered as professionals/employees.
3.38	0.719	16	The field needs clear measures of best practices in TFC.

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3.36	0.633	14	The implementation of TFC must address organizational factors.
3.36	0.633	14	There is a need to clarify how to determine the responsibility for funding a TFC placement.
3.31	0.479	16	The field needs to integrate research findings across child-serving agencies to assure effective out-of-home care practices in the field.
3.27	0.799	15	There is a need for quality assurance to monitor TFC model fidelity.
3.25	0.622	12	The field needs to accept the cost of implementing TFC well.
3.19	0.981	16	SAMHSA should provide ongoing support for evidence-based youth focused mental health interventions.
3.19	0.911	16	The Children's Bureau should provide ongoing support for evidence-based youth focused mental health interventions.
3.13	0.640	15	Organizational level factors determine whether providers maintain fidelity to a TFC model.
3.13	0.500	16	Regulations on supervision within TFC need to reflect the current state of the knowledge base.

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3.08	0.760	13	The field needs manualized TFC programs.
3.07	0.730	14	Effective TFC is expensive.
3.06	0.998	16	The Children's Bureau should provide training and technical assistance on evidence-based youth focused mental health interventions.
3.00	0.577	13	The field needs a vehicle for disseminating generic information about the implementation of TFC.
3.00	1.095	16	SAMHSA should provide training and technical assistance on evidence-based youth focused mental health interventions.
3.00	1.033	16	The Children's Bureau should assure that evidence-based youth focused mental health interventions are delivered with fidelity to the model.
2.94	1.063	16	SAMHSA should assure that evidence-based youth focused mental health interventions are delivered with fidelity to the model.
2.93	0.917	14	There is a need for a more appropriate title for TFC parents.

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2.81	0.655	16	There is a need to clarify which child serving agency/agencies should be responsible for placing youth in TFC.
2.73	0.704	15	TFC should be re-named to accurately reflect its status as a community-based individualized home-based treatment-focused intervention.
2.69	0.855	13	The field needs implementation strategies that encourage the development of regional resources to assure MTFC fidelity.
2.18	0.603	11	The field should use Dr. Farmer's 104 point scale as a tool to assess all TFC programs.

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What Does the Research Tell Us About Services for Children in Therapeutic/Treatment Foster Care With Behavioral Health Issues?
Technical Expert Panel Consensus Process Results Question 3, Round 1

Question 3. What are the Recommendations for Advancing the Knowledge Base?

N=16

1. What Do We Know About Therapeutic/Treatment Foster Care?

MEAN	Standard Deviation	n	Comment
3.73	0.458	15	The field needs to develop fidelity measures of TFC model implementation.
3.67	0.488	15	There is a need to increase knowledge of who benefits from what models of TFC, under what conditions.

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3.67	0.488	15	Quasi-experimental research when done with methodological rigor can contribute to the knowledge base on TFC.
3.62	0.506	13	The field needs rigorous research in order to increase the power of the results and improve generalizability of TFC findings.
3.60	0.507	15	There is a need to determine which characteristics of TFC youth mediate/moderate positive outcomes.
3.60	0.507	15	The field needs to study the long-term mental health outcomes of TFC intervention models for youth in state custody.
3.60	0.507	15	There is a need to evaluate the cost-effectiveness of TFC.
3.60	0.507	15	There is a need to publish research on TFC models.
3.57	0.514	14	The field needs to look beyond safety and permanency and focus on well-being outcomes for youth in TFC.
3.57	0.646	14	It is important to move 'promising' models of TFC with good outcomes in real world settings to rigorous randomized controlled trial testing.
3.57	0.646	14	The field needs short term and long term research of TFC youth with larger sample sizes.

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3.57	0.514	14	The field needs research on costs of TFC.
3.54	0.877	13	The field needs to fund randomized controlled trials of TFC models.
3.53	0.640	15	There is a need to evaluate short and long term outcomes of currently implemented TFC programs.
3.53	0.516	15	There is a need for racially, ethnically and culturally diverse representative samples of youth currently in TFC.
3.50	0.707	10	The field needs more careful designation of who is in TFC in the Statewide Automated Child Welfare Information Systems database.
3.50	0.650	14	The field needs researchers with the ability to successfully implement studies of TFC with representative samples of TFC youth.
3.50	0.519	14	The field needs to better understand how model fidelity impacts outcomes of TFC that already show promise as an evidence-based practice.
3.47	0.640	15	The field needs more research on child welfare system-involved youth in TFC.

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3.47	0.640	15	The field needs funding support for research on racially, ethnically and culturally diverse youth in TFC.
3.47	0.743	15	The field needs to encourage the funding of comparative effectiveness research on TFC models.
3.40	0.737	15	There is a need for research on ways to assess readiness and fit of both youth and TFC parents so that these factors may be examined in relation to outcomes.
3.40	0.507	15	The field needs studies of how well mature TFC programs are implemented with fidelity to the model.
3.40	0.828	15	There is a need for more research on the effectiveness of the types of TFC currently in use nationwide.
3.40	0.737	15	The field needs to determine to what extent biological/birth family parent involvement contributes to TFC youth outcomes.
3.40	0.828	15	There is a need for research on how TFC works for different racial, ethnic and cultural youth populations in order to implement it in real world practice.
3.40	0.632	15	TFC models may require model adaptation for racially, ethnically or culturally diverse populations.

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3.40	0.737	15	The field needs funding to support short- and long-term research on TFC youth and alumni.
3.36	0.633	14	Randomized controlled trials are the accepted standard of measuring treatment efficacy.
3.33	0.651	12	The field lacks research about the impact of the individual components of aggregated TFC models such as MTFC.
3.33	0.888	12	The field should conduct propensity studies of TFC practices that have evidence of good outcomes in real world settings.
3.33	0.900	15	The field should use both qualitative and quantitative research methods to determine the efficacy of TFC.
3.33	0.617	15	There is a need for research on the impact of implementation strategies for scaling up and sustaining TFC.
3.33	0.900	15	The field needs to better understand how sample selection (e.g., youth history, characteristics, connection to community, etc.) affects outcomes of youth in TFC research.
3.33	0.488	15	The field needs to evaluate the efficacy and effectiveness of approaches to TFC step-down care.
3.33	0.617	15	The field needs to research cost effective ways of providing TFC to youth prior to youth experiencing multiple other

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			placements.
3.33	0.724	15	The field should implement the two currently-tested TFC models with fidelity checks to ensure each model's ability to produce long-term positive outcomes.
3.29	0.825	14	There is a need to monitor progress for reduced symptoms and improved youth functioning.
3.29	0.914	14	Alternative permanency supports (e.g., connections to caring, supportive adults) should be a variable in TFC outcome measurement.
3.27	0.704	15	The field needs to understand service use trajectories post TFC placement.
3.27	0.799	15	There is a need for more research on the fidelity of TFC models with racially, ethnically and culturally diverse populations.
3.27	0.799	15	The field needs funding to support real time program evaluation of TFC models across diverse regions of the United States.
3.21	0.699	14	The samples of youth in TFC studies currently represent only specific segment(s) of the out-of-home placement population.
3.21	0.802	14	The field must include in-house researchers from the large private TFC providers in the conversation about necessary research.

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3.21	0.699	14	Researchers should study the effectiveness of trauma informed interventions in TFC.
3.20	0.941	15	There is a need for research to disaggregate the outcomes associated with TFC youth by racially, ethnically and culturally diverse groups.
3.20	0.676	15	The field needs additional research on the sustainability of TFC programs.
3.20	0.676	15	There is a need to study the efficacy and effectiveness of TFC as an initial out-of-home placement.
3.20	0.775	15	There is a need to develop better screening to identify TFC parents who will fully participate in the treatment team.
3.18	0.603	11	MTFC model trials have small numbers in homogenous samples.
3.17	0.937	12	The field needs to fund studies of TFC using secondary analysis of administrative data from TFC providers.
3.14	0.770	14	The field needs research on other manualized TFC models using randomized controlled trials.
3.14	0.770	14	There is a need for research on the efficacy of TFC for Native American youth.

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3.14	0.770	14	The field needs to determine the impact of TFC model fidelity on meeting performance standards.
3.13	0.915	15	The field lacks research about which youth will do well in TFC.
3.13	0.915	15	There is a need to develop TFC discharge criteria.
3.13	1.060	15	There is a need for an operational definition of youth well-being.
3.08	0.862	13	Research on TFC needs to include variables for the provider and system characteristics that impact the services provided.
3.07	0.829	14	There is a need to use practice based evidence to add context to what is known about TFC.
3.07	0.616	14	The gap in TFC effectiveness research could be a barrier to TFC implementation.
3.07	0.829	14	There is a need for studies on the appropriate length of stay for youth in residential care.
3.07	0.799	15	Researchers should study which components of TFC models predict desirable outcomes for the family of the youth in TFC.

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3.00	0.655	15	The field needs to understand how TFC builds resilience in youth.
3.00	1.000	15	The field needs to study the trajectory of service needs of youth in TFC.
3.00	0.632	11	Large private TFC providers' in-house researchers have significant unpublished research that could really benefit the field.
3.00	1.155	13	Researchers should test different theoretical approaches to TFC.
3.00	0.877	14	The field needs more research on the business aspects of TFC.
2.93	0.704	15	The field needs to understand prior youth and family service use history and its impact on TFC outcomes.
2.93	1.141	14	There is a need to study how outcomes differ for youth who are referred to TFC from different child serving agencies (child welfare, juvenile justice, mental health, etc.).
2.86	0.864	14	The field needs studies that systematically test varying levels of service use in TFC.
2.75	0.866	12	The field needs research on the extent to which residential facilities identity community resources at intake for the purpose of

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			an appropriate transfer of the youth back to the community.
2.67	1.047	15	Medicaid should not base reimbursement decisions on findings from research on only two TFC models.
2.50	1.080	10	The field needs randomized controlled trials comparing KEEP to TFC programs.

2. What Do We Know About Identifying Youth Appropriate for Therapeutic/Treatment Foster Care?

MEAN	Standard	n	Comment

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	Deviation		
3.64	0.497	14	TFC measures should be scientifically sound.
3.50	0.650	14	Assessment measures should be selected based on an established set of criteria (e.g., reliability, validity, feasibility, etc.).
3.40	0.828	15	Measures should provide actionable information, i.e. information that assists in treatment planning and policy decisions.
3.36	0.633	14	The field needs to better understand how to identify youth that are appropriate for TFC.
3.36	0.745	14	Measuring the level of fidelity to TFC models is essential in evaluating TFC's contribution to youth outcomes.
3.29	0.825	14	Assessment measures and tools should be free or open source.
3.21	0.699	14	Individual items in assessment measures may be informative in TFC planning.
3.21	0.699	14	There is a need for multiple measures to be available for TFC providers and clinicians.

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3.21	0.802	14	Measurement criteria should be established for measures used in assessing care outcomes.
3.20	0.862	15	The field needs to develop scientifically sound, comprehensive measures to assess the appropriate level of care.
3.15	1.068	13	The field needs to develop valid, reliable and comprehensive measures for TFC.
3.07	0.917	14	There is a need for research to identify the best practices for assessing youth entering TFC.
3.07	0.730	14	There is a need to study the sensitivity of measures used to assess the youth's progress in TFC.
3.00	0.667	10	There is a need for information on problem based interventions for youth in TFC.
3.00	0.816	13	TFC fidelity measures must have established validity.
3.00	0.845	15	The field needs to examine whether existing TFC fidelity measures are generalizable to all TFC treatment sites.
3.00	0.877	14	There is a need for additional public funding for measure development.

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2.93	0.884	15	Measures of therapeutic alliance between TFC caregivers and youth need to be developed and tested.
2.93	1.033	15	The field needs a consistent measurement approach to assess the fidelity to TFC models.
2.93	1.100	15	Multiple scientifically sound, comprehensive measures are needed to assess the outcomes of care.
2.93	0.917	14	There is a need for research to develop tools to assess the strengths and needs of biological families of youth entering TFC.
2.92	0.862	13	There is a need to continue refining the psychometric properties of assessment tools to improve referral to appropriate therapeutic interventions.
2.92	0.954	13	The field should study whether the models of TFC are appropriate for medically fragile youth.
2.87	0.990	15	There is a need for a sensitive measure to screen for the appropriateness of a TFC for youth.
2.79	0.893	14	There is a need to establish relative importance of assessment components used in TFC (e.g., symptomatology versus functioning, etc.).

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2.77	0.927	13	There is a need to better understand the TFC parents' own psychodynamics to insure a better fit with the youth's needs.
2.77	0.832	13	Idiosyncratic changes and 'tweaks'? to measures compromise the ability to compare information.
2.67	0.707	9	Person or item fit data can be valuable.
2.50	1.160	14	There is a need for studies that identify the relative contributions of the TFC system, parents and youth to outcomes.

3. What Do We Know About the Essential Elements of Therapeutic/Treatment Foster Care?

MEAN	Standard Deviation	n	Comment
3.69	0.479	16	TFC effectiveness should be assessed over both the short and long term.
3.56	0.512	16	It is important to have TFC youth input into the evaluation of TFC.

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3.38	0.650	13	There is a need for more research on the effectiveness of a tiered level of model TFC.
3.38	0.619	16	It is important to have TFC parent input into the evaluation of TFC.
3.36	0.929	14	There is a need for research on less costly versions of TFC.
3.31	0.602	16	It is important to have biological family input into the evaluation of TFC.
3.31	0.602	16	It is important to have TFC clinician input into the evaluation of TFC.
3.27	0.594	15	Further research is needed on essential TFC elements that promote effective transitions for TFC youth between levels of care.
3.20	1.014	15	There is a need for research on optimal training methods for TFC parents.
3.20	0.561	15	There is a need for more research to determine the appropriate reimbursement rates and models for TFC.
3.19	0.655	16	There is a need to study which aftercare resources (i.e. bio/adoptive parent or community 'caring supportive adults' etc.) are most effective for TFC youth under which particular permanency discharge option (e.g. reunification, emancipation, etc.).

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3.13	0.990	15	There is a need to determine the essential elements that must be provided by the TFC parent(s).
3.13	0.957	16	There is a need for research on optimal training methods for TFC providers.
3.07	1.033	15	There is a need to determine the impact of length of stay limits in TFC.
3.06	0.854	16	There is a need for more research on the effects of TFC parents' engagement in TFC youth's mental health treatment.
3.06	0.929	16	There is a need to further investigate how race, ethnicity and culture impact the essential elements of TFC care.
2.94	0.854	16	There is a need to study the relative contribution of each essential element (e.g., 24/7 support for TFC parents) on outcomes for TFC youth.
2.93	0.829	14	There is a need for research to determine the needs of young people who remain in TFC until age 26 and how well states address these needs.
2.85	0.987	13	There is a need to clearly define the tested models of TFC in research studies.

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2.85	0.987	13	There is a need to study if every TFC model must employ all essential elements.
2.64	1.008	14	There is a need to develop a research framework to study TFC.
2.56	1.094	16	There is a need for comparative cross-national studies of TFC.
2.53	1.125	15	There is a need for further research on the effective individual TFC components before supporting randomized trial studies of bundled models.
2.36	1.082	14	There is a need to mandate studies of the direct and indirect contribution of each essential TFC element to youth outcomes.
2.36	1.082	14	There is a need to develop a research framework to understand the effectiveness of the two basic TFC models.

4. What Do We Know About the Psychosocial Treatment of Youth in Therapeutic/Treatment Foster Care?

MEAN	Standard	n	Comment

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	Deviation		
3.31	0.602	16	There is a need to compare TFC to other types of 24-hour care in real world settings.
3.31	0.704	16	There is a need for more research on trauma-informed models of TFC.
3.27	0.704	15	Research in TFC needs to specify the types and amounts of mental health services that youth in TFC study samples are receiving.
3.27	0.799	15	There is a need for more research on the mental health service needs of TFC youth.
3.27	0.799	15	There is a need to understand the relative contribution of behavioral consultation to TFC foster parents.
3.25	0.577	16	There is a need to use common definitions of levels of out-of-home care when comparing TFC programs with other 24-hour care models.
3.20	0.775	15	There is a need to better understand the variations that exist in the TFC models.
3.20	0.862	15	There is a need for research to establish criteria for levels of out-of-home care.

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3.20	0.676	15	There is a need to study patterns of service utilization for young children (0-3), children (4-12) and for youth 13 and older in TFC.
3.19	0.834	16	There is a need to identify specific mental health disorders that can effectively be addressed within the context of TFC.
3.14	0.663	14	Studies by the Foster Family Treatment Association (FFTA) could contribute to the knowledge base on evidence-based practice in TFC.
3.13	0.719	16	There is a need to identify the most effective array of mental health services for youth in TFC.
3.13	0.719	16	There is a need for more research on the types of mental health and other services and other youth in TFC need.
2.92	0.862	13	The organization of TFC providers, the Foster Family Treatment Association (FFTA) should be involved in evaluating TFC.
2.88	0.885	16	There is a need to study the minimum education and training levels of staff needed to implement TFC programs with fidelity.
2.73	1.100	15	Given the limited knowledge on the state of treatment foster care nationally, researchers should explore the possibility of extracting national level data on treatment foster care from the National Survey of Child and Adolescent Well-Being.

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2.73	1.100	15	Given the limited knowledge on the state of treatment foster care nationally, researchers should explore the possibility of extracting national level data on treatment foster care from the Chapin Hall Multi-State Child Welfare data archive.
2.10	0.738	10	There should be a similar consensus process for in-house researchers and providers of TFC.

5. What Do We Know About Outcomes for Youth in Therapeutic/Treatment Foster Care?

MEAN	Standard Deviation	n	Comment
3.63	0.619	16	There is a need for evaluation of wide scale implementation of evidence-based TFC practices to assess outcomes.
3.56	0.629	16	There is a need for more research on the efficacy of TFC models.
3.53	0.516	15	There is a need to compare TFC outcomes with appropriately matched samples of youth in more restrictive treatment settings (group care, psychiatric residential treatment facilities, residential treatment, etc.)

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3.44	0.629	16	There is a need for more research on how TFC improves outcomes.
3.38	0.719	16	There is a need for more studies of TFC in a variety of settings and sub-populations.
3.36	0.842	14	There is a need to clearly differentiate outcomes of TFC from outcomes of regular foster care.
3.36	0.633	14	There is a need for research on cost-savings for child welfare youth in TFC versus other placement settings.
3.31	0.602	16	There is a need for evaluation of wide scale implementation of evidence-based TFC practices to assess fidelity to the models.
3.31	0.873	16	There is a need for evaluation of wide scale implementation of evidence-based TFC practices to assess sustainability.
3.31	0.704	16	There is a need to study the most effective methods of taking a TFC intervention to scale.
3.31	0.602	16	There is a need to learn more about why TFC services do not work for specific youth.
3.27	0.704	15	There is need to study the causes of turnover in TFC families.

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3.25	0.856	16	There is a need for more studies of TFC with larger sample sizes, including minority populations.
3.25	0.775	16	There is a need to study why TFC implementation fails.
3.25	0.683	16	There is a need to determine if the promising TFC outcomes can be replicated with other diverse populations.
3.25	0.856	16	There is a need to use varied research designs beyond randomized controlled trials in studying TFC outcomes.
3.20	0.676	15	There is a need for comparative effectiveness studies on evidence-based models of mental health treatment for foster care youth.
3.19	0.834	16	There is a need for cost-effectiveness studies of TFC that incorporate a range of outcomes measures beyond the cost to child-serving agencies (e.g., child welfare, juvenile justice, mental health, etc.).
3.19	0.750	16	There is a need for outcome studies of TFC programs in diverse geographic locations.
3.13	0.915	15	To maintain treatment gains, there is a need to extend access to long-term mental health services for TFC alumni.

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3.13	0.915	15	There is a need for concurrent randomized trails and field-based studies on TFC best practice models.
3.13	0.885	16	There is a need to clarify appropriate comparison groups for studies of TFC.
3.07	0.730	14	There are outcomes data available from large TFC providers on outcomes for youth who have completed TFC programs which could inform the understanding of this intervention.
3.07	0.829	14	There is a need for research on specific TFC outcomes across genders.
3.07	0.799	15	There is a need to study the causes of turnover of therapists/staff in TFC.
3.07	0.884	15	There is a need for randomized controlled trials of MTFC with child welfare involved youth.
3.07	0.594	15	There is a need for additional studies of TFC on youth substance use disorder outcomes.
3.06	0.854	16	The field needs research on the connection between short-term and long-term well-being outcomes for TFC youth.
3.00	0.756	15	There is a need to study outcomes for youth in kinship TFC versus non-kinship TFC.

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3.00	1.000	15	There is a need to fund TFC implementation studies.
2.94	0.998	16	There is a need for longitudinal studies with larger samples of racial, ethnic and cultural minority TFC alumni.
2.93	0.799	15	Randomized controlled trials should provide supports to participating agencies to enable them to address random assignment requirements in research.
2.93	0.799	15	There is a need to understand the relative contribution of ancillary services (e.g., wraparound, recovery supports, pro-social skills development, etc.) on outcomes for TFC youth.
2.93	0.917	14	There is a need for follow-up studies of mental health outcomes of former TFC youth by gender.
2.77	1.166	13	There is a need for more research on the applicability of MTFC for Native Americans.
2.75	0.931	16	There is a need for TFC outcome studies comparing public and private TFC providers.
2.64	1.082	14	There is a need for a paper describing the current practices in foster care (regular foster care, Together Facing the Challenge, MTFC, KEEP).

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2.60	1.183	15	There is a need to conduct retrospective research on adults who were in regular foster care versus TFC.
2.50	1.095	16	There is a need for longitudinal studies comparing outcomes of youth from public and private TFC programs.
2.46	1.127	13	There is a need for more randomized controlled trials of MTFC because of limited sample size of existing studies.
2.38	1.044	13	There is a need for more randomized controlled trials of MTFC because of limited outcomes in existing studies.

6. What Do We Know About Organizational Issues in Therapeutic/Treatment Foster Care?

MEAN	Standard Deviation	n	Comment
3.20	0.941	15	Research linking organizational characteristics, TFC treatment model, other implementation factors and outcomes will help the field better understand which TFC models can be implemented in which settings.

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3.17	0.577	12	Implementation science paradigms must inform the evaluation of TFC implementation.
3.14	0.864	14	The field needs to study common elements for training TFC parents.
3.13	0.990	15	The field needs to know more about how usual care TFC agencies are organized/operating.
3.08	0.996	12	The field needs to research solutions to implementation issues related to access to TFC for rural populations.
3.07	0.961	15	There is a need for research on what types of out-of-home care are working in practice.
3.00	0.926	15	The field needs to study the influence of business practices on treatment aspects of TFC models.
3.00	0.845	15	There is a need for research on TFC training/supervision models that are effective.
3.00	0.926	15	There is a need for research on the organizational structure needed to sustain TFC.
2.93	1.033	15	The field needs research on the essential organizational components that influence youth outcomes in TFC.

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2.93	0.917	14	There is a need for more research on the components of clinical supervision in TFC.
2.93	0.917	14	The field needs to study common elements of TFC supervision.
2.86	0.949	14	The field needs studies to determine the optimal number of youth in a TFC home.
2.86	1.027	14	There is a need to and evaluate TFC models based on the existing evidence base and practice.
2.85	0.987	13	The field needs to study how to avoid unintended consequences of providing access to TFC only through a specific agency or funding mechanism.
2.80	1.014	15	The field needs research on barriers to implementing TFC programs.
2.54	1.050	13	Federal funders should prioritize research on the impact of organizational factors on the implementation and outcomes of TFC.

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What Does the Research Tell Us About Services for Children in Therapeutic/Treatment Foster Care With Behavioral Health Issues?
Technical Expert Panel Consensus Process Results Question 1, Round 2

Question 1. What Does the Research Tell Us About Therapeutic/Treatment Foster Care?

N = 14

1. What Do We Know About Therapeutic/Treatment Foster Care?

MEAN	Standard Deviation	n	Comment
1.90	0.316	10	Together Facing the Challenge has shown effectiveness in producing positive outcomes for youth.
1.75	0.452	12	A modified MTFC model was developed because it is difficult to implement MTFC in real settings.
1.75	0.452	12	The dissemination of the MTFC model is quite limited.

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1.64	0.505	11	There is evidence of the efficacy of TFC for youth in the long term.
1.55	0.522	11	Multidimensional Treatment Foster Care (MTFC) is the original Therapeutic/Treatment Foster Care model.
1.50	0.527	10	MTFC has been shown to be a cost-effective TFC model.
1.50	0.522	12	Together Facing the Challenge is a modified version of MTFC.
1.50	0.535	8	Length of stay for child welfare-supervised youth in TFC is considerably longer than for similar youth in regular foster care.
1.33	0.492	12	The research base is too limited to encourage widespread funding and utilization of TFC.
1.23	0.439	13	The field should recognize all foster care as therapeutic.

2. What Do We Know About Identifying Youth Appropriate for Therapeutic/Treatment Foster Care?

MEAN	Standard Deviation	n	Comment

[1]Red shading denotes that the statement reached a consensus of disagreement and, per the consensus process, was eliminated from further consideration.

1.79	0.426	14	Length of stay in TFC will vary by youth's diagnostic profile.
1.75	0.452	12	MTFC, a model focused on changing behavior, is most appropriate for youth with conduct disorder.
1.71	0.469	14	Standardized measures do not capture the nuances of a youth's psychological status.
1.57	0.514	14	Little attention has been given to the psychometric qualities of the measures used in TFC.
1.56	0.527	9	Young children with attachment problems need a longer-term TFC model.
1.36	0.497	14	Standardized measures are available for assessing the appropriate level of care.
1.11	0.333	9	MTFC is not appropriate for youth with anxiety disorders or post-traumatic stress disorder.

3. What Do We Know About the Essential Elements of Therapeutic/Treatment Foster Care?

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MEAN	Standard Deviation	n	Comment
1.92	0.277	13	TFC may be a long-term placement option.
1.89	0.333	9	Therapists working with TFC youth should also be compensated for delivering care management services.
1.67	0.492	12	The field does not know the cost of TFC services.
1.64	0.497	14	Higher education institutions must prepare behavioral health students to work in TFC programs.
1.62	0.506	13	It is essential that TFC models estimate the intended length of stay from the outset.
1.55	0.522	11	Given the state of research knowledge on TFC, it is premature to consider any list of essential elements as the standard for funding a TFC program.
1.45	0.522	11	Assuring that TFC homes have only one TFC youth except in the case of kinship groups is an essential TFC element.
1.43	0.535	7	The essential elements of the Multidimensional Treatment Foster Care (MTFC) model are so costly that few youth are able to benefit from that model.

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1.40	0.516	10	TFC is not a singular methodological therapeutic approach that can be manualized.
1.33	0.500	9	Youth tend to stay in TFC longer than regular foster care.

4. What Do We Know About the Psychosocial Treatment of Youth in Therapeutic/Treatment Foster Care?

MEAN	Standard Deviation	n	
1.64	0.497	14	There is little information about psychosocial treatment of children (age 8 and younger) in TFC.
1.50	0.519	14	The field currently knows very little about mental health outcomes for youth currently served by TFC.
1.50	0.522	12	MTFC is the only TFC program that has demonstrated efficacy over a range of important outcomes.
1.18	0.405	11	The field only knows about the psychosocial treatment of youth in one model of foster care, Multidimensional Treatment Foster Care (MTFC).

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5. What Do We Know About Outcomes for Youth in Therapeutic/Treatment Foster Care?

MEAN	Standard Deviation	n	Comment
1.83	0.389	12	RCTs of MTFC have demonstrated improved child welfare outcomes for TFC youth.
1.80	0.422	10	MTFC is most effective for youth with the most severe behavioral problems.
1.73	0.467	11	RCTs of MTFC have demonstrated improved outcomes for "crossover" youth (youth who are involved in both the child welfare and the juvenile justice systems).
1.71	0.469	14	There is very little research on substance abuse outcomes in TFC.
1.50	0.535	8	TFC shows greater improvements than regular foster care over time for girls.
1.40	0.516	10	TFC produces short-term gains in youth outcomes that are not necessarily sustained long term.
1.38	0.518	8	RCTs of Together Facing the Challenge have demonstrated improved juvenile justice outcomes for TFC youth.

[1]Red shading denotes that the statement reached a consensus of disagreement and, per the consensus process, was eliminated from further consideration.

1.17	0.408	6	Placement disruption is more common for girls.

6. What Do We Know About Organizational Issues in Therapeutic/Treatment Foster Care?

MEAN	Standard Deviation	n	Comment
1.67	0.492	12	TFC parents see themselves as substitute parents.
1.31	0.480	13	The field must avoid licensing a foster home for both regular foster care and TFC to preserve the integrity of the TFC model of treatment.
1.25	0.452	12	TFC parents do not see themselves as treatment professionals.

[1]Red shading denotes that the statement reached a consensus of disagreement and, per the consensus process, was eliminated from further consideration.

What Does the Research Tell Us About Services for Children in Therapeutic/Treatment Foster Care With Behavioral Health Issues?
Technical Expert Panel Consensus Process Results Question 2, Round 2

Question 2. What are Recommendations for the Implementation of What We Know?

N = 14

1. What Do We Know About Therapeutic/Treatment Foster Care?

MEAN	Standard Deviation	n	Comment
1.83	0.389	12	Medicaid reimbursement is based on medical necessity.
1.70	0.483	10	The federal definition of medical necessity does not require a DSM diagnosis.
1.54	0.519	13	Higher education training programs for mental health professionals must include education in TFC.

[1]Red shading denotes that the statement reached a consensus of disagreement and, per the consensus process, was eliminated from further consideration.

2. What Do We Know About Identifying Youth Appropriate for Therapeutic/Treatment Foster Care?

MEAN	Standard Deviation	n	Comment
1.71	0.469	14	The field knows very little about the quality of measures for specific populations.
1.54	0.519	13	The field needs different measures to determine placement for different youth populations.

3. What Do We Know About the Essential Elements of Therapeutic/Treatment Foster Care?

MEAN	Standard Deviation	n	Comment
1.73	0.467	11	The Parent Daily Report should capture what is going well for the TFC youth.

[1]Red shading denotes that the statement reached a consensus of disagreement and, per the consensus process, was eliminated from further consideration.

1.64	0.497	14	The clinical judgment of the treatment team should determine the appropriateness of length of placement in TFC for youth.
1.64	0.505	11	TFC parents should be reimbursed at a rate that enables one parent to be in the home at all times.
1.62	0.506	13	TFC should not mix TFC youth with regular foster care youth within the same home.
1.50	0.527	10	The Parent Daily Report is a validated assessment tool that can monitor youth well-being.
1.50	0.527	10	The Parent Daily Report is a validated assessment tool that can monitor caregiver well-being.
1.46	0.519	13	The child welfare system should have input into the essential elements of TFC and the approval of any exceptions.
1.44	0.527	9	Two levels of TFC are needed to address specific assessed needs of youth.

4. What Do We Know About the Psychosocial Treatment of Youth in Therapeutic/Treatment Foster Care?

MEAN	Standard Deviation	n	Comment

[1]Red shading denotes that the statement reached a consensus of disagreement and, per the consensus process, was eliminated from further consideration.

1.67	0.492	12	TFC therapists need to coordinate care.
1.00	-	10	TFC youth are as likely to go to more intensive placement as a less-intensive placement or to return home following TFC.

5. What Do We Know About Outcomes for Youth in Therapeutic/Treatment Foster Care?

MEAN	Standard Deviation	n	Comment
1.46	0.519	13	TFC programs that operate without an evidence-based, manualized program should not be eligible for Medicaid reimbursement.

6. What Do We Know About Organizational Issues in Therapeutic/Treatment Foster Care?

MEAN	Standard Deviation	n	Comment

[1]Red shading denotes that the statement reached a consensus of disagreement and, per the consensus process, was eliminated from further consideration.

1.75	0.452	12	SAMHSA should assure that evidence-based youth focused mental health interventions are delivered with fidelity to the model.
1.58	0.515	12	The field needs implementation strategies that encourage the development of regional resources to assure MTFC fidelity.
1.54	0.519	13	There is a need to clarify which child serving agency/agencies should be responsible for placing youth in TFC.
1.50	0.522	12	There is a need for a more appropriate title for TFC parents.
1.45	0.522	11	TFC should be re-named to accurately reflect its status as a community-based individualized home-based treatment-focused intervention.
1.30	0.483	10	The field should use Dr. Farmer's 104 point scale as a tool to assess all TFC programs.

[1]Red shading denotes that the statement reached a consensus of disagreement and, per the consensus process, was eliminated from further consideration.

What Does the Research Tell Us About Services for Children in Therapeutic/Treatment Foster Care With Behavioral Health Issues?
Technical Expert Panel Consensus Process Results Question 3, Round 2

Question 3. What are the Recommendations for Advancing the Knowledge Base?

N =14

1. What Do We Know About Therapeutic/Treatment Foster Care?

MEAN	Standard Deviation	n	Comment
1.85	0.376	13	The field needs studies that systematically test varying levels of service use in TFC.
1.77	0.439	13	There is a need to study how outcomes differ for youth who are referred to TFC from different child serving agencies (child welfare, juvenile justice, mental health, etc.).

[1]Red shading denotes that the statement reached a consensus of disagreement and, per the consensus process, was eliminated from further consideration.

1.75	0.452	12	The field needs research on the extent to which residential facilities identify community resources at intake for the purpose of an appropriate transfer of the youth back to the community.
1.69	0.480	13	The field needs to understand prior youth and family service use history and its impact on TFC outcomes.
1.64	0.505	11	Medicaid should not base reimbursement decisions on findings from research on only two TFC models.
1.42	0.515	12	The field needs randomized controlled trials comparing KEEP to TFC programs.

2. What Do We Know About Identifying Youth Appropriate for Therapeutic/Treatment Foster Care?

MEAN	Standard Deviation	n	Comment
1.93	0.267	14	There is a need to continue refining the psychometric properties of assessment tools to improve referral to appropriate therapeutic interventions.
1.86	0.363	14	Multiple scientifically sound, comprehensive measures are needed to assess the outcomes of care.

[1]Red shading denotes that the statement reached a consensus of disagreement and, per the consensus process, was eliminated from further consideration.

1.83	0.389	12	There is a need to establish relative importance of assessment components used in TFC (e.g., symptomatology versus functioning, etc.).
1.82	0.405	11	Person or item fit data can be valuable.
1.79	0.426	14	The field needs a consistent measurement approach to assess the fidelity to TFC models.
1.71	0.469	14	There is a need for studies that identify the relative contributions of the TFC system, parents and youth to outcomes.
1.69	0.480	13	There is a need for research to develop tools to assess the strengths and needs of biological families of youth entering TFC.
1.64	0.497	14	Measures of therapeutic alliance between TFC caregivers and youth need to be developed and tested.
1.64	0.505	11	The field should study whether the models of TFC are appropriate for medically fragile youth.
1.62	0.506	13	There is a need for a sensitive measure to screen for the appropriateness of a TFC for youth.
1.57	0.514	14	Idiosyncratic changes and 'tweaks' to measures compromise the ability to compare information.
1.46	0.519	13	There is a need to better understand the TFC parents' own psychodynamics to ensure a better fit with the youth's needs.

[1]Red shading denotes that the statement reached a consensus of disagreement and, per the consensus process, was eliminated from further consideration.

3. What Do We Know About the Essential Elements of Therapeutic/Treatment Foster Care?

MEAN	Standard Deviation	n	Comment
2.00	-	13	There is a need to clearly define the tested models of TFC in research studies.
1.79	0.426	14	There is a need to develop a research framework to study TFC.
1.69	0.480	13	There is a need for research to determine the needs of young people who remain in TFC until age 26 and how well states address these needs.
1.69	0.480	13	There is a need for comparative cross-national studies of TFC.
1.64	0.497	14	There is a need to study the relative contribution of each essential element (e.g., 24/7 support for TFC parents) on outcomes for TFC youth.
1.62	0.506	13	There is a need to study if every TFC model must employ all essential elements.
1.50	0.519	14	There is a need to mandate studies of the direct and indirect contribution of each essential TFC element to youth outcomes.

[1]Red shading denotes that the statement reached a consensus of disagreement and, per the consensus process, was eliminated from further consideration.

1.46	0.519	13	There is a need to develop a research framework to understand the effectiveness of the two basic TFC models.
1.43	0.514	14	There is a need for further research on the effective individual TFC components before supporting randomized trial studies of bundled models.

4. What Do We Know About the Psychosocial Treatment of Youth in Therapeutic/Treatment Foster Care?

MEAN	Standard Deviation	n	Comment
1.83	0.389	12	Given the limited knowledge on the state of treatment foster care nationally, researchers should explore the possibility of extracting national level data on treatment foster care from the Chapin Hall Multi-State Child Welfare data archive.

[1]Red shading denotes that the statement reached a consensus of disagreement and, per the consensus process, was eliminated from further consideration.

1.77	0.439	13	Given the limited knowledge on the state of treatment foster care nationally, researchers should explore the possibility of extracting national level data on treatment foster care from the National Survey of Child and Adolescent Well-Being.
1.75	0.452	12	The organization of TFC providers, the Foster Family Treatment Association (FFTA) should be involved in evaluating TFC.
1.75	0.452	12	There is a need to study the minimum education and training levels of staff needed to implement TFC programs with fidelity.
1.58	0.515	12	There should be a similar consensus process for in-house researchers and providers of TFC.

5. What Do We Know About Outcomes for Youth in Therapeutic/Treatment Foster Care?

MEAN	Standard Deviation	n	Comment
1.86	0.363	14	There is a need to understand the relative contribution of ancillary services (e.g., wraparound, recovery supports, pro-social skills development, etc.) on outcomes for TFC youth.
1.86	0.363	14	There is a need for follow-up studies of mental health outcomes of former TFC youth by gender.

[1]Red shading denotes that the statement reached a consensus of disagreement and, per the consensus process, was eliminated from further consideration.

1.83	0.389	12	There is a need for more randomized controlled trials of MTFC because of limited sample size of existing studies.
1.79	0.426	14	Randomized controlled trials should provide supports to participating agencies to enable them to address random assignment requirements in research.
1.71	0.469	14	There is a need for a paper describing the current practices in foster care (regular foster care, Together Facing the Challenge, MTFC, KEEP).
1.64	0.497	14	There is a need for longitudinal studies with larger samples of racial, ethnic and cultural minority TFC alumni.
1.64	0.497	14	There is a need for more research on the applicability of MTFC for Native Americans.
1.62	0.506	13	There is a need for more randomized controlled trials of MTFC because of limited outcomes in existing studies.
1.50	0.519	14	There is a need to conduct retrospective research on adults who were in regular foster care versus TFC.
1.43	0.514	14	There is a need for longitudinal studies comparing outcomes of youth from public and private TFC programs.
1.36	0.497	14	There is a need for TFC outcome studies comparing public and private TFC providers.

[1]Red shading denotes that the statement reached a consensus of disagreement and, per the consensus process, was eliminated from further consideration.

6. What Do We Know About Organizational Issues in Therapeutic/Treatment Foster Care?

MEAN	Standard Deviation	n	Comment
2.00	-	14	The field needs research on barriers to implementing TFC programs.
1.79	0.426	14	The field needs research on the essential organizational components that influence youth outcomes in TFC.
1.71	0.469	14	The field needs studies to determine the optimal number of youth in a TFC home.
1.71	0.469	14	There is a need to evaluate TFC models based on the existing evidence base and practice.
1.71	0.469	14	The field needs to study how to avoid unintended consequences of providing access to TFC only through a specific agency or funding mechanism.
1.57	0.514	14	There is a need for more research on the components of clinical supervision in TFC.
1.57	0.514	14	The field needs to study common elements of TFC supervision.

[1]Red shading denotes that the statement reached a consensus of disagreement and, per the consensus process, was eliminated from further consideration.

1.46	0.519	13	Federal funders should prioritize research on the impact of organizational factors on the implementation and outcomes of TFC.

[1]Red shading denotes that the statement reached a consensus of disagreement and, per the consensus process, was eliminated from further consideration.

Appendix E: Assessing the Evidence Base

Assessing the Evidence Base

A Systematic Review of the Evidence for Selected Services for Youth in Therapeutic/Treatment Foster Care With Behavioral Health Issues

Prepared by

Johna Hughes Bruton, M.S.W.

University of North Carolina

Review of Therapeutic/Treatment Foster Care Research

The purpose of this literature review is to assess the research evidence base for therapeutic/treatment foster care (TFC).

Summary of Review

Summary Frameworks were completed for 25 articles: 1 systematic review, 14 randomized trials, 5 exploratory studies using secondary data analysis, 2 studies with pretest/posttest designs, 2 descriptive studies, and 1 qualitative interview study. The systematic review (Turner and Macdonald, 2011) included five randomized controlled trials, one of which is also used in some of the individual manuscripts), all of which are randomized controlled trials. The remaining 24 individual articles refer to 15 studies; 2 studies are used in 2 articles, 2 studies are used in 3 articles, and 1 study is used in 4 articles. Therefore, in total, the 25 articles refer to 19 studies.

The present review includes a total of 19 randomized controlled trials (RCTs), 5 exploratory studies with secondary data analysis, 2 studies with pretest/posttest designs, 2 descriptive studies, and 1 study involving a qualitative interview. The publication dates ranged from 1994 to 2011. This review also included 25 articles included in the text that are not in the matrices to provide additional background and context.

Results

1) The Nature of the Service or Settings That Are Covered in the Research

Therapeutic/Treatment Foster Care (also known as Therapeutic Foster Care, Foster Family-Based Treatment, or Specialized Foster Care) is a service type within the continuum of out-of-home, 24-hour care. Breland-Noble, Farmer, Dubs, Potter, & Burns (2005) assert that it has become the preferred level of care for youth with severe emotional and behavioral disorders who are in need of out-of-home placement. Burns, Hoagwood, and Mrazek (1999) and Chamberlain (2000, 2002) describe TFC as the least restrictive form of residential placement for children and youth with severe emotional and behavioral disorders. It is a community-based, residential intervention that has established national standards of practice, but information on the extent to which these national standards are implemented is limited (Farmer, Burns, Dubs, & Thompson, 2002; Farmer, Burns, & Murray, 2009). TFC is used as a step-down approach from a more restrictive placement and as a preventive measure to avoid a higher level of care (Farmer, Dorsey, & Mustillo, 2004; Farmer, Wagner, Burns, & Richards, 2003).

Treatment Foster Care has evolved out of services for mental health, child welfare, and juvenile justice populations. Although these populations differ, the service systems share a need to improve the emotional and behavioral health and functional outcomes of the children they serve (Dore & Mullin, 2006; Leve, Fisher, & Chamberlain, 2009). TFC is a frequently utilized intervention for these populations; however, little information about the variability in training, implementation, and quality of care exists in the field.

There are two researched models of TFC: Multidimensional Treatment Foster Care developed by Chamberlain and colleagues and Together Facing the Challenge developed by Farmer and colleagues. Some programs implement the TFC approach without subscribing to a particular model. Studies have identified some elements that are essential to the implementation of TFC; for example, foster parents must be trained specifically to work with children with severe emotional and behavioral issues. Typically, only one child is placed in the home at a time (Breland-Noble, Farmer, Dubs, Potter, & Burns, 2005; Burns, Hoagwood, & Mrazek, 1999). Supervisory caseloads are very small to allow for a large amount of interaction with the family. Foster parents who are trained in TFC are paid at a higher rate than foster parents who provide routine care (Burns, Hoagwood, & Mrazek, 1999).

Other factors leading to positive treatment outcomes have been identified as preservice training of the foster parents, a thoughtful match between the child and the trained foster parents, implementation of an individualized and very specific youth behavior management program, and the separation and stratification of the roles of all staff, including the trained foster parents as treatment staff (Davis, et al., 1997; Fisher & Chamberlain, 2000). Receiving care in a family setting allows the child to receive an intensive level of care in the least restrictive environment (Chamberlain & Weinrott, 1990). Few studies, often with small sample sizes, and the fact that much of the research was conducted by model developers have caused some findings to be called into question because of methodological flaws or potential researcher bias.

2) The Range of Populations and Diagnostic Groups Studied

All studies involved children and youth who were in out-of-home placements or were at risk of out-of-home placement. The literature review showed that youth in TFC who had severe emotional and behavioral problems were often violent and assaultive, had severe trauma or abuse and neglect histories, or had juvenile justice involvement. Children in TFC often experienced multiple (often four or more) failed placements prior to referral to TFC, and they typically had higher rates of severe emotional and behavioral problems and trauma histories than children referred for regular foster care (Baker & Curtis, 2006; Burns, Hoagwood, & Mrazek, 1999; Fisher, Kim, & Pears, 2009; Hussey & Guo, 2005; Kerker & Dore, 2006; Smith, Stormshak, Chamberlain, & Bridges Whaley, 2006).

The studies included children aged 2 to 18 years. For studies that reported racial/ethnic and sex characteristics of the participants, the children and youth were largely White and male; a few of the studies approached an equal representation of race/ethnicity and sex. The largest of the RCTs had a sample that included 57 percent of youth who were African-American (Farmer, Burns, & Murray, 2009; Farmer, Burns, Wagner, Murray, & Southerland, 2010). Racial composition of each study was representative of the population in that particular geographic area. In studies utilizing control groups, there were no significant differences in composition between the control and experimental groups. Most of the studies were conducted in the United States. However, three independent studies were conducted in Sweden (Gustle, Hansson, Sundell, Lundh, & Löfholm, 2007; Westermark, Hansson, & Olsson, 2010; Westermark, Hansson, & Vinnerljung, 2008).

3) The Degree to Which There is an Accepted "Model" of Service with Clear Standards

The bulk of the research has focused on Chamberlain's Multidimensional Treatment Foster Care (MTFC) model and its earlier precursors. This model was based on social learning theory and research on antisocial behavior and coercive family processes in the family of origin (Smith, 2004; Sprengelmeyer & Chamberlain, 2001). It was developed for youth involved with the juvenile justice system who mostly presented with externalizing disorders (Dore & Mullin, 2006). It focuses on recruitment and screening of foster parents, intensive preservice parent training, treatment fidelity, positive reinforcement, daily structure, close supervision of youth and foster parents in the program, coordination of services with strong case management interaction, a view of the foster parents as professionals, intensive services, consistency of discipline, a team approach, clinical services, respite care, work with the youth's family when possible, aftercare services, and the promotion of positive peer relationships (Chamberlain, 1998; Jivanjee, 1999; Moore & Chamberlain, 1994; Moore, Sprengelmeyer, & Chamberlain, 2001). MTFC is listed in the Substance Abuse and Mental Health Services Administration National Registry of Evidence-based Programs and Practices (NREPP). It is the most well-known and well-researched model of TFC.

The MTFC model was recently implemented and tested in Sweden, although sample sizes were very small (Westermark, Hansson, & Olsson, 2010; Chamberlain, 2003). The model was adapted for children up to 8 years old. It was called Early Intervention Foster Care (EIFC) or Multidimensional Treatment Foster Care Program for Preschoolers (MTFC-P). Results were similar in effectiveness to those from studies in the United States (Fisher & Kim, 2007).

A second model, Together Facing the Challenge, was developed to provide inservice training for existing TFC programs. It is a hybrid intervention that includes ideas and elements from existing TFC agencies (Chamberlain's model) and other sources to fill in gaps that were seen in practice but not filled by MTFC. In particular, Together Facing the Challenge works to fill gaps in transition to adulthood skills and treatment of previous trauma (Farmer, Burns, & Murray, 2009; Murray, Southerland, Farmer, & Ballentine, 2010). Together Facing the Challenge is not listed on the NREPP, but it is listed as supported by research evidence on the California Evidence-Based Clearinghouse for Child Welfare.

4) Assessment of the Overall Level of Evidence Found for the Service

The overall level of evidence found for the service is well developed based on the recent emergence of this intervention. Multiple RCTs with a range of sample sizes and descriptive studies have yielded evidence showing positive effects of TFC. However, the body of research is still relatively small, and many of the existing studies are limited in rigor, power, and generalizability.

Despite its limited size, this research base has strengths. This review looked at 19 RCTs ranging in sample sizes from 20 to 247 and at 10 observational and quasi-experimental studies ranging in sample sizes from 88 to 2168. The research has been directed toward multiple high-risk populations—youth with mental health and substance use concerns, youth in child welfare systems, and youth involved in juvenile justice. As mentioned above, the largest of the RCTs reviewed included a high rate of African American youth and four of the other studies had largely diverse samples ranging from 41 to 88 percent minorities. Five of the individual studies and one study in the Turner and Macdonald (2011) review were conducted

by investigators who were not affiliated with the key model developers (Baker & Curtis, 2006; Gustle, Hansson, Sundell, Lundh, & Löfholm, 2007; Hussey & Guo, 2005; Turner & Macdonald, 2011; Westermark, Hansson, & Olsson, 2010; Westermark, Hansson, & Vinnerljung, 2008). Several of the more recent studies have been conducted outside of the United States by researchers who are not model developers, and they found similarly positive effects (Gustle, Hansson, Sundell, Lundh, & Löfholm, 2007; Westermark, Hansson, & Olsson, 2010; Westermark, Hansson, & Vinnerljung, 2008).

5) Effectiveness of Treatment Foster Care

Understanding that the research base is small, results from the studies that we do have reveal positive outcomes for children and youth including reducing substance use, increasing the likelihood of achieving permanency, reducing caregiver stress, strengthening attachment to caregivers, reducing delinquency and antisocial behavior, reducing violent behaviors and criminal activity, reducing adolescent pregnancy, reducing the number of placements, decreasing the chance of incarceration and number of days spent in locked settings, and improving school performance (Chamberlain & Reid, 1994; Eddy, Bridges Whaley, & Chamberlain, 2004; Eddy & Chamberlain, 2000; Fisher, Chamberlain, & Leve, 2009; Fisher, Kim, & Pears, 2009; Kerr, Leve & Chamberlain, 2009; Knorth, Harder, Zandberg, & Kendrick, 2008; Leve & Chamberlain, 2006; Leve, Chamberlain, & Reid, 2005; Smith, Chamberlain, & Eddy, 2010).

The majority of studies with significant findings in this review suggest improved outcomes for children and youth in TFC over youth in regular foster care, group care, or treatment as usual (e.g., Chamberlain, Leve, & DeGarmo, 2007; Chamberlain & Moore, 1998). Results indicate that intensive and individualized supports for youth are effective in producing positive outcomes. Youth in TFC show significant improvements that are sustained, at least for a short time; some studies showed initial positive results at 6 months that were not necessarily sustained at the same level of significance at later time points (Burns, Hoagwood, & Mrazek, 1999; Farmer, Burns, Wagner, Murray, & Southerland, 2010).

Breland-Noble, Farmer, Dubs, Potter, & Burns (2005) found that youth in TFC were significantly less likely than youth in group homes to work with a therapist, visit an emergency room, serve time in detention, have a probation officer, or attend a special school. Breland-Noble, Elbogen, Farmer, Dubs, Wagner, & Burns (2004) also found that youth in TFC were less likely to receive psychotropic medications (67 percent in TFC and 77 percent in group homes), and Hussey and Guo (2005) found that 51 percent of youth in TFC had a history of pharmacological treatment. Youth in an early study of Together Facing the Challenge showed significant improvement over the control group (63 percent versus 40 percent, respectively) and at significantly faster rates of change (Farmer, Burns, & Murray, 2009; Farmer, Burns, Wagner, Murray, & Southerland, 2010).

In studies of Early Intervention Foster Care or the Multidimensional Treatment Foster Care Program for Preschoolers, the latter has been shown to lead to greater likelihood of successful permanent placement, increased secure behaviors, and decreased avoidant behaviors (Fisher & Kim, 2007; Fisher, Kim, & Pears, 2009). Farmer et al. (2003) found that the stability of the TFC placement was an important factor in improving youth functioning. Sixty-four percent of youth in that study remained in TFC for the entire year of the study period. Gustle, Hansson, Sundell, Lundh, & Löfholm (2007) found that youth in MTFC had higher symptom loads than youth enrolled in Functional Family Therapy, but they had similar profiles to youth in MST.

Southerland and colleagues (2009) and Farmer and colleagues (2009) examined the importance of (1) the therapeutic relationship between treatment foster parents and youth in TFC programs and (2) the relationship between the foster parents and the supervisor or agency. The authors found that the relationships were positively and significantly associated with better child functioning. However, according to Turner & Macdonald (2011), "while the results of individual studies generally indicate that TFC is a promising intervention for children and youth experiencing mental health problems, behavioral problems, or problems of delinquency, the evidence base is not robust and more research is needed due to the limited number of studies in this area" (p. 501).

6) Recommendations for Future Research

The research conducted to date is promising, but there is a need for additional work in this area. Few studies, often with small sample sizes, and the fact that much of the research was conducted by model developers have caused some findings to be called into question. More studies should be conducted in a variety of settings, with a variety of populations and larger sample sizes. In addition, the bulk of the research has been conducted by research teams that include model developers, who may introduce potential bias. The results would gain strength if there were more independent trials that could replicate the positive or promising outcomes. Also, while recognizing that random assignment is difficult in a foster care setting, there is a great need for more RCTs (Redding, Fried, & Britner, 2000). Improving the experimental rigor will increase the power of the results.

Great variability exists among TFC agencies and TFC homes, making generalizability difficult. Future studies should focus on randomized controlled studies in multiple models and environments to improve the generalizability of the results (Breland-Noble, Farmer, Dubs, Potter, & Burns, 2005; Chamberlain, 1996; Curtis, Alexander, & Lunghofer, 2001; Dorsey, Farmer, Barth, Greene, Reid, & Landsverk, 2008).

Even though much of the existing research indicates positive outcomes, little is known about the sustainability of the outcomes over time. Future longitudinal research will add information about the long-term effects of the treatment modality, even after the youth is out of this level of care (Curtis, Alexander, & Lunghofer, 2001).

As mentioned in the description of the study populations, much of this research has been conducted with White, nonminority populations. Future studies should make attempts to apply the model in diverse settings with African American, Asian/Pacific Islander, Latino, Hispanic, Native American, and mixed racial/ethnic populations to determine whether there is generalizability to nonmajority cultural groups. Much of the research has also been limited to select geographic locations in the United States.

There is a need for more information about how service use history prior to TFC placement and, most critically, postdischarge service use trajectories (1) post-discharge relate to child and treatment agency characteristics and (2) predict return to a family versus placement in a more restrictive setting.

Another future research focus needs to address how variations in the quality of TFC program implementation influences long-term outcomes for youth. In addition, it is important to understand the impact of the variation in training approaches and cost of training. This is a topic that has not been addressed in published literature, although the existing models promote combining formal didactic and

experiential approaches followed by long-term consultation. Other areas without any prior research are related to variations in state and Medicaid requirements for TFC eligibility, monitoring of performance standards, and documentation of outcomes.

A final issue for which there is no published research relates to the cost and financing approaches for an intervention provided under different reimbursement mechanisms (e.g., child welfare, Medicaid, state funds) and across private and public agencies. The potential for coverage of TFC under the Affordable Care Act would also benefit from consideration.

The critical importance of this population of children and youth and the ramifications of foster care on their well-being and their futures as they go forward in society must be emphasized. It is incumbent upon the federal system to employ resources that will significantly increase the research focus in this area. Future research will continue to identify and strengthen the evidence base for programs that lead to effective and sustainable outcomes for these youth.

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Acronym Glossary

ADHD	Attention deficit hyperactivity disorder
API	Academic Performance Index
BERS	Behavioral and Emotional Rating Scale
BPRS-C	Brief Psychiatric Rating Scale for Children
BSI	Brief Symptom Inventory
CASA	Child and Adolescent Strengths Assessment
CBCL	Child Behavior Checklist
CFC	Child and Family Characteristics Form
CGAS	Children's Global Assessment Scale
DISC	Diagnostic Interview Scale for Children
DSMB	Devereux Scales of Mental Disorders
FFT	Functional Family Therapy
GC	Group care
GH	Group home
IQ	Intelligence quotient
MST	Multisystemic Therapy
MTFC	Multidimensional Treatment Foster Care
MTFC-P	Multidimensional Treatment Foster Care for Preschoolers
NIMH	National Institutes of Mental Health
NREPP	National Registry of Evidence-based Programs and Practices
ODD	Oppositional defiant disorder

PAD	Parent Attachment Diary
PDR	Parent Daily Report
PTSD	Posttraumatic stress disorder
RCT	Randomized controlled trial
RFC	Routine foster care or regular foster care
RTC	Residential treatment center
SAMHSA	Substance Abuse and Mental Health Services Administration
SCL-90	Symptom Checklist 90
SDQ	Strengths and Difficulties Questionnaire
SED	Serious emotional disturbance
TAU	Treatment as usual
TFC	Treatment foster care, therapeutic foster care
TRQ	Trusting Relationship Questionnaire
Willie M	Program established following an NC class action lawsuit in 1981. It was started to ensure that youth with mental health problems and aggressive behaviors could receive appropriate treatment. Youth in the Willie M class were "seriously emotionally, neurologically, or mentally handicapped youth who are violent or assaultive." (Weisz, Walter, Weiss, Fernandez, & Mikow, 1990)
YSR	Youth Self Report

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Framework for Data on Individual Articles

Service: Treatment Foster Care **Name of Reviewer**: Johna Hughes Bruton

Note: Acronyms used in this matrix are defined in the Glossary contained in Appendix E: AEB Narrative.

Citation for Article	Service as Described in Article; Purpose of Study	Population /N/and Comparison Group(s)	Provider Qualifications/ and Fidelity	Outcome(s) Measured/ and Instruments Used	Evidence of Effectiveness	Level of Evidence	Other Comments
Baker, A. J., & Curtis, P. (2006). Prior placements of youth admitted to therapeutic foster care and residential treatment centers: The Odyssey Project population. *Youth and Adolescent Social Work Journal, 23*, 38-60.	Purpose was to compare 2 samples of youth in the child welfare system—those in RTCs and those in TFC—based on 3 questions: Where were youth living prior to the current placement, had they been treated in other systems of care, and how many prior placements did they have? Was the study conducted by a team that is independent of the service developer? No	Study Population: Age: RTC 14.4 years, TFC 12.4 years Sex: RTC 72.3% male, TFC 53.7% male Ethnicity: RTC 29.6% White, TFC 62.1% White N=2168 (924 in TFC, 1244 in RTC) Groups were significantly different on age (t=14.22, p<.001); sex, chi-square [(1, N=2168)=80.58, p<.001]; ethnicity,	No provider qualifications or fidelity were discussed in the model.	Outcomes Measured: Demographic data Prior Placement data Instruments Used: CFC	Demographic data are described in the study population and comparison group data. Most recent living environment: **home** (21.9% for RTC; 25.1% for TFC), **foster home** (4.5% for RTC; 16.6 for TFC), **TFC** (0.9% for RTC; 18.4% for TFC), **GH** (5.7% for RTC; 5.7% for TFC), **RTC** (18.8% for RTC; 11.5% for TFC), **psychiatric setting** (19.8% for RTC; 8.7% for TFC), **juvenile justice setting** (13.6% for RTC; 4.8% for TFC). For RTC, 41.6% were taking a step up, 21% were making a lateral move, and 37.4% were stepping down. For TFC, 59.4% were taking a step up, 15.3% were	Secondary data analysis	

Citation for Article	Service as Described in Article; Purpose of Study	Population /N/and Comparison Group(s)	Provider Qualifications/ and Fidelity	Outcome(s) Measured/ and Instruments Used	Evidence of Effectiveness	Level of Evidence	Other Comments
	Is the service listed in NREPP? No	chi-square [1, N+2153)=230.67, p<.001]; permanency goal of return to family (65% for RTC and 57.4% for TFC); legal status of abuse or neglect (36.8% for RTC and 17.4% for TFC).			making a lateral move, and 25.3% were stepping down. This is statistically significant, chi-square (1, N=2012)=63.78, p<.001) with an effect size of .36. RTC: 37.6% were admitted from the mental health or juvenile justice systems compared to only 13.8% of the TFC sample. This is statistically significant, chi-square (1, N=1990)=142.03, p<.001, and the effect size is moderate at .55. On average, the whole sample lived in almost 5 places prior to admission.		

Citation for Article	Service as Described in Article; Purpose of Study	Population /N/and Comparison Group(s)	Provider Qualifications/ and Fidelity	Outcome(s) Measured/ and Instruments Used	Evidence of Effectiveness	Level of Evidence	Other Comments
Breland-Noble, A. M., Farmer, E. M. Z., Dubs, M. S., Potter, E., & Burns, B. J. (2005). Mental health and other service use by youth in therapeutic foster care and group homes. *Journal of Child and Family Studies, 14*, 167-180.	The purpose of the study is to articulate patterns of mental health and other service use among youth in TFC and group homes Was the study conducted by a team that is independent of the service developer? Yes Is the service listed in NREPP? No	Data drawn from NIMH-funded study of TFC and group home care. Study Population: Average age 14.1 years 42% African American All members of sample were Willie M class members, which includes "seriously emotionally, neurologically, or mentally handicapped youth who are violent or assaultive"	No provider qualifications or fidelity were discussed in the model.	Outcomes Measured: Service Use Functioning and Clinical Status (in this paper these were only included in the study sample description) Instruments Used: CASA BERS CBCL PDR Note: Because of high correlation among BERS,	There were 5.37 types of services used in study period (TFC=5.5, range=0–13; GH=5.2, range=1–10). Youths in TFC were more likely to use respite care (p<.0001); be in in-home counseling/crisis services (p<.03); see a medical doctor; participate in after school program (p<.001); have a mentor (p<.011); and receive DSS services (p<.04).Youth in GH were more likely to serve time in detention (p<.04); have a probation officer (p<.001); work with a therapist (p<.003); visit an ER; and attend a special school (p<.002). Data suggest that the	Pretest and posttest interviews using standardized instruments. This study includes data from the parent baseline interviews only.	

Citation for Article	Service as Described in Article; Purpose of Study	Population /N/and Comparison Group(s)	Provider Qualifications/ and Fidelity	Outcome(s) Measured/ and Instruments Used	Evidence of Effectiveness	Level of Evidence	Other Comments
		N=304 (184 in TFC, 120 in group homes) All youth were receiving residential services through mental health referrals in North Carolina. Youth in both groups were similar on nearly all factors. Group homes served fewer girls than TFC (74% compared to 87%) and fewer youth in state custody (45% in GH and 58.7% in TFC). Youth in the 2 groups were similar in clinical and functional		CBCL, and PDR, only one could be used in multivariate modeling. CBCL is used for current analyses. The target time window is 4 months preceding the interview.	amount of service does not vary by setting. Youth in GH were 2–3 times as likely to receive services in special schools, juvenile justice, or as outpatients. Youth in GH were half as likely to receive in-home counseling or mentor services.		

Citation for Article	Service as Described in Article; Purpose of Study	Population /N/and Comparison Group(s)	Provider Qualifications/ and Fidelity	Outcome(s) Measured/ and Instruments Used	Evidence of Effectiveness	Level of Evidence	Other Comments
		Youth in both groups were similar on nearly all factors. Group homes served fewer girls than TFC (74% compared to 87%) and fewer youth in state custody (45% in GH and 58.7% in TFC). Youth in the 2 groups were similar in clinical and functional status.					

Citation for Article	Service as Described in Article; Purpose of Study	Population /N/and Comparison Group(s)	Provider Qualifications/ and Fidelity	Outcome(s) Measured/ and Instruments Used	Evidence of Effectiveness	Level of Evidence	Other Comments
Breland-Noble, A. M., Elbogen, E. B., Farmer, E. M. Z., Dubs, M. S., Wagner, H. R., & Burns, B. J. (2004). Use of psychotropic medications by youth in therapeutic foster care and group homes. *Psychiatric Services, 55*, 706-708.	The article describes rates of use and factors associated with pediatric psychopharmacology in children and youth in TFC and group homes. Purpose was to explore whether rates of psychopharmacology and polypharmacology were similar in TFC and group homes and to examine the role of setting type, combined with demographic and clinical factors, for use of medication.	Study Population: Average age 14.1 years 42% African American All youth were Willie M class members, so they had SED and violent and assaultive behaviors N=304 (184 in TFC, 120 in group homes) All youth were receiving residential services through mental health referrals in	No provider qualifications or fidelity were discussed in the model.	Outcomes Measured: Child behaviors Prescribed medications, dosage, and current use Psychiatric symptoms Instruments Used: CBCL CASA BPRS-C	Medications: During 4 focal months, 67% in TFC and 77% in GH took psychotropic meds. Youth in GH significantly more likely to take meds (OR=1.8, CI=1.03 to 3.2, p<.05). Use of meds was greater in youth who were under 13 years (OR=.14, CI=.06 to .41, p<.01), were White (OR=1.89, CI=1.04 to 3.06, p<.05), or had a score in clinical range on externalizing CBCL subscale (OR=2.41, CI=1.12 to 5.2, p=.02) or on both externalizing and internalizing subscales (OR=2.66, CI=1.33 to .36, p<.001). Polypharmacy was	Pretest and posttest interviews using standardized instruments. This study includes data from the parent baseline interviews only.	Findings point to the importance of future research on the effectiveness of current practices in pediatric psychopharmacology and polypsychopharmacy. They also suggest a necessity of including a full range of interventions in effective treatment of childhood disorders.

Citation for Article	Service as Described in Article; Purpose of Study	Population /N/and Comparison Group(s)	Provider Qualifications/ and Fidelity	Outcome(s) Measured/ and Instruments Used	Evidence of Effectiveness	Level of Evidence	Other Comments
	Was the study conducted by a team that is independent of the service developer? Yes Is the service listed in NREPP? No	North Carolina. Youth in both groups were similar on nearly all factors. Group homes served fewer girls than TFC (74% compared to 87%).			related to being younger (OR=.28, CI=.1 to .59, p=.002) and having clinical externalizing and internalizing scores on CBCL (OR=2.66, CI=1.11 to 5.85, p=.02). Youth in TFC were significantly less likely to be on antipsychotics ($\chi 2$=3.96, df=10, p=.05) or mood stabilizers ($\chi 2$=8.65, df=10, p=.003).		

Citation for Article	Service as Described in Article; Purpose of Study	Population /N/and Comparison Group(s)	Provider Qualifications/ and Fidelity	Outcome(s) Measured/ and Instruments Used	Evidence of Effectiveness	Level of Evidence	Other Comments
Chamberlain, P., Leve, L. D., & DeGarmo, D. S. (2007). Multidimensional treatment foster care for girls in the juvenile justice system: 2-year follow-up of a randomized clinical trial. *Journal of Consulting and Clinical Psychology, 75,* 187-193.	Youth were placed in highly trained and supervised foster homes, which included standard components: daily phone contact with foster parents to monitor fidelity and track progress; weekly foster parent group training, supervision, and support sessions; individual therapy for the youth, family therapy for family of origin, monitoring of school functioning, on-call program staff, and psychiatric consultation. Also included gender-related components (TFC parents and	Study Population: Girls aged 15–19 years at the time of the follow-up study (average age 17.3) 74% Caucasian, 2% African American, 9% Hispanic, 12% Native American, 1% Asian, 2% other or mixed heritage N=81 (37 in TFC, 44 in GC). No group differences at baseline.	No provider qualifications or fidelity were discussed in the model.	Outcomes Measured: Multiple-method delinquency construct computed from number of criminal referrals, number of days in locked settings, and self-reported delinquency. Instruments Used: State police records and circuit court data Girls' report of total days spent in detention, correctional facilities, jail, or prison	After controlling for age, MTFC was associated with greater reductions in delinquency than GC (β=-.36, $p<.01$). Older girls had lower levels of delinquency at 2 years (β=-.36, $p<.01$). Girls in MTFC spent over 100 fewer days in locked settings in the 2-year follow-up period than those in GC.	Randomized controlled trial (2-year follow-up to original RCT)	Limitations are small sample size, majority of sample was White, and findings need to be replicated.

Citation for Article	Service as Described in Article; Purpose of Study	Population /N/and Comparison Group(s)	Provider Qualifications/ and Fidelity	Outcome(s) Measured/ and Instruments Used	Evidence of Effectiveness	Level of Evidence	Other Comments
	therapists were training to teach and reinforce girls to avoid social-relational aggression and to develop alternative strategies for dealing with rejection and stress. Purpose of the study was to conduct a 2-year follow up (original study Leve & Chamberlain, 2005; included in Turner & MacDonald, 2010 review) to determine maintenance of effects.			Elliott General Delinquency Scale			

Citation for Article	Service as Described in Article; Purpose of Study	Population /N/and Comparison Group(s)	Provider Qualifications/ and Fidelity	Outcome(s) Measured/ and Instruments Used	Evidence of Effectiveness	Level of Evidence	Other Comments
	Was the study conducted by a team that is independent of the service developer? No Is the service listed in NREPP? Yes						

Citation for Article	Service as Described in Article; Purpose of Study	Population /N/and Comparison Group(s)	Provider Qualifications/ and Fidelity	Outcome(s) Measured/ and Instruments Used	Evidence of Effectiveness	Level of Evidence	Other Comments
Chamberlain, P. & Moore, K. J. (1998). A clinical model of parenting juvenile offenders: A comparison of group versus family care. *Clinical Child Psychology and Psychiatry, 3*, 375-386.	Purpose was to compare the outcomes for boys who participated in TFC and GHs, evaluate key treatment process variables thought to predict later outcomes, the extent to which the boy was well supervised, the level of consistent discipline he received, the extent to which he associated with delinquent peers, and the quality of the boy's relationship with his adult caretaker. Was the study conducted by a team that is	Study Population: Boys Aged 12–17 years; average age 14.4 years Referred from local juvenile court Average of 13 previous arrests and 4.6 felonies at the time of referral Had spent average of 76 days during the previous year in lockup and had been arrested for the first time at the average age of 12.3 years Average of 1.3 previous out-of-home placements; 75% had history of	No provider qualifications or fidelity were discussed in the model.	Outcomes Measured: Subsequent arrests, program completion rates, rates of running away from placement, and number of days incarcerated in follow-up. Instruments Used: PDR	Boys in TFC had significantly fewer arrests at 1 year; Boys in GH had 2 fewer arrests than in the year before treatment, whereas boys in TFC had 6 fewer arrests after than before treatment. A 2x2 ANOVA was significant at the p=.003 level. Fewer boys in TFC ran away than boys in GH (31 vs 58% respectively, $\chi 2$=.02). More boys in TFC completed the program (73 vs 36%, $\chi 2$ p<.001). Boys in TFC spent 60% fewer days in lock up (p<.001). Boys in TFC spent nearly twice the number of days living with their	Randomized controlled trial	

Citation for Article	Service as Described in Article; Purpose of Study	Population /N/and Comparison Group(s)	Provider Qualifications/ and Fidelity	Outcome(s) Measured/ and Instruments Used	Evidence of Effectiveness	Level of Evidence	Other Comments
	independent of the service developer? No Is the service listed in NREPP? Yes	running away. N=79 (39 in TFC, 40 in group homes) No significant differences in groups			parents or other relatives during the year after enrollment.		

Citation for Article	Service as Described in Article; Purpose of Study	Population /N/and Comparison Group(s)	Provider Qualifications/ and Fidelity	Outcome(s) Measured/ and Instruments Used	Evidence of Effectiveness	Level of Evidence	Other Comments
Chamberlain, P. & Reid, J. (1994). Differences in risk factors and adjustment for male and female delinquents in treatment foster care. *Journal of Child and Family Studies, 3,* 23-29.	The Monitor program uses a TFC model and is a community-based alternative to institutionalization for chronic juvenile offenders. Each youth has an individualized daily point program implemented by parents who have daily supervision. There is weekly therapy (individual and family), regular visits to family of origin, and intensive supervision. Purpose of the study was to examine differences by sex	Study Population: Youth referred to the Monitor program 58% Male Aged 12–18 years N=88 There was no comparison group.	No provider qualifications or fidelity were discussed in the model.	Outcomes Measured: Problem behaviors Number of offenses Risk factors Instruments Used: PDR Official arrest data Presence or absence of 18 risk factors	At baseline, the rate aggression is lower for females than males (F=4.51, df=1.47, p=.04). At 6 months, males had shown slight improvement, whereas females' scores had increased to the level of the males in month 1. Sex x time interaction (F=8.7, df=1.47, p=.005). No significant difference found for program completion rates. Preprogram: females committed more status offenses and males committed more property offenses. No differences in person-to-person crimes, and males were more likely to have traffic offenses.	Exploratory Study—secondary data analysis	Limitations are small sample size, majority of sample was White, and findings need to be replicated.

Citation for Article	Service as Described in Article; Purpose of Study	Population /N/and Comparison Group(s)	Provider Qualifications/ and Fidelity	Outcome(s) Measured/ and Instruments Used	Evidence of Effectiveness	Level of Evidence	Other Comments
	in risk factors, patterns of previous delinquency, and response to treatment for a set of youth placed in TFC. Was the study conducted by a team that is independent of the service developer? No Is the service listed in NREPP? Yes				Postprogram: Females continued to show higher rates of status offenses ($p<.05$). No other differences in other categories. Status offenses: Both sexes showed significant reduction in number of arrests ($F=23.05$, $df=78.1$, $p=.00$). Property offenses: Both sexes showed significant reduction in number of arrests ($F=34.47$, $df=78.1$, $p=.00$). Boys showed greater improvement. Both sexes showed significant reduction in number of arrests ($F=3.65$, $df=78.1$, $p=.06$). Person-to-person crimes: Reduction for both sexes ($F=12.69$,		

Citation for Article	Service as Described in Article; Purpose of Study	Population /N/and Comparison Group(s)	Provider Qualifications/ and Fidelity	Outcome(s) Measured/ and Instruments Used	Evidence of Effectiveness	Level of Evidence	Other Comments
					df=73.1, p=.001). Regardless of sex, there was a drop in all types of crime from pre to post treatment with 1 exception: 14-year-old girls increased rate of status offenses. Sexual abuse is a risk factor: those who were abused were more at risk and less responsive to treatment. No differences between abused and nonabused youth in pretreatment offense rates, but the abused youth had significantly more total offenses in the follow-up year than nonabused youth (means 2.85 vs 1.53) and significantly more status offenses (means 1.15 vs .27).		

Citation for Article	Service as Described in Article; Purpose of Study	Population /N/and Comparison Group(s)	Provider Qualifications/ and Fidelity	Outcome(s) Measured/ and Instruments Used	Evidence of Effectiveness	Level of Evidence	Other Comments
Eddy, J.M., & Chamberlain, P. (2000). Family management and deviant peer association as mediators of the impact of treatment condition on youth antisocial behavior. *Journal of Consulting and Clinical Psychology, 68,* 857-863.	Youth were placed in highly trained and supervised foster homes, which included standard components: daily phone contact with foster parents to monitor fidelity and track progress; weekly foster parent group training, supervision, and support sessions, individual therapy for the youth, family therapy for family of origin, monitoring of school functioning, on-call program staff, and psychiatric consultation.	Study Population: Original sample was N=79 (37 in MTFC, 42 in GC). 85% White, 6% African American, 6% Hispanic, 3% American Indian Average age 14.9 years Boys Average age at first criminal referral=12.6 years Average number of criminal referrals at baseline=13.5 Sample for current analysis:	Fidelity to the model was monitored in the MTFC condition with the PDR, taped therapy sessions, and daily supervision. There were no fidelity checks in the GC condition.	Outcomes Measured: Family management and deviant peer association Antisocial behavior Instruments Used: PDR Official records of criminal activity Self-reports of criminal activity	At baseline assessment, the group means for antisocial behavior in the 6 months prior did not differ. At the midpoint and follow-up, the groups differed significantly for each of the variables in the analysis. The MTFC means in all cases were in the more favorable direction (lower antisocial behavior scores, more positive family management scores, lower deviant peer association scores). Group assignment was significantly associated with mediators during the midst of placement (β=.89, $p<.01$); group assignment was significantly associated with subsequent antisocial behavior (β=-.51, $p<.05$); mediators	Randomized controlled trial	Limitations are small sample size, majority of sample was White, and findings need to be replicated.

Citation for Article	Service as Described in Article; Purpose of Study	Population /N/and Comparison Group(s)	Provider Qualifications/ and Fidelity	Outcome(s) Measured/ and Instruments Used	Evidence of Effectiveness	Level of Evidence	Other Comments
	Purpose of the study was to examine the influence of family management skills, and deviant peer association on youth' antisocial behavior. Was the study conducted by a team that is independent of the service developer? No Is the service listed in NREPP? Yes	N=53 (23 in MTFC, 30 in GC) Final sample had fewer criminal referrals prior to baseline and spent fewer days in detention in the year prior to baseline. No group differences at baseline.			were significantly associated with antisocial behavior (β=-.71, p<.01); impact of group on antisocial behavior was not significant.		

Citation for Article	Service as Described in Article; Purpose of Study	Population /N/and Comparison Group(s)	Provider Qualifications/ and Fidelity	Outcome(s) Measured/ and Instruments Used	Evidence of Effectiveness	Level of Evidence	Other Comments
Eddy, M. J., Bridges Whaley, R., & Chamberlain, P. (2004). The prevention of violent behavior by chronic and serious male juvenile offenders: A 2-year follow-up of a randomized clinical trial. *Journal of Family Psychology, 12,* 2-8.	Youth were placed in highly trained and supervised foster homes, which included standard components: daily phone contact with foster parents to monitor fidelity and track progress; weekly foster parent group training, supervision, and support sessions; individual therapy for the youth, family therapy for family of origin, monitoring of school functioning, on-call program staff, and psychiatric consultation.	Study Population: Original sample was N=79 (37 in MTFC, 42 in GC). 85% White, 6% African American, 6% Hispanic, 3% American Indian Average age 14.9 years Boys Average age at first criminal referral=12.6 years Average number of criminal referrals at baseline=13.5 No group differences at	Fidelity to the model was monitored in the MTFC condition with the PDR, taped therapy sessions, and daily supervision. There were no fidelity checks in the GC condition.	Outcomes Measured: Violent behavior Antisocial behavior Instruments Used: PDR Official records of criminal activity Self-reports of criminal activity using Elliott Behavior Checklist	Group effect for violent behaviors was significant (b=-.81, p<.05); youth in MTFC experienced significantly fewer criminal referrals for violence in the 2 years after baseline than youth in GC, after controlling for prebaseline factors. Youth with higher number of criminal referrals prior to baseline were significantly more likely to receive a criminal referral for a violent act after baseline (b=.05, p<.01). 21% of youth in MTFC had at least 1 criminal referral for a violent offense vs 38% of youth in GC $\chi 2(2, N=79)=5.2$, p<.05.	Randomized controlled trial	Limitations are small sample size, majority of sample was White, and findings need to be replicated.

Citation for Article	Service as Described in Article; Purpose of Study	Population /N/and Comparison Group(s)	Provider Qualifications/ and Fidelity	Outcome(s) Measured/ and Instruments Used	Evidence of Effectiveness	Level of Evidence	Other Comments
	Purpose of the study was to examine ability of MTFC to prevent subsequent violent offending, relative to services-as-usual group home care. Was the study conducted by a team that is independent of the service developer? No Is the service listed in NREPP? Yes	baseline			5% of youth in MTFC had 2 or more referrals vs 24% for youth in GC. The annual number of seriously violent incidents perpetrated by males in MTFC declined in the 2 years after baseline to 1.5/youth (whereas the rate for males in GC (8.7/youth) remained 4–9 times higher.		

Citation for Article	Service as Described in Article; Purpose of Study	Population /N/and Comparison Group(s)	Provider Qualifications/ and Fidelity	Outcome(s) Measured/ and Instruments Used	Evidence of Effectiveness	Level of Evidence	Other Comments
Farmer, E. M. Z., Burns, B. J., & Murray, M. (2009). Enhancing treatment foster care: An approach to improving usual-care practice. *Emotional and Behavioral Disorders in Youth, 9,* 79-84.	Together Facing the Challenge was designed to provide additional training and consultation for key providers of TFC. It includes meeting with participating agencies, training supervisors, training treatment parents, following up with supervisors, and training clinicians. It also addressed two major issues not focal in the Chamberlain model: treatment of prior trauma and preparation for adulthood The **observational**	NOTE: This article included 2 studies: An observational study and an RCT. **Observational Study Group:** Average age, 14.1 years 74% male Approximately 50% were minorities (mostly African American) Youth were Willie M class members, so they had SED and violent or assaultive behaviors Clinical range for total score on	Providers in the RCT had to be trained according to the Together Facing the Challenge train-the-trainer model. The observational study suggests that usual care TFC was not done with fidelity to TFC.	**Observational study** Outcomes Measured: Conformity to FFTA standards and conformity to MTFC model Instrument Used: Interviews with youth, treatment parents, and agency directors **RCT study** Outcomes Measured: Behavior problems	**Observational study**: TFC in usual care settings showed substantial variation in its conformity to the FFTA standards of care. Larger programs had higher conformity and for-profit agencies had lower conformity. Assessment of conformity to FFTA standards and to the MTFC model showed usual care TFC to be a watered-down version of the ideal. 29% had weekly (or more) contact between treatment parents and agency supervisors (daily contact is a tenant of MTFC) 18% of homes had some version of a point system (MTFC uses a	Initial observation study followed by randomized controlled trial	

Citation for Article	Service as Described in Article; Purpose of Study	Population /N/and Comparison Group(s)	Provider Qualifications/ and Fidelity	Outcome(s) Measured/ and Instruments Used	Evidence of Effectiveness	Level of Evidence	Other Comments
	study was designed to determine whether TFC programs resembled the MTFC model, how TFC was being used, and whether TFC usual care produced outcomes similar to MTFC. The **RCT** was designed to test the effectiveness of a hybrid intervention Together Facing the Challenge. Was the study conducted by a team that is independent of the service developer? No	CBCL Mean IQ=82 29% had history of legal involvement 59% were in state custody N=183 There was no comparison group in this observational study. **RCT study:** Average age=13 57% African		Psychiatric symptoms Child's strengths Instruments Used: PDR SDQ BERS	strong social learning approach) Better outcomes for youth were related to: closer supervision of youth, increased contact between treatment parents and agency supervisors, increased training for treatment parents, and better relationship between treatment parents and youth. **RCT study**: 63% of youth in intervention group improved on the SDQ measure of symptoms over 6 months compared to only 40% of control group. Better quality relationship between the treatment parent and the child was		

Citation for Article	Service as Described in Article; Purpose of Study	Population /N/and Comparison Group(s)	Provider Qualifications/ and Fidelity	Outcome(s) Measured/ and Instruments Used	Evidence of Effectiveness	Level of Evidence	Other Comments
	Is the service listed in NREPP? MTFC is listed, Together Facing the Challenge is not.	American 45% Female N=247 (Enhanced TFC=137, Usual TFC=110) Comparison group was Usual Care TFC (N=110). Youth in the groups were comparable.			significantly associated with more improvement in the child's strengths (assessed via the BERS). Increased frequency of meetings between supervisors and parents in TFC was significantly associated with increased use of praise, increased use of privilege removal, and decreased use of physical restraint.		

Citation for Article	Service as Described in Article; Purpose of Study	Population /N/and Comparison Group(s)	Provider Qualifications/ and Fidelity	Outcome(s) Measured/ and Instruments Used	Evidence of Effectiveness	Level of Evidence	Other Comments
Farmer, E. M. Z., Burns, B. J., Wagner, H. R., Murray, M., & Southerland, D. G. (2010). Enhancing "usual practice" treatment foster care: Findings from a randomized trial on improving youth's outcomes. *Psychiatric Services, 61*, 555-561.	Together Facing the Challenge brings together essential components considered to be critical to TFC with elements of MTFC. TFC includes care coordination, view of parents as key change agents, team approach to treatment, respite, and work with youth' families. Enhanced TFC adds intensity of supervision and support of treatment parents by TFC supervisory staff as well as proactive teaching-oriented approaches to problem behaviors.	Study Population: Average age 13 years Half female Two-thirds were racial/ethnic minorities At baseline, youth had been living in their current TFC home for average of 20 months. N=247 (Enhanced TFC=137, Usual TFC=110) Comparison group was Usual Care TFC (N=110).	Training with TFC supervisors and treatment parents followed a train-the-trainer model. Included 2 days of training with TFC supervisors. Follow-up consultation visits with TFC supervisors were held monthly for 1 year. Treatment parents attended training weekly for 6 weeks. The article does not discuss to what extent the service studied met the model's fidelity standard.	Outcomes Measured: Clinical severity Number and type of problem behaviors displayed Youth' strengths Instruments Used: SDQ PDR BERS	For all 3 outcomes, youth in the TFC group showed improvements across time. Youth in control group remained relatively stable or showed minor worsening across time. The PDR and SDQ measures showed rates of changes that were significantly greater in the TFC group. (p=.025 and .009 respectively), and the wave-by-group interaction on the BERS approached significance (p>.078). Change over time effects were strongest and most sustained for the PDR measures. In Enhanced arm, rates of problem behaviors as measured by the PDR decreased across time	Randomized controlled trial	Results are promising but level of change is in the small to moderate range.

Citation for Article	Service as Described in Article; Purpose of Study	Population /N/and Comparison Group(s)	Provider Qualifications/ and Fidelity	Outcome(s) Measured/ and Instruments Used	Evidence of Effectiveness	Level of Evidence	Other Comments
	Purpose: To examine whether additional training and consultation to staff and TFC parents improved outcomes for youth Was the study conducted by a team that is independent of the service developer? No Is the service listed in NREPP? No	Youth in the groups were comparable.			(still significant at 6 and 12 months). (Mean level of problems at baseline PDR score of 5.9, 6 months PDR score of 4.2, and 12 months PDR score of 3.8). Youth in control group SQD showed marked improvement in youth in Enhanced arm at 6 months, but it was not statistically significant by 12 months (SDQ mean score of 17.4 at baseline, 14.3 at 6 months, and 16.0 at 12 months). Amount of change on the BERS was the smallest (86.4) at baseline, 91.0 at 6 months, and back to 86.4 at 12 months).		

Citation for Article	Service as Described in Article; Purpose of Study	Population /N/and Comparison Group(s)	Provider Qualifications/ and Fidelity	Outcome(s) Measured/ and Instruments Used	Evidence of Effectiveness	Level of Evidence	Other Comments
Farmer, E. M. Z., Wagner, H. R., Burns, B. J., & Richards, J. T. (2003). Treatment foster care in a system of care: Sequences and correlates of residential placement. *Journal of Child and Family Studies, 12*, 11-25.	TFC is a promising and utilized residential placement for youth with emotional and behavioral disorders. TFC combines the potential for intensive around-the-clock treatment with opportunities for development and growth within a family and community setting. Purpose: To examine the role of TFC in providing residential care. Study examines placement types	Study Population: Average age, 13 years 75% male Nearly half were minorities (mostly African American) Slightly over half were in state custody BERS mean of 86.6—comparable to the normative mean for youth with emotional and behavioral disorders	No provider qualifications were discussed. There was no mention of fidelity to the model.	Data from an existing study were analyzed. Outcomes Measured: Placement type Demographics Youth's functioning and clinical status Instruments Used: Willie M Management Information System	Immediately prior to TFC placement, GH was most common placement (46.1% of youth). For nearly two-thirds, TFC was a step down from a more restrictive setting. Only 16% moved to TFC from a less restrictive setting. 64% of youth remained in TFC the entire year following the focal TFC placement Most common post-TFC placement was the child's home (43.3% of youth)	Descriptive study	Participants' sex and race were not associated with a risk of moving out of the TFC placement.

Citation for Article	Service as Described in Article; Purpose of Study	Population /N/and Comparison Group(s)	Provider Qualifications/ and Fidelity	Outcome(s) Measured/ and Instruments Used	Evidence of Effectiveness	Level of Evidence	Other Comments
	and level of restrictiveness. It also examines whether demographic and clinical features of youth are systematically related to observed patterns.	Clinical range for total score on CBCL and for externalizing subscale; at borderline for internalizing subscale N=184 There was no comparison group in this study.		Data from baseline interviews with treatment parents BERS CBCL Study time frame	38.3% of youth were discharged to GH (down from a pre-TFC rate of 46.1%). Only 8.3% of youth were discharged to institutional settings compared to 19.1% pre-TFC. However, by the end of 12 months after placement, rates of group home use were similar to those seen in the 12 months before TFC. Immediately, there is a movement toward use of less restrictive placements but longer term follow-up shows a return to more restrictive placements.		

Citation for Article	Service as Described in Article; Purpose of Study	Population /N/and Comparison Group(s)	Provider Qualifications/ and Fidelity	Outcome(s) Measured/ and Instruments Used	Evidence of Effectiveness	Level of Evidence	Other Comments
Fisher, P. A., & Kim, H.K. (2007). Intervention effects on foster preschoolers' attachment-related behaviors from a randomized trial. *Prevention Science, 8,* 161-170.	MTFC-P has been tailored specifically to meet the developmental and social needs of preschoolers in foster care. The intervention is delivered via a team approach to the children, foster parents, and permanent placement resources. Service is similar in structure to MTFC. Purpose: to examine change in attachment-related behaviors among foster preschoolers.	Study Population: Children aged 3–5 years, mean age 4.34 in RFC and 4.54 in MTFC-P RFC group was 58% boys and MTFC-P was 49% boys 89% White Children had to be new to foster care, reentering foster care, or moving between foster placements. N=117 (MTFC-P=57, RFC=60) Comparison group	MTFC-P parents had to meet training requirements for MTFC parents. The article does not discuss to what extent the service studied met the model's fidelity standard.	Outcomes measured: Attachment-related behaviors Age at first foster placement Instruments Used: PAD	No significant group differences on any measures at baseline. Mean percent of secure behavior increased in MTFC-P and decreased in RFC [0.61 (SD=.32) to 0.71 (SD=.33) in MTFC-P and 0.71 (SD=.31) to 0.66 (SD=.33) in RFC]. Mean percent of avoidant behavior decreased in MTFC-P and increased in RFC [0.21 (SD=.25) to 0.15 (SD=.22) in MTFC-P and 0.18 (SD=.25) to 0.25 (SD=.30) in RFC]. Mean percent of resistant behavior decreased for both groups [0.13 (SD=.19) to 0.05 (SD=.12) in MTFC-P & 0.08 (SD=.13) to 0.05	Randomized controlled trial	

Citation for Article	Service as Described in Article; Purpose of Study	Population /N/and Comparison Group(s)	Provider Qualifications/ and Fidelity	Outcome(s) Measured/ and Instruments Used	Evidence of Effectiveness	Level of Evidence	Other Comments
	Was the study conducted by a team that is independent of the service developer? No Is the service listed in NREPP? MTFC is listed, MTFC-P is not.	was regular foster care. There were no differences between these groups.			(SD=.09) in RFC]. Age at first placement was positively associated with MTFC-P children's T5 resistant behavior (r=.27, p<.05).		

Citation for Article	Service as Described in Article; Purpose of Study	Population /N/and Comparison Group(s)	Provider Qualifications/ and Fidelity	Outcome(s) Measured/ and Instruments Used	Evidence of Effectiveness	Level of Evidence	Other Comments
Fisher, P., Kim, H., Pears, K. (2009). Effects of Multidimensional Treatment Foster Care for Preschoolers (MTFC-P) on reducing permanent placement failures among children with placement instability. *Children and Youth Services Review, 31,* 541-546.	MTFC-P has been tailored specifically to meet the developmental and social needs of preschoolers in foster care. The intervention is delivered via a team approach to the children, foster parents, and permanent placement resources. Service is similar in structure to MTFC with daily supervision and contact with program staff, clear limit setting, weekly playgroup sessions, and weekly therapy with family of origin.	These data came from a subset of a larger study. Study Population for larger study: Children aged 3–5 years, mean age 4.34 in RFC and 4.54 in MTFC-P RFC group was 58% boys and MTFC-P was 49% boys 89% White Children had to be new to foster care, reentering foster care, or moving between foster placements.	Fidelity to the model was monitored in the MTFC-P condition via progress notes and checklists completed by clinical staff.	Outcomes Measured: Placement histories and maltreatment experiences Instruments Used: Official case records from the county branch of the Oregon Department of Human Services Child Welfare Division Maltreatment Classification System	Maltreatment experiences: Average of about 8 incidents of maltreatment per child. Total of 88.5% experienced physical neglect, 94.2% experienced supervisory neglect, and 84.6% experienced emotional neglect. Each child experienced maltreatment from about 3 different perpetrators and an average of 3 types of maltreatment. 80.8% had at least 1 permanency attempt during the first 24 months. The group difference was not significant. There was no group difference in permanency attempts by type. 64% of those with a	Randomized controlled trial	Limitations are small sample size, majority of sample was White, and findings need to be replicated.

Citation for Article	Service as Described in Article; Purpose of Study	Population /N/and Comparison Group(s)	Provider Qualifications/ and Fidelity	Outcome(s) Measured/ and Instruments Used	Evidence of Effectiveness	Level of Evidence	Other Comments
	Purposes of the study were (1) to examine the effects of a therapeutic intervention for preschoolers in foster care with histories of placement instability on permanency outcomes and (2) to determine whether the intervention's effectiveness on these outcomes varied based on prior maltreatment experiences. Was the study conducted by a team that is independent of the service developer?	N=117 (MTFC-P=57, RFC=60) Sample for these analyses: History of placement instability (four or more placements prior to study entry) N=52 (23 RFC, 29 MTFC-P) Approximately half boys and half girls Average of 6 transitions per child prior to study entry with mean number of transitions			permanency attempt had a successful placement (39% of children in RFC who attempted and 83.3% of children in MTFC-P who attempted were successful). There was a significance group difference ($\chi 2=8.85$, df=1, $p<.01$). 30.4% of children in RFC and 69% of children in MTFC-P experienced successful permanency attempts during the first 2 years, and the group difference was significant ($\chi 2=7.63$, df=1, $p<.01$). None of the maltreatment variables were significant.		

Citation for Article	Service as Described in Article; Purpose of Study	Population /N/and Comparison Group(s)	Provider Qualifications/ and Fidelity	Outcome(s) Measured/ and Instruments Used	Evidence of Effectiveness	Level of Evidence	Other Comments
	No Is the service listed in NREPP? MTFC is listed, but not MTFC-P	significantly higher in the MTFC-P group (t=-2.11, df=50, p<.04). 90.4% White Only significant group difference was difference in number of prior placements.					

Citation for Article	Service as Described in Article; Purpose of Study	Population /N/and Comparison Group(s)	Provider Qualifications/ and Fidelity	Outcome(s) Measured/ and Instruments Used	Evidence of Effectiveness	Level of Evidence	Other Comments
Gustle, L-H., Hansson, K., Sundell, K., Lundh, L-G., & Löfholm, C.A. (2007). Blueprints in Sweden. Symptom load in Swedish adolescents in studies of Functional Family Therapy (FFT), Multisystemic Therapy (MST) and Multidimensional Treatment Foster Care (MTFC). *Nordic Journal of Psychiatry*, *61*, 443-451.	This study looks at studies of three evidence-based practices to compare symptom load at baseline. Purpose: to compare symptom load in youth treated with FFT, MST, and MTFC Was the study conducted by a team that is independent of the service developer? Yes Is the service listed in NREPP? MST and MTFC are	Study Population: Aged 12–17 years Youth with behavioral and psychiatric problems Treatment groups were predominantly male. Data from a total of 1735 youth were included in this study. This included data from 5 studies (3 of FFT, 1 of MST, 1 of MTFC) and data from a normal control group, child and adolescent psychiatry	No provider qualifications were identified in the article. The article did not discuss the extent to which the services were implemented with fidelity to the model.	Outcomes Measured: Problem behaviors (both internalizing and externalizing) Instruments Used: CBCL YSL Symptom Checklist 90	All clinical groups differed significantly from a normal comparison group on the CBCL. On the YSR, the FFT group did not differ from the normal group on total score and internalization. Mothers in all clinical groups showed worse psychiatric health than mothers in control group. Youth in MST and MTFC group score significantly higher than those in FFT on all measures except YSR internalizing. MST and MTFC groups did not differ significantly from each other. They showed higher symptom load than outpatient care but	Descriptive study using data from multiple existing studies and control populations.	

Citation for Article	Service as Described in Article; Purpose of Study	Population /N/and Comparison Group(s)	Provider Qualifications/ and Fidelity	Outcome(s) Measured/ and Instruments Used	Evidence of Effectiveness	Level of Evidence	Other Comments
	listed in NREPP. FFT is not.	outpatient care, and child and adolescent psychiatry inpatient care. There were 3 comparison groups: A normal group of school-aged children, an inpatient unit group of youth who had been on an inpatient child psychiatric unit for at least 4 weeks, and an outpatient group.			similar to inpatient care.		

Citation for Article	Service as Described in Article; Purpose of Study	Population /N/and Comparison Group(s)	Provider Qualifications/ and Fidelity	Outcome(s) Measured/ and Instruments Used	Evidence of Effectiveness	Level of Evidence	Other Comments
Hussey, D.L., & Guo., S. (2005). Characteristics and trajectories of treatment foster care youth. *Child Welfare, 84*, 485-506.	Children in TFC were assigned a case manager, who was responsible for developing an individualized treatment plan and coordinating services. The services typically included physical and mental health, behavior management, and transportation components. Purpose: to profile and describe the characteristics of a sample of youth in TFC and examine how those characteristics affect behavior change dynamics	Study Population: Children aged 4–18 years in a private, nonprofit treatment foster care program in Cleveland, OH 88.2% African American 59.7% Female More than 95% were covered by Medicaid N=119 There was no comparison group	No provider qualifications were mentioned. The article did not discuss the extent to which the model met fidelity standards.	Outcomes Measured: Psychiatric symptomatology Child characteristics Predictors of Change Instruments Used: Information from databases of the treatment foster care agency serving the children in the study Chart review Psychiatric rating data	Neglect is most common form of child maltreatment (41.2%). Average age of first out-of-home placement is 5.52 years; average age at entry into TFC is 9.7 years. Children in TFC have experienced average of 4.48 out-of-home placements prior to their current admission. Average full-scale IQ score is 82.8. 42% had elevated levels of psychiatric disturbance. 51% have history of use of psychopharmacology. Each out-of-home placement increased the	Exploratory study—Secondary data analysis	

Citation for Article	Service as Described in Article; Purpose of Study	Population /N/and Comparison Group(s)	Provider Qualifications/ and Fidelity	Outcome(s) Measured/ and Instruments Used	Evidence of Effectiveness	Level of Evidence	Other Comments
	Was the study conducted by a team that is independent of the service developer? Yes Is the service listed in NREPP? No			Devereux Scales of Mental Disorders	DSMB total score and externalizing score by 1.1 units, internalizing score by .95 units, and critical pathology (measures acute problems such as psychotic behaviors, fire setting, animal torture, and autism spectrum disorders) by .84 units.		

Citation for Article	Service as Described in Article; Purpose of Study	Population /N/and Comparison Group(s)	Provider Qualifications/ and Fidelity	Outcome(s) Measured/ and Instruments Used	Evidence of Effectiveness	Level of Evidence	Other Comments
Kerr, D., Leve, L. D., Chamberlain, P. (2009). Pregnancy rates among juvenile justice girls in two randomized controlled trials of MTFC. *Journal of Consulting and Clinical Psychology, 77,* 588-593.	This study combines 2 consecutively run RCTs to create a larger sample. Youth were placed in highly trained and supervised foster homes, which included standard components: daily phone contact with foster parents to monitor fidelity and track progress; weekly foster parent group training, supervision, and support sessions; individual therapy for the youth, family therapy for family of origin, monitoring of	Study Population: Girls aged 13–17 years (average age 15.31 years) who had been mandated to out-of-home placement because of chronic delinquency 74% Caucasian, 2% African American, 7% Hispanic, 4% Native American, 1% Asian, 13% reported mixed ethnic heritage At least 1 criminal referral in the prior 12 months Not currently pregnant 61% lived with single parent	No provider qualifications were identified in the article. The article did not discuss the extent to which the services were implemented with fidelity to the model.	Outcomes Measured: Baseline criminal referral history Baseline sexual activity Baseline pregnancy history Follow-up pregnancy Instruments Used: State police records and circuit court records Self-report of sexual activity Self-report and caregiver report of	Within each trial, GC and MTFC participants did not differ on any measure at baseline. Between trials, the only difference at baseline was on sexual activity. (Trial 1=90.1%, Trial 2= 77.4%) $\chi 2(1, N=165) = 4.89$, $p<.05$. Fewer girls in MTFC reported a pregnancy (26.9%) during follow-up than girls in GC (46.9%); n=159, Wald= 8.34, p=.004, OR=0.42, 95% CI= 0.23– 0.75. Baseline number of criminal referrals (OR= 1.05, 95% CI= 1.01–1.08, p=.010, n= 159), sexual activity (OR=3.70, 95% CI= 1.17–11.67, p<.025, n=158), and history of prior pregnancy	Randomized controlled trial	

Citation for Article	Service as Described in Article; Purpose of Study	Population /N/and Comparison Group(s)	Provider Qualifications/ and Fidelity	Outcome(s) Measured/ and Instruments Used	Evidence of Effectiveness	Level of Evidence	Other Comments
	school functioning, on-call program staff, and psychiatric consultation. Trial 2 also included an intervention that targeted HIV-risk behaviors Purpose of the study was to examine whether MTFC relative to treatment as usual decreased pregnancy rates among girls in juvenile justice who were mandated to out-of-home care. Was the study conducted by a team that is	families 32% lived in families earning less than $10k N=166 (81 and 85 for Trials 1 and 2) (81 for MTFC, 85 for GC) There were no group differences at baseline.		pregnancy history	OR=3.12, 95% CI= 1.47–6.64, p=.003, n=158) each predicted follow-up pregnancy. Significant group effect supported that MTFC decreased the probability of pregnancy after baseline relative to GC. Girls were 2.44 times more likely to become pregnant if in GC than MTFC. Baseline pregnancy and criminal referral histories were each associated with increased likelihood of pregnancy.		

Citation for Article	Service as Described in Article; Purpose of Study	Population /N/and Comparison Group(s)	Provider Qualifications/ and Fidelity	Outcome(s) Measured/ and Instruments Used	Evidence of Effectiveness	Level of Evidence	Other Comments
	independent of the service developer? No Is the service listed in NREPP? Yes						

Citation for Article	Service as Described in Article; Purpose of Study	Population /N/and Comparison Group(s)	Provider Qualifications/ and Fidelity	Outcome(s) Measured/ and Instruments Used	Evidence of Effectiveness	Level of Evidence	Other Comments
Leve, L. D. & Chamberlain, P. (2006). A randomized evaluation of Multidimensional Treatment Foster Care: Effects on school attendance and homework completion in juvenile justice girls. *Research on Social Work Practice, 17*, 1-7.	Youth were placed in highly trained and supervised foster homes, which included standard components: daily phone contact with foster parents to monitor fidelity and track progress; weekly foster parent group training, supervision, and support sessions; individual therapy for the youth, family therapy for family of origin, monitoring of school functioning, on-call program staff, and psychiatric consultation.	Study Population: Girls aged 13–17 years at baseline 74% Caucasian, 2% African American, 9% Hispanic, 12% Native American, 1% Asian, 2% other or mixed heritage 68% had been residing in single-parent families 32% lived in families with an income of less than $10k Average lifetime criminal referrals = 11.9, 70% of the girls had a prior felony	No provider qualifications were identified in the article. The article did not discuss the extent to which the services were implemented with fidelity to the model.	Outcomes Measured: Educational engagement Days in locked setting Instruments Used: PDR Child and caregiver interviews	Girls in MTFC had higher mean levels of homework completion and school attendance than those in GC. An ANCOVA for homework completion showed a significant effect for group, $F(1, 70)=6.01$, $p<.05$, with girls in MTFC having spent significantly more days on homework than girls in GC. ANCOVA for school attendance indicated a significant effect for group, $F(1, 68)=5.28$, $p<.05$, with girls in MTFC having significantly greater attendance than girls in GC. There was a significant direct effect of homework completion on days in locked	Randomized controlled trial	

Citation for Article	Service as Described in Article; Purpose of Study	Population /N/and Comparison Group(s)	Provider Qualifications/ and Fidelity	Outcome(s) Measured/ and Instruments Used	Evidence of Effectiveness	Level of Evidence	Other Comments
	Purposes of the study were to address the following questions: (1) Is the MTFC intervention more effective than GC interventions at increasing school attendance and homework completion while girls are enrolled in the intervention and at 1-year postbaseline, and (2) Does homework completion while in the intervention setting mediate the previously found group effects on girls' 12-month lock-up rates? Was the study	Not currently pregnant N=81 (MTFC=37, GC=44) There were no group differences at baseline.			setting while in the intervention setting (β=-.28, p<.01).		

Citation for Article	Service as Described in Article; Purpose of Study	Population /N/and Comparison Group(s)	Provider Qualifications/ and Fidelity	Outcome(s) Measured/ and Instruments Used	Evidence of Effectiveness	Level of Evidence	Other Comments
	conducted by a team that is independent of the service developer? No Is the service listed in NREPP? Yes						

Citation for Article	Service as Described in Article; Purpose of Study	Population /N/and Comparison Group(s)	Provider Qualifications/ and Fidelity	Outcome(s) Measured/ and Instruments Used	Evidence of Effectiveness	Level of Evidence	Other Comments
Leve, L.D., & Chamberlain, P., & Reid, J.B. (2005). Intervention outcomes for girls referred from juvenile justice: Effects on delinquency. *Journal of Consulting and Clinical Psychology, 73*, 1181-1185.	Youth were placed in highly trained and supervised foster homes, which included standard components: daily phone contact with foster parents to monitor fidelity and track progress; weekly foster parent group training, supervision, and support sessions; individual therapy for the youth, family therapy for family of origin, monitoring of school functioning, on-call program staff, and psychiatric consultation. Also included gender-related components (TFC parents and	Study Population: Girls aged 13–17 at baseline 74% Caucasian, 2% African American, 9% Hispanic, 12% Native American, 1% Asian, 2% other or mixed heritage 68% had been residing in single parent families 32% lived in families with an income of less than $10k Average lifetime criminal referrals = 11.9, 70% of the girls had a prior felony	Fidelity to the model was monitored with the PDR, taped therapy sessions, and daily supervision.	Outcomes Measured: Days in locked settings Criminal referrals Caregiver-reported delinquency Self-reported delinquency Instruments Used: Characteristics of Living Situations Court records CBCL Elliott Self-Report of Delinquency Scale	No significant mean-level differences on baseline delinquency. Means on delinquency outcome variables suggest that girls in MTFC spent fewer days in locked settings, had fewer criminal referrals, and fewer delinquent behaviors ANCOVA for number of days in locked setting indicated significant effect for group condition; girls in MTFC had significantly fewer days in locked settings at 1 year than girls in GC $F(1, 76)=4.25$, $p<.05$. Girls in MTFC also showed fewer criminal referrals at 1 year than girls in GC, F(1, 78)	Randomized controlled trial	Limitations are small sample size, majority of sample was White, and findings need to be replicated.

Citation for Article	Service as Described in Article; Purpose of Study	Population /N/and Comparison Group(s)	Provider Qualifications/ and Fidelity	Outcome(s) Measured/ and Instruments Used	Evidence of Effectiveness	Level of Evidence	Other Comments
	therapists were training to teach and reinforce girls to avoid social-relational aggression and to develop alternative strategies for dealing with rejection and stress). Purpose of the study was to examine intervention programs for delinquent girls. Was the study conducted by a team that is independent of the service developer? No	N=81 (37 in TFC, 44 in GC) No group differences at baseline.			=2.78, p=.10. Girls in MTFC had significantly lower 1-year CBCL delinquency, t-scores F(1, 55)=4.06, p<.05.		

Citation for Article	Service as Described in Article; Purpose of Study	Population /N/and Comparison Group(s)	Provider Qualifications/ and Fidelity	Outcome(s) Measured/ and Instruments Used	Evidence of Effectiveness	Level of Evidence	Other Comments
	Is the service listed in NREPP? Yes						

Citation for Article	Service as Described in Article; Purpose of Study	Population /N/and Comparison Group(s)	Provider Qualifications/ and Fidelity	Outcome(s) Measured/ and Instruments Used	Evidence of Effectiveness	Level of Evidence	Other Comments
Smith, D. K. (2004). Risk, reinforcement, retention in treatment, and reoffending for boys and girls in Multidimensional Treatment Foster Care. *Journal of Emotional and Behavioral Disorders, 12,* 38-48.	MTFC places youth in highly trained and supervised foster homes, which included standard components: daily phone contact with foster parents to monitor fidelity and track progress; weekly foster parent group training, supervision, and support sessions; individual therapy for the youth, family therapy for family of origin, monitoring of school functioning, on-call program staff, and psychiatric consultation.	Study Population: 34 boys, 28 girls Referred by state juvenile justice system after being mandated to out-of-home care. History of arrest Aged 12–18 years (average age 15.01) 81% White, 5% African American, 5% Hispanic, 4% American Indian, 5% Other N=62 No control group	No provider qualifications were identified in the article. The article did not discuss the extent to which the services were implemented with fidelity to the model.	Outcomes Measured: Preplacement risk MTFC parent-youth interaction Treatment completion Reoffending behavior Instruments Used: BSI Interviews with child and parents	Girls showed significantly greater **family criminality** (girls: M=.49, SD=.37; boys: M=.11, SD=.18), **family stress** (girls: M=.71, SD=.23; boys: M=.31, SD=.20), and **emotional/behavioral risk** (girls: M=.70, SD=.22; boys: M=.18, SD=.15). No significant relationship between levels of preplacement risk and the mean daily total of points earned in first 2 weeks. Mean daily total points (b=.06, p<.01) earned during first 2 weeks of treatment and youth's risk (b=-4.17, p<.05) were significant predictors of completion.	Randomized controlled trial	

Citation for Article	Service as Described in Article; Purpose of Study	Population /N/and Comparison Group(s)	Provider Qualifications/ and Fidelity	Outcome(s) Measured/ and Instruments Used	Evidence of Effectiveness	Level of Evidence	Other Comments
	Purposes of the study were (1) to examine the relationship between MTFC parent-youth interactions and treatment completion and outcome and (2) to explore the impact of youth and family preplacement risk factors on MTFC parent-youth interactions and youth's treatment completion and outcome. Was the study conducted by a team that is independent of the service developer? No	was used in this study. This sample came from 2 larger studies but only the MTFC group was used in this study.			An increase of 1 daily point decreases the probability of leaving MTFC before treatment completion by 1%. Mean total daily points for the first 2 weeks is a stronger predictor of leaving MTFC prior to completing treatment than youth's risk. Program completion ($b=-1.40$, $p<.01$) and sex (i.e., being male; $b=-1.39$, $p<.05$) were significant predictors of reoffending in the 12 months postplacement. Girls who completed treatment were significantly less likely to reoffend in the 12 months postplacement than were boys who did not complete treatment ($b=2.17$, $p<.01$) and girls who did not complete treatment		

Citation for Article	Service as Described in Article; Purpose of Study	Population /N/and Comparison Group(s)	Provider Qualifications/ and Fidelity	Outcome(s) Measured/ and Instruments Used	Evidence of Effectiveness	Level of Evidence	Other Comments
	Is the service listed in NREPP? Yes				(b=1.54, p<.05).		

Citation for Article	Service as Described in Article; Purpose of Study	Population /N/and Comparison Group(s)	Provider Qualifications/ and Fidelity	Outcome(s) Measured/ and Instruments Used	Evidence of Effectiveness	Level of Evidence	Other Comments
Smith, D., Chamberlain, P., & Eddy, M. (2010). Preliminary support for Multidimensional Treatment Foster Care in reducing substance use in delinquent boys. *Journal of Child & Adolescent Substance Abuse, 19*, 343-358.	MTFC places youth in highly trained and supervised foster homes, which included standard components: daily phone contact with foster parents to monitor fidelity and track progress; weekly foster parent group training, supervision, and support sessions; individual therapy for the youth, family therapy for family of origin, monitoring of school functioning, on-call program staff, and psychiatric consultation.	Study Population: 85% White, 6% African American, 6% Latino, 3% American Indian Aged 12–17 years (Average age 14.9 years) Boys referred by local county juvenile court screening committee after being mandated to out-of-home placement Average age at first criminal referral=12.6 years Average number of criminal referrals at baseline=13.5 and more than 4	Fidelity to the model was monitored in the MTFC condition with the PDR, taped therapy sessions, and daily supervision. No fidelity checks in the GC condition.	Outcomes Measured: Substance Use Instruments Used: Self-reported substance use	At baseline assessment, 71% reported having used at least 1 substance (68% used **tobacco**, with 81% indicating daily use; 68% used **marijuana**, with 41% indicating daily or weekly use; 72% used **alcohol**, with 37% indicating daily or weekly use; and 51% used **other drugs**, with 57% indicating at least occasional use). Participants in MTFC had significantly lower levels of other drug use compared to those in GC (β=-.26, $p<.05$) at 12 months. Participants in MTFC had significantly lower levels of tobacco use (β=-.34, $p<.01$), marijuana use (β=-.31, $p<.01$), and other drug	Randomized controlled trial	Limitations are small sample size, self-report of substance use, majority of sample was White, and findings need to be replicated.

Citation for Article	Service as Described in Article; Purpose of Study	Population /N/and Comparison Group(s)	Provider Qualifications/ and Fidelity	Outcome(s) Measured/ and Instruments Used	Evidence of Effectiveness	Level of Evidence	Other Comments
	Purpose was to examine substance use outcomes for adolescent boys in MTFC. Was the study conducted by a team that is independent of the service developer? No Is the service listed in NREPP? Yes	felonies 56% came from single-parent households 70% had at least 1 parent who had been convicted of a crime 70% had at least 1 prior out-of-home placement N=79 (37 in MTFC, 42 in GC). No group differences at baseline.			use (β=-.24, $p<.05$) at 18 months than youth in GC.		

Citation for Article	Service as Described in Article; Purpose of Study	Population /N/and Comparison Group(s)	Provider Qualifications/ and Fidelity	Outcome(s) Measured/ and Instruments Used	Evidence of Effectiveness	Level of Evidence	Other Comments
Smith, D. K., Stormshak, E., Chamberlain, P., & Bridges-Whaley, R. (2006). Placement disruption in treatment foster care. *Journal of Emotional and Behavioral Disorders, 9,* 200-205.	Youth were placed in highly trained and supervised foster homes, which included standard components: daily phone contact with foster parents to monitor fidelity and track progress; weekly foster parent group training, supervision, and support sessions; individual therapy for the youth, family therapy for family of origin, and consistent structure, discipline, and reinforcement. Purpose of the study was to	Study Population: 51 boys and 39 girls Aged 2–16 years Average number of Axis I diagnoses was 3.33 (most common were ODD, PTSD, ADHD) Average number of placements prior to referral was 4.75 N=90 (MTFC=37, GC=44) There were no group differences at baseline.	No provider qualifications were identified in the article. The article did not discuss the extent to which the services were implemented with fidelity to the model.	Outcomes Measured: Placement disruptions Instruments Used: None listed	Girls experienced significantly more previous placements than boys, $t(42)=3.10$, $p<.05$. Disruption rates: 17.8% in first 6 months, 9.2% for second 6 months, for combined year rate of 25.5%. A total of 70% of the youth experiencing a disruption did so in the first 6 months. Age was the only significant predictor of placement disruption; older youth were significantly more likely to experience a disruption during the first 6 months ($b=1.40$, $p<.05$). Younger girls ($b=-2.64$, $p<.01$), younger boys ($b=-2.46$, $p<.01$), and	Secondary data analysis	

Citation for Article	Service as Described in Article; Purpose of Study	Population /N/and Comparison Group(s)	Provider Qualifications/ and Fidelity	Outcome(s) Measured/ and Instruments Used	Evidence of Effectiveness	Level of Evidence	Other Comments
	examine placement disruption rates for a sample of adolescents with SED. Was the study conducted by a team that is independent of the service developer? No Is the service listed in NREPP? It was not called MTFC at the time of study, but it is a precursor to MTFC, which is listed.				older boys (b=-2.15, p<.05) were significantly less likely to experience a disruption than older girls during the first 6 months of placement. Older girls had a 55% probability of experiencing a disruption in the first 6 months; older boys had a 12.7% chance; younger girls and younger boys had an 8.1% and 9.6% chance of disruption.		

Citation for Article	Service as Described in Article; Purpose of Study	Population /N/and Comparison Group(s)	Provider Qualifications/ and Fidelity	Outcome(s) Measured/ and Instruments Used	Evidence of Effectiveness	Level of Evidence	Other Comments
Southerland, D. G., Mustillo, S. A., Farmer, E. M. Z., Stambaugh, S. A., & Murray, M. (2009). What the relationship got to do with it? Understanding the therapeutic relationship in therapeutic foster care. *Child and Adolescent Social Work Journal, 26,* 49-63.	TFC is a family-based, residential mental health treatment intervention for children with SED. It includes (1) preservice training and in-service supervision and training for the on-site providers and (2) planned treatment that combines treatment technologies from more restrictive settings with an emphasis on daily interactions with treatment parents and others in a less restrictive setting. Purpose: To examine the	Study Population: 74% male 59% White Aged 4–19 years, with majority being in the 13–15 and 16–19 age groups Mean length of stay 18 months All youth were Willie M class members, so they had SED and violent and assaultive behaviors N=183, analyses conducted on N=177 because data were missing	No provider qualifications were listed in the article. The article does not note whether the model has been implemented to fidelity.	Outcomes Measured: Descriptive statistics Child clinical outcomes Program characteristics Therapeutic relationship Child behavioral and emotional functioning Instruments Used: TRQ BPRS-C BERS	Descriptive statistics—see study population White youth had significantly lower BERS scores than Black youth (b=-5.16, SE=2.6, $p \leq .05$) in bivariate analyses. White parents had treatment foster children with significantly lower BERS (b=-7.86, SE 3.63, $p \leq .05$) in bivariate analyses. Child's age was positively associated with BERS total scale score (b=7.6, SE 3.73, $p \leq .05$ for ages 16–19 years) in bivariate analyses. Treatment parents' satisfaction with their relationship with the	Observational study using qualitative interviews with factor analysis	Child and TFC parent sociodemographic information were included in the model as predisposing characteristics. Adolescent males are more likely to be placed in TFC. Black males are more likely to come from a juvenile justice referral, from which youth and girls tend to have greater clinical severity. However, there is no evidence of differential functional outcomes based on race or sex as a primary predictive factor (Farmer et

Citation for Article	Service as Described in Article; Purpose of Study	Population /N/and Comparison Group(s)	Provider Qualifications/ and Fidelity	Outcome(s) Measured/ and Instruments Used	Evidence of Effectiveness	Level of Evidence	Other Comments
	therapeutic relationship between children with SED and their treatment providers Was the study conducted by a team that is independent of the service developer? No Is the service listed in NREPP? No	for 3% of the interviews Comparisons using state data showed no significant differences on age, demographics, or diagnosis in participating and nonparticipating eligible youth			TFC agency supervisor and endorsement of their role was significantly associated with better child functioning (b=7.09, SE 1.64, p≤.01) in bivariate analyses. Multivariate analyses showed that the only variables significantly related to child functioning were the parents' view of their role as parent vs professionals (b=4.13, SE 1.50, p≤.01) and the parents' perception of the child's view of the quality of the therapeutic relationship (b=18.46, SE 2.90, p≤.001).		al., 2003)

Citation for Article	Service as Described in Article; Purpose of Study	Population /N/and Comparison Group(s)	Provider Qualifications/ and Fidelity	Outcome(s) Measured/ and Instruments Used	Evidence of Effectiveness	Level of Evidence	Other Comments
Turner, W. & Macdonald, G. (2011). Treatment foster care for improving outcomes in children and young people: A systematic review. *Research on Social Work Practice, 21*, 501-527.	Definition of TFC in this review includes 9 ingredients: Goal is to serve children who would otherwise be in more restrictive settings Clearly articulated philosophy with strong community links and individualized treatment plans Foster parents are selected and trained to provide therapeutic care Care is provided in a family setting No more than 2 children in the	Study Population: Chamberlain & Reid, 1991: N=20, children and youth with emotional and behavioral problems; aged 9–18 years; were in psychiatric hospitals with SED and required out-of-home placements; no information on ethnicity Chamberlain, et al., 1992: N=72, children aged 4–18 years who were in out-of-home placements for reasons of abuse or neglect; either had emotional or behavioral problems or were at risk of		Outcome Measures: Child outcomes: behavioral outcomes, psychological functioning, educational outcomes, interpersonal functioning, mental health status Treatment foster caregiver outcomes: measures of skills, interpersonal functioning TFC agency outcomes: Placement stability, Attainment of treatment goals, Level of	Chamberlain & Reid, 1991: Results from an ANOVA (2 groups x 3 time points) did not reveal any significant results. Chamberlain, et al., 1992: A repeated measures ANOVA showed a significant decrease in problem behaviors in the experimental condition, but the groups varied widely at baseline. Clarke & Prange, 1994: No within-subjects effects, but several sex x time and age x time interactions. For externalizing factors, there were significant interactions only for condition by sex ($F(7, 245)=2.53$, $p<.01$) and delinquency ($F(7, 245)=2.90$, $p<.001$).	The studies included in this review were all randomized controlled designs	

Citation for Article	Service as Described in Article; Purpose of Study	Population /N/and Comparison Group(s)	Provider Qualifications/ and Fidelity	Outcome(s) Measured/ and Instruments Used	Evidence of Effectiveness	Level of Evidence	Other Comments
	home Foster parents receive intensive support from professionals Foster parents are regarded as professional members of the service team Foster parents receive larger payments than parents in regular foster care Program is administered by specialist agencies Purpose: to assess the impact of TFC on psychosocial and behavioral outcomes,	developing them; 86% White Clarke & Prange, 1994: N=132; children aged 7–18 years who were in out-of-home placements for reasons of abuse or neglect; either had emotional or behavioral problems or were at risk of developing them; 62% White Chamberlain & Reid, 1998: N=85, boys aged 12–17 years with histories of chronic delinquency; 85% White Level & Chamberlain, 2005: N=81, chronically		restrictiveness, level of independent living skills Costs Instruments Used: PDR Interviews and previous records BSI CGAS API Social Interaction Task and Taxonomy of Problematic Social Situations CBCL and YSR	Only a significant time effect for both YSR and CBCL. No effect size of time spent incarcerated could be computed. A 2x2x2 pre-post repeated measures ANOVA revealed no significant main or interaction effects of condition, sex, or age. **Diagnostic Interview**: ANOVA revealed only a significant interaction for sex by condition ($F(1, 124)=5.41$, $p<.05$). Results not statistically significant for school attendance, dropouts, suspensions, or school-to-school movement. Chamberlain & Reid, 1998: Days on the run at 1 year statistically nonsignificant (effect size -0.38 [-0.83, 0.06]); runaway behavior a moderate statistically significant result (effect		

Citation for Article	Service as Described in Article; Purpose of Study	Population /N/and Comparison Group(s)	Provider Qualifications/ and Fidelity	Outcome(s) Measured/ and Instruments Used	Evidence of Effectiveness	Level of Evidence	Other Comments
	delinquency, placement stability, and discharge status for children and adolescents who—for reasons of severe medical, social, psychological, and behavioral problems—were placed in out-of-home care in restrictive settings or at risk of placement in such settings. Were studies conducted by teams that are independent of the service developer? No	delinquent girls aged 13–17 years; 74% White Studies comparing TFC to control were included. Control groups might be no treatment, wait-list control, or regular foster care. A total of 5 studies including 390 participants were included in this review.		Elliot Behavior Checklist DISC	size -0.52 [-1.01, -0.02]); statistically significant effects of moderate size at 1 year follow-up on index offenses, felony assaults, and general delinquency. Large statistically significant effect indicating that youth in TFC spend fewer days in locked settings than youth in GH at 1 and 2 year follow-ups. Moderate statistically significant effect indicating that youth in TFC have fewer criminal referrals than youth in GH at 1 and 2 year follow-ups. There was a positive, nonsignificant result for days spent at Job Corps; there was a statistically significant, large, clinically meaningful effect indicating less time between referral to the study and placement		

Citation for Article	Service as Described in Article; Purpose of Study	Population /N/and Comparison Group(s)	Provider Qualifications/ and Fidelity	Outcome(s) Measured/ and Instruments Used	Evidence of Effectiveness	Level of Evidence	Other Comments
	Is the service listed in NREPP? MTFC is listed. Fostering Individualized Assistance Program is not listed.				for TFC participants; there was a statistically significant, large, clinically meaningful effect favoring TFC for days in treatment at 1 and 2 years. Leve & Chamberlain, 2005: Statistically significant effect relating to caregivers' perceptions of girls in TFC engaging in fewer delinquent acts; statistically nonsignificant effect in which girls in TFC report less law violation or delinquent acts and behavior at 1 and 2 year follow-ups; moderate statistically significant effect size suggesting that girls in TFC spent fewer days in locked settings compared to girls in GH; statistically nonsignificant effect on number of criminal		

Citation for Article	Service as Described in Article; Purpose of Study	Population /N/and Comparison Group(s)	Provider Qualifications/ and Fidelity	Outcome(s) Measured/ and Instruments Used	Evidence of Effectiveness	Level of Evidence	Other Comments
					referrals between GH and TFC, favoring TFC at 1 and 2 years; statistically significant clinically meaningful effects of moderate size on level of school attendance and on homework completion rates favoring girls in TFC.		

Citation for Article	Service as Described in Article; Purpose of Study	Population /N/and Comparison Group(s)	Provider Qualifications/ and Fidelity	Outcome(s) Measured/ and Instruments Used	Evidence of Effectiveness	Level of Evidence	Other Comments
Westermark, P. K., Hansson, K., & Olsson, M. (2010). Multidimensional treatment foster care (MTFC): Results from an independent replication. *Journal of Family Therapy, 33,* 1-23.	MTFC is a community-based, multimodal treatment program that addresses antisocial behavior. It includes formalized cooperation between a treatment team and the youth's parents, school, leisure activities, and social services. Purpose: to test the effectiveness of MTFC against treatment as usual in a Swedish population. Was the study	Study Population: Young people with serious behavioral problems and a diagnosis of conduct disorder Aged 12–18 years (average 15.4) 17 females, 18 males 25% from immigrant backgrounds Most were from single parent families Two-thirds were in care voluntarily N=35 (MTFC=20,	Providers were required to have the training specified in the MTFC model. The article discusses that they monitored whether the service studied adhered to the program manual.	Outcomes Measured: Symptom load in youth Symptom load in mothers Problem behaviors Instruments Used: CBCL YSR SCL-90	In all variables, MTFC showed a significant reduction in symptoms between baseline and post-baseline TAU showed a significant reduction on externalizing symptoms and totals on CBCL and YSR and no significant reduction on SCL-90. MTFC had more youth reducing their symptoms at a minimum of 1 SD of a normal population on all 9 variables except for YSR internalization. However, not all differences in reduction between the groups showed a statistical significance. Effect sizes favored MTFC in all variables.	Randomized controlled trial	

Citation for Article	Service as Described in Article; Purpose of Study	Population /N/and Comparison Group(s)	Provider Qualifications/ and Fidelity	Outcome(s) Measured/ and Instruments Used	Evidence of Effectiveness	Level of Evidence	Other Comments
	conducted by a team that is independent of the service developer? Yes Is the service listed in NREPP? Yes	TAU=15) Comparison group was treatment as usual. There were no differences in these 2 groups.			Most youth in MTFC presented a reduction of at least 30% of symptoms in all 9 variables. Most youth in TAU did not reach that level of reduction except for SCL-90 Depression. Differences in MTFC and TAU were significant on YSR externalizing and total scores and CBCL internalizing, externalizing, and total scores—all in favor of MTFC.		

Citation for Article	Service as Described in Article; Purpose of Study	Population /N/and Comparison Group(s)	Provider Qualifications/ and Fidelity	Outcome(s) Measured/ and Instruments Used	Evidence of Effectiveness	Level of Evidence	Other Comments
Westermark, P. K., Hansson, K., & Vinnerljung, B. (2008). Does Multidimensional Treatment Foster Care (MTFC) reduce placement breakdown in foster care. *International Journal of Child and Family Welfare, 4*, 155-171.	MTFC is a community-based, multimodal treatment program that addresses antisocial behavior. It includes formalized cooperation between a treatment team and the youth's parents, school, leisure activities, and social services. Purpose: to compare breakdown rates and relative risk of breakdown of adolescents with behavior problems in three different samples.	Study Population: This study included 3 study samples: Subsample of MTFC in Sweden: N=31; 17 boys, 14 girls; aged 13–17 years; serious problems as documented on the CBCL and YSR Subsample of Swedish national cohort study on out-of-home care for adolescents focused on breakdown: N=275; 99 girls, 176 boys; placed in care because of antisocial behaviors US MTFC study:	No provider qualifications were listed in the article. The article does not note whether the model has been implemented with fidelity.	Outcomes Measured: Time of breakdown Breakdown by type of care Breakdown by participant's sex Instruments Used: CBCL YSR SCL-90 Police reports	Breakdowns within 6 months were lower in the Swedish MTFC program than in RFC. Only significant difference was between the Swedish MTFC study (10%) and RFC (27%)—2.7 times an increased risk of breakdown. One-third of the girls in RFC broke their placement—a 4.7 times higher relative risk compared to the Swedish MTFC program. At 12 months, differences in breakdown rates between the Swedish MTFC study (13%) and the Swedish breakdown study (45%) were larger. There was a 1.7 to 8 times increased risk	Secondary data analysis	

Citation for Article	Service as Described in Article; Purpose of Study	Population /N/and Comparison Group(s)	Provider Qualifications/ and Fidelity	Outcome(s) Measured/ and Instruments Used	Evidence of Effectiveness	Level of Evidence	Other Comments
	Was the study conducted by a team that is independent of the service developer? Yes Is the service listed in NREPP? Yes	N=90; 51 boys, 39 girls; referred by Oregon Child Welfare Dept; aged 2–16 years; experienced SED N=396 The 3 groups were compared to each other			of breakdown for RFC (RR = 1.7–8.0). A total of 57% of girls in RCF experienced breakdown within 1 year. This was 8 times higher than the Swedish MTFC. There were a higher number of nonadolescents in the US MTFC study than Swedish MTFC study, but the breakdown rates were still 2 times as high in the US MTFC program, regardless of follow-up time. Results showed a two-fold risk of breakdown for the US MTFC, but there was no statistical significance because sample size. Trend displaying differences in breakdown rates between the 2 Swedish		

Citation for Article	Service as Described in Article; Purpose of Study	Population /N/and Comparison Group(s)	Provider Qualifications/ and Fidelity	Outcome(s) Measured/ and Instruments Used	Evidence of Effectiveness	Level of Evidence	Other Comments
					studies. Within 12 months the breakdowns within the RFC were 3 times more frequent than in MTFC and 8 times greater for the girls placed in RFC.		

Appendix F: Contributors

The Therapeutic/Treatment Foster Care Technical Expert Panel Planning Committee consisted of Larke Huang, Ph.D.; Jean Close, M.A.; Clare Anderson, MSW, LICSW; Kelley Smith, Ph.D., MSW; David DeVoursney, MPP; Rebecca Flatow, J.D., MSSW; Nadia Sexton, Ph.D.; Kara Ker, MSW, LCSW-C; Paul DiLorenzo, ACSW, MLSP; Sam Schildhaus, Ph.D.; and Doreen Cavanaugh, Ph.D.

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