TO STUDY THERAPEUTIC FOSTER CARE PROGRAMS DEVELOPED FOR FOSTER FAMILIES CARING FOR CHILDREN WITH INTELLECTUAL DISABILITY AND AUTISM.

THE WINSTON CHURCHILL MEMORIAL TRUST OF AUSTRALIA

REPORT BY - JULIE DINI – 2007 CHURCHILL FELLOW

SENIOR PSYCHOLOGIST
DISABILITY SA
CHILD & YOUTH SPECIALIST SERVICES
171 DAYS RD REGENCY PARK 5010 SA
Julie.dini@dfc.sa.gov.au

Agreement with Respect to this Report

I understand that the Churchill Trust may publish this Report, either in hard copy or on the internet or both, and consent to such publication.

I indemnify the Churchill Trust against any loss, costs or damages it may suffer arising out of any claim or proceedings made against the Trust in respect of or arising out of the publication of any Report submitted to the Trust and which the Trust places on a website for access over the internet.

I also warrant that my Final Report is original and does not infringe the copyright of any person, or contain anything which is, or the incorporation of which into the Final Report is, actionable for defamation, a breach of any privacy law or obligation, breach of confidence, contempt of court, passing-off or contravention of any other private right or of any law.

Signed Julie Dini Dated
<table>
<thead>
<tr>
<th>Contents</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 Acknowledgements</td>
<td>3</td>
</tr>
<tr>
<td>1.2 Executive Summary</td>
<td>4</td>
</tr>
<tr>
<td>1.3 Highlights</td>
<td>4</td>
</tr>
<tr>
<td>1.4 Major Lessons Learnt</td>
<td>5</td>
</tr>
<tr>
<td>1.5 Dissemination and Implementation</td>
<td>6</td>
</tr>
<tr>
<td>1.6 Limitations of Report</td>
<td>6</td>
</tr>
<tr>
<td>2. Program</td>
<td>7</td>
</tr>
<tr>
<td>3.1 Introduction</td>
<td>11</td>
</tr>
<tr>
<td>3.2 What is Therapeutic foster care?</td>
<td>13</td>
</tr>
<tr>
<td>3.3 How did Therapeutic foster care develop?</td>
<td>14</td>
</tr>
<tr>
<td>3.4 What are the differences between Therapeutic and</td>
<td>14</td>
</tr>
<tr>
<td>Traditional foster care?</td>
<td></td>
</tr>
<tr>
<td>3.5 Why is Therapeutic foster care important for children</td>
<td>15</td>
</tr>
<tr>
<td>with disabilities?</td>
<td></td>
</tr>
<tr>
<td>3.6 What are the components of therapeutic foster care?</td>
<td>15</td>
</tr>
<tr>
<td>3.7 Why do children with disabilities come into care?</td>
<td>17</td>
</tr>
<tr>
<td>3.8 What happens when children with disabilities come into care?</td>
<td>17</td>
</tr>
<tr>
<td>4 Therapeutic Programs visited</td>
<td>19</td>
</tr>
<tr>
<td>4.1 Kennedy Kreiger TFC Baltimore</td>
<td>19</td>
</tr>
<tr>
<td>4.2 Barnardo’s Break Away Dudley</td>
<td>22</td>
</tr>
<tr>
<td>4.3 William Strikker PIP Netherlands</td>
<td>24</td>
</tr>
<tr>
<td>4.4 Groden Network PFLA Rhode Is</td>
<td>26</td>
</tr>
<tr>
<td>5.1 How do Programs Recruit foster families?</td>
<td>29</td>
</tr>
<tr>
<td>5.2 How are Families Assessed?</td>
<td>31</td>
</tr>
<tr>
<td>5.3 How are Foster Children matched to families?</td>
<td>32</td>
</tr>
<tr>
<td>5.4 How are foster parents prepared?</td>
<td>33</td>
</tr>
<tr>
<td>5.5 How do foster families relate to birth families?</td>
<td>34</td>
</tr>
<tr>
<td>5.6 How are foster families helped with behaviour difficulties?</td>
<td>35</td>
</tr>
<tr>
<td>5.7 What respite is provided to foster families?</td>
<td>37</td>
</tr>
<tr>
<td>5.8 What training is provided to foster families?</td>
<td>37</td>
</tr>
<tr>
<td>5.9 What are therapeutic foster families paid?</td>
<td>39</td>
</tr>
<tr>
<td>5.10 What monitoring occurs?</td>
<td>40</td>
</tr>
<tr>
<td>5.11 What other supports are provided?</td>
<td>41</td>
</tr>
<tr>
<td>6 A Therapeutic Program for families with Children with</td>
<td>42</td>
</tr>
<tr>
<td>Disabilities in Finland</td>
<td></td>
</tr>
<tr>
<td>6.1 A Therapeutic Program for Families in the Bronx, NY</td>
<td>45</td>
</tr>
<tr>
<td>Professional Foster Homes in Finland and Netherlands</td>
<td>46</td>
</tr>
<tr>
<td>7 FFTA Conference</td>
<td>49</td>
</tr>
<tr>
<td>8 Recommendations</td>
<td>50</td>
</tr>
</tbody>
</table>
Acknowledgements

I would like to particularly thank the Winston Churchill Memorial Trust for believing in the worthiness of this project and for providing me with the opportunity to undertake it. The experience has been a remarkable one, rich with incredible learning opportunities and experiences.

I would like to particularly thank my employer Department of Families and Communities (Disability SA) for allowing me the opportunity to embark on this project and the support and strong interest they have shown in it. In particular, my Manager Janice Clark and Acting Regional Director Jill Marks for allowing me to be on duty to undertake this Fellowship. I would also like to thank my previous Director Lyn Zeidler for her encouragement and support in applying for this Fellowship.

My sincere thanks to my colleagues James Parker, Barbara Yates and Renee Muller for their dedication to the work of the Alternative Care Disability Support Program whilst I was overseas.

In particular my heartfelt thanks to Nina Mellenius, Julia Tanner, Dr June Groden, Bruce Ruby, and Rob Basler who all agreed to host my visit and who arranged such a stimulating and valuable program for me. To the many agencies and individual therapists and other staff who made time in their schedules to meet with me and answer my endless questions.

I also want to pay tribute the wonderful foster families who welcomed me into their homes and shared their experiences with me.

Finally, a very special thank you to my husband Ralph Olivieri and my sons Dominic and Elliot who supported me with a project that required such a significant commitment on their part.
Executive Summary

Highlights

Staying as a guest at the incredible and inspiring Huvitus Centre in Finland. Spending time with the highly skilled therapists there, in particular Nina Mellenius who arranged such a wonderful visit and who showed me such kindness. Participating in the professional presentations of Theraplay and Video Interaction Guidance with the Huvitus therapists was a privilege.

Experiencing my first ever sauna under the careful guidance of Karin Olsson Director of Mannerheim Child Welfare League whilst overlooking a beautiful lake in Finland. My journey back to Helsinki through the stunning Finnish country side conversing with Helena Miller, Director of Huvitus.

Visiting Pesapuu in Helsinki and enjoying a wonderful lunch and afternoon learning about the Finnish foster care system from Paula Männikö and Ilse Niekka.

My week at Barnardos Break Away in Dudley where I was made so welcome and learnt so much from Julia Tanner and Denise De Longhi. Meeting with Jennifer Cousins from BAAF.

Spending an unforgettable day and evening with the remarkable Joke and Eddie Nijland and especially sharing a fabulous paella with them and their foster family in Montfoort, Netherlands.

Visiting Professional Family Living Arrangement PFLA in Providence and visiting all of the Groden programs. Meeting Dr June Groden who was so generous with her time. My conversations particularly with Bruce Ruby, from whom I learnt so much about treatment foster care and spending time with Nancy Mabry.

In the Bronx, New York meeting Dr Susan Chintz, whose articles I have admired and who despite being very busy went out of her way to be helpful to me.

My time at Kennedy Kreiger TFC in East Baltimore, meeting Rob Basler and his team and their therapeutic foster parents who shared their stories with me.

Meeting Nancy Rosenau from Everychild Inc, Texas. Presenting at the Annual Foster Family Based Treatment Conference in Houston, Texas.
Major Lessons Learnt

Fostering children with disabilities and in particular autism and intellectual disability is recognised by many overseas agencies as an extremely valuable but highly demanding undertaking.

Therapeutic foster care programs developed in recognition that foster parents caring for children with disabilities require foster programs which are professionalised and specialised in disability.

Therapeutic foster parents are viewed as professional parents and are highly valued as the major change agent in the child’s life. The foster parent is considered as part of a team that works together to achieve the best outcomes for the child. They are not viewed as carers or volunteers.

Therapeutic foster care programs employ multi-disciplinary clinicians and therapists who have significant experience working with children with disabilities. Foster programs often have developed from agencies with an expertise in disability.

Therapeutic foster care programs undertake specific recruitment for therapeutic foster parents and then provide them with extensive training and pre-placement preparation, individualised intervention plans, guaranteed respite, higher levels of payment and 24/7 on call support.

Therapeutic foster care programs offer much more than case management, referral and supportive counselling models of practice as these are considered to be inadequate to provide for the complex needs of children with disabilities and the foster parents who care for them.

PRIDE training is used widely in Europe and the US to prepare foster parents. Assessment of therapeutic foster parents is extensive and the matching process is taken extremely seriously.

Extensive pre-placement preparation including providing foster parents with all available information about the child, their history and development is considered crucial to the success of placements.

Therapeutic foster programs visited have dedicated positions for recruitment and assessment and a respite co-ordinator. Respite is family based and there is a strong emphasis on ensuring that the same respite carer is used for the child.

1 www.cwlq.org/programs/frieschman/pride.htm
Therapeutic foster families often have a major role working with birth families, especially if the child is being reunified and receive training from their foster care agency to prepare them for this.

Relationship based therapies which address problems involving both child and foster parent are recognised as extremely important components of therapeutic programs. In Finland and the Netherlands Theraplay® and Video Interaction Guidance are used as clinical interventions to strengthen the relationships between the child and foster parent.

Professional foster homes are used in Netherlands and Finland where foster parents use their own home and are paid a professional level salary to provide fulltime care for children with disabilities.

Foster parents caring for children In Finland are able to access a Therapeutic Centre (Huvitus) for residential and out patient therapy to assist them with children’s behaviour and emotional difficulties.

In the UK and the US permanency planning has meant children may be adopted as long term foster care is not a preferred option. In reality for children with disabilities, some foster families can be reluctant to adopt as they lose the benefits and supports associated with therapeutic foster care.

**Dissemination and Implementation**

I will be presenting this year at the Disability SA Annual Conference and also at the National Australian Association for the Study of Intellectual Disability (ASSID) Conference in Melbourne.

I plan to present my findings to Disability SA and Families SA management and to meet with the Alternative Care Directorate in South Australia to discuss the possibility of implementing some of my recommendations.

I will also be presenting to my Psychology Colleagues in Disability SA and Families SA and my colleagues in Child and Youth Specialist Services and to Connecting Foster Carers.

I will also make my report available on line through my employer the Department of Families and Communities and will disseminate my findings to any organisation with has an interest in improving services to foster families who are caring for children with disabilities in Australia.

**Limitations of this Report**

The intention of this report is to provide an overview of the programs visited whilst overseas. It is based on the information provided to me and gathered whilst on my Fellowship and is therefore a descriptive report.
Programme
May 27th- July 16th 2008

Week 1 Finland  28th-31st May 2008

Consultations with

Nina Mellenius  Supervising Therapist
Helena Miller  Director, Huvitus
Liisa Heino Head of Program Development
Mari Kerminen Psychologist
Huvitus Development and Rehabilitation Centre  Yläne, Finland

Karin Olsson  Director
Foundation for the Rehabilitation of Children and Young People  Mannerheim
League for Child Welfare

Paula Männikö  Ilse Niekka
Centre of Expertise of Child Welfare
(Pesapuu)
Helsinki, Finland

Participated in
Staff Clinical Supervision session
Theraplay Review session at Huvitus with foster Parents

Presented to
Huvitus Therapists

Visited
Huvitus Development and Rehabilitation Centre
Yläne, Finland
Centre of Expertise of Child Welfare,
Helsinki, Finland

Week 2 United Kingdom  2nd-5th June 2008

Consultations

Julia Tanner Manager
Denise Longhi Senior Practitioner
Sarah Timmington  Social Worker
Barnardo’s Break Away Family Placement Service
Dudley, UK

Jennifer Cousins
Disability Project Consultant
British Association for Adoption and Fostering (BAAF)
Annette Callear  
Service Manager  
Children with Disabilities Team  
Dudley Metropolitan Borough Health and Social Care

Children with Disability Team staff  
Dudley Metropolitan Borough Health and Social Care

Visited  
Blakebrook Special School, Kidderminster

Participated in  
Home visit to foster family, Worstershire  
Foster review meeting Cherry Trees Special School  
Visit to staff by Martin Neery Barnardo’s National Director

---

Week 3 Netherlands 9-15th June 2008

Consultations with  
Jeannette Reukers  
Manager  
Pleegzorg Netherlands  
Utrecht, Netherlands

Joke & Eddie Nijland & Family  
Professional Foster Parents  
Montfoort, Netherlands

Dorothe Van Kempen  
Program Manager  
PIP Program  
William Strikker Group  
Amsterdam

Delia Van Tilburg  
Intake, Matching and Assessment Trainer  
William Strikker Group  
Amsterdam
Consultations with
Bruce Ruby
Program Director
Professional Family Living Arrangement (PFLA)
Groden Network
Providence, USA

Nancy Mabry
Clinician
Professional Family Living Arrangement (PFLA)
Groden Network
Providence, Rhode Island

Dr June Groden
Executive Director
Groden Network Inc
Providence, Rhode Island

Andrea Buffkin
Recruitment Co-ordinator
Professional Family Living Arrangement (PFLA)
Groden Network
Providence, Rhode Island

Peggy Stockton
Admissions Officer
Groden School
Groden Network
Providence, Rhode Island

Participated In
Directors Clinical Meeting
Funding Meeting with Craig Stenning Executive Director
Mental Health, Retardation & Hospitals Developmental Disabilities Department
Rhode Island

Visited
The Cove Vocational Centre & Greenhouse Groden Network
Livingston Centre Preschool Groden Network
Groden Center Special School
Week 4 & 5 New York & Baltimore USA 26 June-July 10th

Consultations

Dr Susan Chinitz
Director
&
Marian Silverman
Family Therapist
Early Childhood Center
Rose F Kennedy Center
Children’s Evaluation and Rehabilitation Center
Albert Einstein College of Medicine
Yeshiva University
Bronx, New York

Rob Basler
Director
Therapeutic Foster Care
Kennedy Krieger Institute
Baltimore, Maryland

Bruce McClary
Senior Clinical Social Worker & Co-ordinator Transitions
Therapeutic Foster Care
Kennedy Krieger Institute
Baltimore, Maryland

Amy Meyerl
Respite Co-ordinator
Therapeutic Foster Care
Kennedy Krieger Institute
Baltimore, Maryland

Participated in
Foster Parent Advisory Meeting
Staff Clinical Meeting
Therapeutic Foster Care
Kennedy Krieger Institute
Baltimore, Maryland

Visited
Early Childhood Center
Children’s Evaluation and Rehabilitation Center
Albert Einstein College of Medicine
Bronx, New York

Paediatric Rehabilitation Unit
Neurobehavioural Unit
Kennedy Kreiger Institute, Baltimore
Introduction

“Parenting and family life are the natural social arrangements by which children’s essential needs are met”. Rosenau 2005

Children with disabilities who come into the child protection system do so primarily because they have been victims of abuse and/ or neglect. A small but persistent number of children with disabilities come into state care because their birth parents find themselves unable to manage and therefore make the painful decision to request an out of home placement for their child.

Finding foster placements for children has become a serious nationwide issue with increasing rates of children entering the child protection system and declining foster placements. Less people are volunteering to foster and retaining foster carers is becoming increasingly difficult. Many are reporting they are becoming exhausted and disillusioned by the foster care system.

It is even more challenging to find foster placements for children with disabilities such as autism or intellectual disability, often because of serious behaviour difficulties. In South Australia in response to this now critical situation, some children are placed in units or apartments with paid rotating staff sometimes for extremely lengthy periods whilst waiting for a foster placement.

Rosenau 2005 www.everychildtexas.org
This type of arrangement is extremely concerning. Placing children into these types of care has major ramifications for the child’s emotional development and often severely exacerbates the child’s behaviour difficulties. It is difficult for children to develop an enduring relationship with rotating shift staff, the characteristic arrangement of group homes.

Children need to experience consistent parenting and stable family life as this is the mechanism by which their needs for optimal emotional development are met. Children develop essentially through a special relationship with a particular parenting figure whose relationship is enduring. It is recognised that the nurturing experience of family life goes much beyond providing a care-giver environment. High quality foster care models can replicate a parenting relationship for children, if their own birth family or kin are unable to provide it.

Children with disabilities who are in foster care have unique and often extremely complex behaviours. The foster families who care for these children require a high level of professional and specialist support to ensure that the foster placement can be maintained. Foster parents report that they struggle to receive specialist support as generic foster care programs often do not have the expertise in disability to adequately assist them. Instead case management and support groups are usually provided with a referral to another agency (if available) for help with behaviour issues. Some foster parents report on going struggles with receiving adequate respite and complain they receive little training in areas specific to their particular child, ie disability.

The significant decline in family based options for children with disabilities is serious and unless more sophisticated and professional models of foster care are developed then the situation for all children who enter the child protection system, but particularly those with disabilities remains dire.

I am a Psychologist and Program Co-ordinator of a relatively new but very small program in South Australia known as the Alternative Care Disability Support Program (ACDSP). This program is specifically funded by the SA Department of Families and Communities to provide intervention to foster families caring for children with disabilities who need help managing their foster child’s behaviour. The advantage of the program is that it can provide a specialist developmental and behavioural assessment of the child. Intervention is then provided to the foster family to assist them with strategies to address the behaviour, strengthen the relationship between the foster parent and the child, and assist the child develop new skills. The ultimate goal is to strengthen and sustain the foster placement.
Consequently, I have become increasingly interested in further developing therapeutic interventions for foster families who are caring for children with disabilities and improving the foster system for children with disabilities in general.

Programs such as the one I co-ordinate are rare and the extent of specialist support to foster families is often inadequate.

Overseas countries such as the U S, the UK, and a number of European countries have developed their foster care models to incorporate therapeutic or treatment foster care and have in some instances professionalised the role of foster carers for children with disabilities.

Receiving the Churchill Fellowship has provided me with a valuable opportunity to examine these programs overseas and to hopefully return with suggestions for new and improved models of service and clinical interventions for foster families caring for children with developmental disabilities.

**What is therapeutic foster care?**

**Terminology**

Therapeutic foster care is also commonly referred to as treatment foster care, specialised foster care, professional foster care, professional treatment homes, professional parenting, foster family based treatment and intensive foster care. Throughout this report the term therapeutic foster care and foster parent or foster family will primarily be used.

Therapeutic or treatment foster care is described by the FFTA\(^3\) as a unique model of care that provides children with a combination of the elements of traditional foster care and residential treatment in a family based placement. With therapeutic foster care, the positive aspects of a nurturing and therapeutic family environment are combined with active and structured treatment. Therapeutic foster parents provide intensive and individualised treatment of children and adolescents who would otherwise be placed in institutional settings.

A therapeutic foster care program is always family based and treatment is delivered through the integrated range of services with key interventions and supports provided by treatment or therapeutic foster parents who are trained, supervised and supported by qualified foster care program staff.

---

\(^3\) Foster Family Based Treatment Association, Bereika, G www.ffta.org
How did therapeutic foster care develop?

The first therapeutic foster care programs emerged in the US in the 1960’s where they were initiated by institutions to provide after care for children who were ready to be discharged from an institution but were not yet ready to return to their own families. Early therapeutic foster care homes were not different from regular foster homes except for servicing a more difficult population of children. Foster parent provided the home but treatment or therapy was done with mental health professionals outside of the foster home. Through out the 1960’s onward programs evolved to include planned therapeutic changes, professionalising the role of foster parents with appropriate training and remuneration, and a consultative, supervisory and clinical role for foster program staff.

Therapeutic foster care is now seen in the US as an alternative to restrictive residential treatment.

In the U.S. it is also seen as a temporary arrangement whereby the child remains in therapeutic foster care until they can be safely returned to their biological family or if this is not possible a permanency plan will be developed with adoption as the goal.

What are the differences between therapeutic foster care and traditional foster care?

Traditional foster care provides nurturing, safe and custodial care for children who require placement outside their biological family. Treatment or therapy if any, usually occurs outside of the foster home.

Program staff in the US I spoke to informed me that the traditional foster families may have a number of children placed with them at any one time where as with therapeutic foster care there is usually only one child placed with the therapeutic foster parent at a time. Traditional foster parents receive much lower rates of subsidy than therapeutic foster parents and often receive very little history or information on the child placed with them. Traditional foster parents receive a much lower level of support from the foster care agency and are often left to manage the child as best as they can due to high work loads of statutory social workers. Currently there are many concerns across the US around the condition of traditional foster care.

Therapeutic foster care has developed from the need to have a model of foster care for children who, because their needs are much more complex require a more therapeutic response. For example, youth at risk or involved with the criminal justice system, children with extreme
behavioural difficulties, and children with serious health or developmental disabilities.

Therapeutic foster care places high value on the foster family as the agent of change and recognises that the experience of family life is invaluable in assisting the child to develop. Therapeutic foster care recognises that such progress can only occur when a foster family is well trained and professionally supported to work therapeutically with the child.

Therapeutic foster families may need to work with birth families and family re-unification is promoted if it can be facilitated.

Therapeutic foster care is not simply higher payments or more training for traditional foster families working with more difficult children or youths.

**Why is Therapeutic foster care important for children with disabilities?**

Children with disabilities who enter the child protection system are especially disadvantaged, not only because they have experienced removal and separation from their birth family, but especially if they have also suffered from chronic neglect, abuse and trauma. This may in some instances have caused their disability or in cases of abuse and neglect certainly has exacerbated it. Therapeutic foster care recognises that this group of children require a specialised model of foster care which can meet their needs and which adequately prepares and sustains the foster parents who undertake this type of fostering.

**What are the components of Therapeutic Foster Care programs?**

While treatment foster care programs vary, there are several program features, including:
1) Families in the community are recruited, trained, and supported to become treatment foster families.
2) Treatment foster families are considered to be part of the treatment team; they are trained, supported, and supervised to enable them to provide a safe and therapeutic environment for the child, and to diffuse crisis situations.
3) Treatment foster parents receive higher reimbursements for their services than traditional foster parents in recognition of their knowledge and skill and the special needs of the treatment foster child.

---

* Program Standards for Treatment Foster Care Revised 2004 FFTA
4) Treatment foster care provides extended pre-service training and in-service supervision/support for treatment foster parents.
5) Treatment foster care caseworkers/social workers carry smaller caseloads than do caseworkers/social workers in traditional foster care programs. In most treatment foster care programs a caseload consists of between 10 and 15 treatment foster children and youth. Such small caseloads make it more possible for intensive and frequent interaction with each child.
6) In most treatment foster care programs, caseworkers/social workers are on call 24 hours a day.
7) Psychotherapy and other services designed to foster the child’s emotional or physical well being are provided.
8) Planned treatment that combines technologies from more restrictive settings with an emphasis on daily interactions with treatment foster families and others provided.
9) A family therapy component with the biological parent(s) and/or aftercare resources to support families after reunification is provided.\(^5\)

Therapeutic foster care programs are active and structured and intervention occurs within the foster home. The foster parent(s) are a vital resource in assisting the child’s progress and development. In all of the programs I visited, clinical intervention to address the presenting issues for the child, were imbedded in the foster care program. Individual therapy or treatment plans are designed to produce a planned outcome in a child’s behaviour, attitude or general condition. Plans are based on a thorough professional assessment of the possible contributing factors. Plans are developed with stated measurable goals and written procedures for achieving these. Plans are individualised and flexible to meet changing needs of the child and their foster family.

Therapeutic foster care parents are provided with extremely comprehensive pre placement and ongoing training. With the programs I visited, foster families are expected to be fully cognisant of the therapeutic approach and guiding philosophy of the treatment foster care agency that has placed the child with them. They are required to implement treatment plans and to present themselves as part of the professional team who is working with the child. They are required to take responsibility for understanding and explaining the rationale for why treatment plans are developed for the child and how the strategies and interventions are implemented to achieve goals and objectives. Their role includes fully participating in all meetings concerning the child they are fostering and frequently interacting with biological families. Therapeutic foster parents are not however responsible for the design of therapy programs. This is a team function undertaken by qualified clinical staff of the placing foster care program.
Why do children with disabilities come into foster care?

In the UK, US, Finland and Netherlands as in Australia, the majority of children with disabilities who enter the foster care system do so as a result of serious child protection concerns. A small minority may also be placed in some form of alternative care under a voluntary agreement if their birth family indicate that they are no longer able to care for them.

In Finland the primary social issue contributing to parental abuse and neglect was reported to be very high levels of alcohol use with a subsequently very high rate of babies born with foetal alcohol syndrome. In the UK poverty, along with mental illness and drug and alcohol use were reported to be contributing factors.

In the Netherlands increasing numbers of parents with an intellectual impairment are a major contributing factor resulting in children coming into care along with mental illness and drug and alcohol abuse.

In Providence, drug use and parental cognitive limitations were factors and in Baltimore a very high rate of drug use and domestic violence were all contributing factors to children coming into care.

What happens when children with disabilities come into care?

In the UK, the local child protection authority involved in the removal of the child has legal responsibility for the child. Children who come into care are referred to as “looked after children” in the UK. The local child protection authority will contact a foster care agency specialising in placement for children with disabilities for a temporary foster care placement. In recent years there has been a significant and rapid growth in foster placement agencies from the profit and not for profit sectors within the UK.

In the UK children with disabilities who come into care may be placed initially in an emergency foster placement or a small residential group home. Some children may remain in this type of arrangement for 12-18 months until a foster placement is found for them. Attempts are always made for the child to be re-unified with their birth family. If this does not succeed then the local authority will usually seek adoption as the preferred option.

A similar arrangement exists in Rhode Island and Maryland where the respective state departments (Children Youth and Families in Rhode Island and Department of Social Services in Maryland) have the legal responsibility for the child and will seek a placement from a foster care
program specialising in therapeutic foster care if the child has a disability and comes into care. The child may go into emergency foster care where they will stay until a placement in a therapeutic program is found. Some who have severe behaviour problems such as aggression or mental illness may be admitted to a psychiatric hospital where they may remain until a placement is found or their health insurance ceases. Some children may go into a residential facility usually small group home, also until placement is found.

In Maryland approximately 21% of children in care are in residential facilities, mainly small group homes. In Rhode Island the rate of children in residential homes is much higher with rates of 36% quoted.6

Foster care in the US is seen as a temporary option and not as part of a continuum of care. Permanency isn’t considered achieved until the child is either reunified or adopted. If the child is not able to be reunited with their birth family or placed with kin within 12 months of entering care, then adoption is pursued.

In reality, however many children with disabilities who have adoption in their care plans do not necessarily become adopted. Barnardos and the US programs visited, reported that one of the major reasons that this often doesn’t occur is foster families consistently told them they did not want to lose the intervention and support they receive from their agencies, as they found this invaluable.

Another contributing factor is that once the child is adopted any subsidies are not longer paid (although in the UK and the US a smaller adoption stipend is paid to some families to assist them with the costs of adopting a child with disabilities.) Maryland has attempted recently to build in incentives to encourage adoption, such as having an allowance for rare and expensive medication, equipment etc.

The financial component is a significant consideration for many families and if they choose to adopt the child they will need to be able to financially manage without the foster payments. One UK foster family I spoke to, where the father had recently become unemployed, told me that they would adopt their foster child tomorrow “if we won the lottery”.

In the Netherlands a child can be removed and the birth family placed under Supervision if there are serious child protection concerns. This lasts for a year at a time and is used when attempts are being made to assist the family resolve the issues of concern. If the family does not make the desired progress an application for removal of parental

---

6 Child Welfare League of America National Data System
No of Children in out of home care by Placement Setting 2005
authority can be made and a Guardian appointed. The Guardian may be an institution if they child is placed in a residential placement or an agency. Guardianship can eventually be transferred to a foster parent but in reality this occurs in only about 5% of Guardianship orders. Adoption can occur but it is not common.

**THERAPEUTIC FOSTER CARE PROGRAMS VISITED**

I visited a number of specific therapeutic foster care programs designed for children with developmental disabilities in the UK, the Netherlands and in the United States. Recruitment, intervention and therapy, respite, comprehensive training, 24/7 on call response and social groups for foster families were characteristic of the programs I visited.

**The Kennedy Krieger Foster Care Program (TFC), Baltimore US.**

The Therapeutic Foster Care TFC program is one of many programs provided by the Kennedy Krieger Institute, an internationally recognised centre for children with developmental disabilities, located in Baltimore, Maryland.

The Kennedy Krieger Institute was established in 1937 to improve the lives of children and adolescents with paediatric developmental disabilities through patient care, special education research and professional training.

In 1986 it developed the Therapeutic Foster Care program with 10 children who were moving out of group care. This was one of the first treatment foster care programs for children with disabilities in Maryland. The program was expanded in the 1990’s to include children with severe emotional problems.

Being part of the Kennedy Krieger Institute means that the TFC program is extremely well positioned as it is able to utilise a very high level of specialist and therapeutic support from the Institute for the children and families it works with.
For example, the Kennedy Kreiger Centre is a 70 bed speciality paediatric hospital which contains a Paediatric Rehabilitation Unit for children who have suffered a brain injury, a Paediatric Feeding Disorder Unit for addressing complex eating disorders. There is also a Neurobehavioural Unit which provides an inpatient behavioural program to address self injurious and aggressive behaviour in children with developmental disabilities. There are 30 paediatric outpatient clinics, including the Centre For Autism and Related Disorders, Behaviour Management Clinic, Child Neurology Clinic and many more.

Foster children who are part of the Kennedy Kreiger Therapeutic Foster Care Program are able to access these clinics if required. I was fortunate to be able to visit the Neurobehavioural Clinic whilst with the TFA program.

East Baltimore neighbourhood

Maryland has a total population of just over 5.6 million people and has approximately 10,867 children in out of home care. Approximately 37% are in a foster care placement and 31% are in a kinship placement. Baltimore city, has a population of approximately 630,000 and has 7000 children in out of home care. Baltimore city has a very high crime rate and has the highest homicide rate per 100,000 of all US cities. The city also has a significant drug problem which is impacting on many of the African American families from the impoverished area of East Baltimore. Approximately one third of Baltimore city families live in poverty. Many of the children who come into the TFC program come from backgrounds of family drug use and violence and may have experienced or witnessed very significant trauma including the death and injury of parents by firearms.

---

7 Child Welfare League of America National Data Analysis System
No of children in out of home care by Placement Setting 2005
Co-located with the TFC program in East Baltimore is Kennedy Kreiger’s Family Centre, which specialises in treating trauma in children. It is staffed by a multidisciplinary team which includes child psychiatrists, clinical psychologists, clinical social workers, certified professional counsellors etc who use a trauma focussed cognitive behaviour therapy model with these children. Children in the TFC program can attend the Family Centre if they have experienced trauma.

Currently the TFC program supports 50 therapeutic foster care places (8-10 of these are now adults) The program serves more than 100 children in foster care each year. The children referred have multiple diagnoses with seizure disorder, intellectual disability, medically fragile conditions and ADHD being common. They accept referrals for children 0-21 years. The program is funded primarily through the Maryland Social Services and Developmental Disabilities Administration. The program does have difficulty finding homes for children in wheelchairs due to the type of narrow and multi-story housing common in Baltimore city.

The vast majority of TFC foster parents are middle aged African American women, many of whom are single and whose biological children have grown up. They come primarily from the inner city area of Baltimore. TFC allow usually only one child to be placed but at times will allow up to two children in the one placement. The program refers to their foster parents as Treatment Parents and regards them as professional parents. Participation in training, undertaking personal development and undergoing annual evaluation are requirements of the treatment parent’s role.

The TFC program staff provide a very high degree of professional supervision to their foster parents.

All program staff are qualified social workers and the program ensures that the clinical social worker visits at least twice a month, although it is frequently more often. They also attend any school or medical appointments with the foster family. The clinical social workers may also undertake some individual therapy with the foster child around areas such as life story work.

Kennedy Kreiger Therapeutic Foster Care Team
The clinical social workers have a case load of 8-9 treatment foster parents. There is also a dedicated social worker whose role is to provide specialist support to foster families who are caring for children with medically fragile conditions. Many of these children require high levels of personal care as they may be tube fed etc.

The TFC program provides a 24 hour on call service for its foster families. Whilst visiting the program I had the opportunity to meet with three foster parents who described very high levels of satisfaction with the support that the program provides to them. One foster parent gave an impressive example which illustrated how responsive the program staff are to their foster parents after hours.

The TFC program is also a licensed adoption agency as adoption is integral to their program. Approximately 4-5 children a year from their program are adopted by their therapeutic foster family. Program Director Rob Basler informed me that adoption provides a very important emotional component to the child’s sense of identity and belonging.

Meeting with Foster Parents from the Kennedy Krieger TFC program

BARNARDO’S BREAK AWAY PROGRAM.

In the UK I visited the Barnardo’s Break Away in Dudley in the West Midlands. Barnardos is one of the UK’s largest children’s charities. It provides a very wide range of services to children and families across
the UK, including many foster care programs. The Dudley Break Away project commenced in the 1985, initially to move children with disabilities out of a large institution and into family life.

Dudley, UK

This was an extremely successful project and it developed into a specialised foster care program for children with disabilities in the West Midlands area. It currently supports approximately 26 foster families caring for children with disabilities.

Break Away refer to their foster parents as foster carers and many are recruited from an area close to Dudley, known as Kidderminster. Many of these families have had a long association with the program and much recruitment is by word of mouth.

The program Manager Julia Tanner informed me that placement breakdowns occur very rarely with their program. She believes this is due to very careful matching of families to the child and the extent of support they provide to their foster families.

Barnardo’s Break Away is primarily staffed by qualified social workers and social welfare support workers. They use the welfare support workers to provide practical assistance to their foster families, for example they will help transport the child to medical appointments, will source equipment or make appointments for families. The social workers carry a case load of approximately 10 foster families and will undertake some of the assessment for prospective carers.

Break Away Barnardo’s social workers visit their foster families weekly for the first three months after a child is initially placed. They then visit at least once a month. These visits are referred to as supervision sessions and during these visits the goals for the child and the foster family are reviewed and discussed. Topics covered may include any issues relating to the child’s emotional or behavioural development, respite, progress at school, linking into the community etc.

Barnardos also employ sessional support workers to undertake leisure and recreational activities with the child, linking them into community
groups. The Manager Julia Tanner reported that the program used to employ a Psychologist which they found extremely beneficial whose role was to work with each family to develop programs to address behavioural difficulties and to provide training for foster families. Unfortunately, they have had difficulty recruiting a Psychologist in recent years.

During my visit I had the opportunity to interview two foster families who are fostering though Barndardos Break Away. The reported being extremely pleased with the quality of support they receive from the program.

Barnardos Break Away Social Workers Denise DeLonghi & Pam Deacon

William Strikker PIP program

In the Netherlands I spent time with the PIP program which is part of the William Strikker Group (WSG).

The William Strikker Group is an organisation named after a Dutch pioneer in mental disabilities, William Strikker who over 60 years ago promoted the view that children with disabilities could live with families rather than in institutions. Today the WSG is a totally government funded agency with the mandate to provide a wide variety of services to people with disabilities across the Netherlands. It employs over 800 staff.

WSG provides a foster care program for children who cannot live at home who have mental, physical or chronic medical conditions and it operates across the Netherlands. The program is assisted by a specialist team within the William Strikker Group known as PIP Placement Intervention Program. This team work with foster families for up to 18 months if they are experiencing significant behavioural and or emotional difficulties with their foster child. Foster families will be referred and the PIP program will work with them for 12-18 months,
visiting the foster family every three weeks. PIP operates across the Netherlands with approximately 16 staff.

PIP’s practice is influenced by the work of family therapist Ivan Boszmormenyi-Nagy. Nagy is known for developing the contextual approach to family therapy. Based on the psychodynamic model, contextual therapy accentuates the need for ethical principles to be an integral part of the therapeutic process. Trust, loyalty, and mutual support are the key elements that underlie family relationships.

Video Interaction Guidance (VIG) is one of the main therapeutic techniques the program uses to assist the foster family. VIG involves video recording some of the usual daily routines that occur between the foster parent and the foster child and then viewing this footage with the foster parent to identify where they can strengthen their interaction and attachment to the child.

Video Interaction Guidance sessions are held over 6 weeks and Program Manager Dorothe van Kempen reports that they are very pleased with the outcome of this therapy for many of the foster families they work with.

They use an assessment tool developed by the University of Leiden which has been designed specifically to assess the relationship between the foster family and the foster child to assist them in their clinical work.

---

10 University of Leiden Department of Education and Child Studies
Professional Family Living Arrangement (PFLA) Providence, Rhode Is.

PFLA is based in Providence, Rhode Island. This state which is the smallest in the US, has a population of just over one million people. Providence county has a population of just over 600,000. There are around 2509 children in out of home care Rhode Island. 34% are in foster care and 23% are in kinship care.11

The Groden Network is largest non profit organisations in Rhode Island which specialises in providing a wide range of services to people with an intellectual disability and autism.

Providence Rhode Island, USA

The Groden Network provides programs which range from preschools, early intervention, family services, foster care programs, schools, vocational programs and residential care and employs 800 staff.

Founders of the Groden Network, Dr June and Gerry Groden are recognised as international experts in the field of intellectual disability and autism. They commenced working with children with autism and intellectual disabilities in the 1970’s initially establishing a special school.

In 1993 the need for a specialised foster care program for children with autism and intellectual disabilities in Rhode Island was recognised and the Groden Network developed their Professional Family Living Arrangement (PFLA). This program now provides foster placements for 46 children and pays it’s foster parent the highest subsidies in Rhode Island. Approximately 95% of children referred to their program have an intellectual disability and most come into care because of abuse and neglect. Typically most children are aged between 10-15 years old. Some children who do not have an intellectual disability but have

11 Child Welfare League of America National Data Analysis System
No of children in out of home care by Placement Setting 2005
severe behaviour difficulties are also referred to the program. Approximately 20% of children who are with the PFLA program are adopted by their foster parents. 60% are reunified and the remainder are under a Permanently Planned Living with Other Order. Children can remain in foster care until age 21 when they transition to adult care.

As the PFLA is part of the Groden Network of programs it is ideally situated within this large organisation which specialises in service delivery to people with autism and intellectual disability. The foster program can access all of the other services that the Network provides such as its special preschool and school as well as it’s extremely experienced clinical staff.

The Cove Centre location of PFLA
Providence, Rhode Island

The PFLA program has a full time Director and seven Clinicians. All PFLA Clinicians must have a Master degree usually in social work, child development or special education. The PFLA program also has an experienced sessional Psychologist Dr John Wincze who attends the clinical team meetings weekly for case discussions. There are many Psychologists attached to the Groden Network including Dr's June and Gerry Groden who can be called upon for clinical input if required.

With Dr June Groden at Groden School

PLFA recruit families from the Rhode Island area and refer to their foster parents as providers.
Their provider families understand the expectation that their role is a 24/7 job. They are required to understand the philosophy of the Groden Network and to advocate for the child and to undertake regular documentation with regard to the child’s treatment plan. Many of the foster parents may work at least part time due to the fact that health insurance is linked in the US to an individual’s employment. The PFLA prefer at least one of their foster parents to be at home if the child is under 5 years. They will only place one child with a foster family.

PFLA are required to visit their foster families at least monthly but in reality it is frequently more often as they attend all meetings relating to the child ie school, medical etc. With new foster families the extent of involvement is often much more frequent i.e. daily calls whilst the child is settling in. PFLA allocates a primary and secondary clinician to each foster family so there is always a staff member available who knows their situation and can respond if they call.

They provide a 24 hour on call system which the program staff are rostered to cover with clinical supervision provided by the Program Director if needed. Case load is approximately 7-8 foster families per clinician.

The clinicians also work closely with the child and all children have behaviour protocol in place as a component of their treatment plan which is developed by the PFLA clinician allocated to the family. Intervention programs address, the ecological, developmental and behavioural needs of the child. The program monitors the child’s development and progress using the Child and Functional Assessment Scale (CAFAS)12 every three months.

This measure assesses areas such as school, community and adaptive skills, behaviour, moods and emotions, self harm etc. It is used to develop the treatment plan for the child and to monitor their progress and is one of the tools recommended by the FFTA.

Meeting with Executive Director Mental Health, Retardation, Hospitals Division of Developmental Disabilities, Rhode Island

12 CAFAS, Hodges, K., www.cafas.com
PFLA foster families are required to keep very detailed data and records relating to the child’s treatment program and these records are monitored carefully by the program staff.

Program Director Bruce Ruby reported that their program experiences very few placement breakdowns. He believes that this is due to having very high standards around the type of families they recruit, explaining that they must be able to meet the demands associated with therapeutic foster care. His clinicians know the children extremely well so they can be very particular about matching. They often take months to ensure the correct match, before placing a child, therefore finding they rarely have to move a child out of a placement.

How do the Programs Recruit Foster Families?

All of the specialist foster care programs I visited, invest considerably in continual recruitment as finding adequate foster families is a high priority. With the PFLA and Kennedy Kreiger program they have a dedicated full time position for recruitment. This person is co-located with the clinical team and is supervised in both instances by the Program Directors. All programs I spoke to emphasised that the majority of foster families came to them via word of mouth from other foster families already involved with their program, therefore it was essential that all their families feel valued, respected and very well supported as they are the most valuable resource the programs have with regard to ongoing recruitment.

All programs I visited commence the recruitment process with the first phone enquiry they receive. During this initial phone call the recruitment officer explains the type of children they are requiring placements for explaining in detail the type of disability, behavioural/emotional issues and care needs typical of the children referred to their program. They stress this is essential as it ensures that people are fully aware that they are applying to a therapeutic program. The recruitment officer may refer people onto traditional foster care programs if they feel that the person enquiring is not really suited to this type of foster care.

The two US programs also offer a financial bonus if one of their current foster families refer a potential new foster family to them. The PFLA program for example offers a total of $US 500 paid in increments depending on how far the person they have referred has progressed with the recruitment, assessment and training requirements.

Jennifer Cousins from BAAF explained the recent growth of the private agency foster care sector in the UK has meant that finding foster
parents has become even harder as more and more agencies are competing to attract them. The reputation of the program and the level of support available for the foster parents, are now critical factors for recruitment and retention as foster parents “shop around” for the best packages of support.

Kennedy Krieger is currently using a marketing campaign in newspaper advertisements and flyers. They receive approximately 500 calls a month from this. They have also commenced using recruitment parties where one of their current foster families will invite people they think may be interested in learning more about foster care and the program will do a presentation on their program. The also do email blasts to all Kennedy Krieger Institute employees.

The British Association for Adoption and Fostering BAAF have produced an excellent resources on finding foster families for children with disabilities written by BAAF Consultant Jennifer Cousins.13

In the Netherlands all foster care recruitment is co-ordinated with a central agency known as Pleegzorg Netherlands (Foster care Netherlands). I met with the Co-ordinator Ms Jeannette Reukers who explained that the Dutch Government and all foster care agencies contribute to this organisation which engaged a marketing firm to develop their most recent campaign which they felt was their most successful yet. This campaign is tied to a very successful webpage, www.pleegzorg.nl. Approximately two thirds of all first contact is apparently now made through this webpage. There is a toll free information line and potential families are then redirected to their closest foster care program in the Netherlands for more specific information.

Approximately 900 children are waiting for a foster care placement in the Netherlands. Ms Reukers explained that there are approximately 800 approved foster families also waiting for a placement but many factors such as the need for siblings to be placed together or cultural background of the child means appropriate matching needs to occur before placements can be finalised.

Pleezorg Netherlands have identified that the profile of foster care is not high in the Netherlands with many people not really knowing what it is and so a consistent approach to advertising and recruitment is important. Another challenge for the Netherlands is recruiting foster carers from diverse cultural backgrounds as there are increasing

---

13 Everychild is Special Placing Disabled Children for Permanence Jennifer Cousins 2006 www.baaf.org.uk
numbers of children coming into care who have Turkish, Moroccan and Algerian heritage.

Finding foster carers for children under 5 years is also an issue as many families prefer to foster once the child has settled into school. In the Netherlands foster care recruitment is growing approximately 10% a year but this is not keeping pace with the demand.

In Finland a united recruitment campaign with a budget of €100,000 is underway using a variety of media to try and raise the profile of foster care across Finland.

Paula Manniko & Ilse Niekka
Centre of Expertise of Child Welfare (Pesapuu)
Helsinki, Finland

In all of the countries I visited, applications to foster can be accepted from singles, couples and families, as well as gay and lesbian applicants.

How are Therapeutic Foster Families Assessed?

The assessment process for potential foster families in all of the specialist programs I visited was very comprehensive.

All programs required comprehensive police checks on all people living in the home, medical and personal referee checks, along with a comprehensive home study which usually involved between 3-5 home visits.

Barnardos use the British Adoption And Fostering (BAAF) Home assessment which takes around 6 months to complete. It requires fortnightly visits to the home, police and medicals, extensive referee checks and interviews with every member of the household.
In the US all adults living in the foster home need to attend pre-placement training and be subject to fingerprinting and criminal records checks as well as home visits and interviews. CPR and first aid training are also provided. All of the programs reported that the time taken from first telephone enquiry to final approval is usually between 6-9 months.

**How Do Programs Match Foster Families to Children with Disabilities?**

All of the programs visited stressed that the matching process they undertook was critical to the success of their programs. As all programs were responsible for their own recruitment, assessments and home visits they become very familiar with their prospective foster families. The program staff also have an in depth understanding of the child requiring placement, therefore they feel very confident that they can ensure the best match between child and family.

All programs stressed that matching was a slow process and is never undertaken reactively. Matching may take months. For example, PFLA program Director Bruce Ruby explained that their program has had potential families waiting for an allocation for up to 12 months. This does not mean that they have doubts about the family’s capacity but rather want to be certain that this is the right family for the right child.

According to Julia Tanner from BreakAway, the thoughts and opinions of the prospective foster family are very much taken into account in the matching process. If placements are to be successful in her opinion there must be an emotional connection between the foster family and the child. In the UK BAAF publish a newspaper each month known as Be My Parent. This publication is distributed to foster programs and registered foster families and contains feature articles including a photograph on hard to place children from across the country. BAAF Disability Consultant Jennifer Cousins, informed me this publication has led to many successful outcomes for children who otherwise would have not been successfully placed.

The William Strikker Group program Manager Dorothe Van Kempen explained their matching process is a graduated and considered one where the foster family are given time to consider carefully before they make a commitment to care for a child. They also involve the child’s birth family in this process. This process will take a number of visits and meetings before the final placement is made. The foster family are provided with significant information about the child, for example they will be given a detailed history about why the child came into care. This is regarded as very important. They will be provided with full information about the child’s disability and the expectations around working with the child’s birth family.
How are Foster Families Prepared for a Foster Placement?

Pre-placement training is an essential part of the assessment process with all programs offering very comprehensive pre-placement programs which are compulsory for applicants to attend. All programs stressed that as the families they had recruited are required to work with children with special needs then they needed to be adequately prepared well before a child was placed with them.

Across Finland PRIDE training is used for all foster families and Paula Männikö of Pesapuu in Finland emphasised that the introduction of the PRIDE14 model has been a major step forward in improving the respect for foster parents in Finland. The PRIDE program has been developed by the Illinois Department of Family and Children’s Services and Child Welfare League of America. It is designed to teach knowledge and skills in five essential competency categories for foster parents and adoptive parents. These are:

- protecting and nurturing children;
- meeting children’s developmental needs, and addressing developmental delays;
- supporting relationships between children and their families;
- connecting children to safe, nurturing relationships intended to last a lifetime; and
- working as a member of a professional team.

Barnardos Break Away program conducts up to 8 basic sessions initially during the assessment/pre-placement process.

The BreakAway program places a great deal of time into ensuring no child is placed with a foster family until all pre-placement work is completed. For example, all of the child’s on going medical and therapy appointments will be made on the foster families behalf and all school placements will be finalised. A very detailed assessment about the child is shared with the prospective family prior to placement so they are totally prepared for the child and any issues that may arise. They see this as an essential component in adequately preparing the new family. The foster family would have met the child usually a number of times before the placement is finalised. Break Away have a initial set up fund of £1000 for foster families to ensure

14 www.cwla.org/programs/trieschman/pride.htm
they can purchase, cots, car seats, fire alarm, etc for the child prior to the commencement of the placement.

William Strikker Group require their foster families to attend 7 three hour sessions during their assessment process. William Strikker also develop two plans, a Helping Plan for the child which will cover all developmental areas that need to be addressed and a plan known as Foster Care Goals which is designed in consultation with the foster family. This includes areas identified by the foster family as important such as behaviour management plan for the child, personal issues and their training needs. A separate Financial Contract is also developed with the Foster Family to identify any costs associated with care. The Local Government area that has the responsibility for the legal care of the child will assist with covering any costs such as modifications to the house prior to the child arriving.

The PFLA program provides pre-placement training which is very specific to the child that the program has identified will be placed with the approved foster family. Families are required to attend 8 hours of orientation. The Kennedy Kreiger program provides an extensive placement training program utilising the PRIDE package.

PFLA and Kennedy Kreiger both have Treatment Foster Care Parent Job Descriptions which are detailed documents outlining the expectations for their therapeutic foster parents.

All of the programs stressed that they would not place a child in a family until they were sure that the family were adequately prepared, with equipment and resources arranged, all ongoing medical and therapy appointments organised, school placements prepared and they were confident that the family had a comprehensive understanding of the child’s needs and circumstances. Most of these arrangements are undertaken by the foster care program staff in collaboration with the child’s statutory social worker.

**How do Therapeutic foster parents relate to birth families?**

Relating to and working with the child’s birth family are an integral part of the therapeutic foster parents role. The foster parents I met all understand that they will need to work with the child’s birth family, often meeting them during access and contact visits. In programs I visited foster parents will take the foster child to and from contact visits as this is seen as critical in ensuring the child stays secure with the person caring for them. As in Australia access arrangements with birth families may vary from weekly visits, to overnight and weekend access, to less frequent contact. Access visits may be supervised or unsupervised by the legal authority depending on what has been ordered by the court. In the UK “letter box” contact in the form of
letters and phone calls may also occur. In Professional Foster Homes in Finland and Netherlands, birth parents may visit the child at their home or come to collect their child for access.

When preparing a child to be placed in a foster family, The William Strikker program will arrange a meeting between the child, their birth family and the foster family, often in the foster family home. This is seen as an important step in helping the child understand that his or her birth family are giving their approval for them to live with the foster family for a time.

How are foster families helped with behaviour difficulties?

An outstanding feature of the therapeutic foster care programs visited was that rather than children or families being referred to professionals from other services for assistance with behavioural difficulties, much of the specialist intervention required was developed for foster families by highly skilled foster program staff, through individual intervention programs and therapy.

I noted that there were no similar programs to the one I co-ordinate in South Australia, as the level of specialist support provided by the therapeutic foster programs visited was so extensive, that referral to another team or service was usually not required.

All therapeutic foster program staff were professionally qualified, many at Master’s level and most staff had very significant long term experience working with children with disabilities. Also significant was the fact that the programs were stable foster care programs with considerable history and expertise in their field of foster care for children with disabilities. Three of the programs visited were attached to agencies whose expertise was in the area of services for children and people with disabilities. The result of this is that program philosophy around disability was sound and staff were highly experienced. All of the programs had been existence for over 10 years, staff were permanently employed resulting in minimal staff turnover. The stability and long term nature of these programs also meant that policies, procedures and practice methodology were all well established and extremely comprehensive. Highly experienced staff, established processes and low staff turnover ensured very high program standards. Both programs visited in the US were members of the Foster Family Based Treatment Association and therefore adhered to this organisation’s practice standards. 15

15 www.ffta.org/publications/standards_tfc.html
The foster program staff visited all saw their role very much as providing clinical intervention to families as opposed to confining themselves to a support, counsellor or case management role. Specialist consultation was at times sought from Psychologists on a session basis if needed. However, all staff I interviewed felt very confident of their ability to assist their foster parents with the majority of behavioural or emotional difficulties that presented themselves.

Emotional and behavioural difficulties experienced by the child were addressed primarily using relationship based therapies by the programs in the Netherlands and Finland where Video Interaction Guidance was particularly used. In Finland Theraplay is also used to develop the child’s attachment to his/her foster parents.

In the United States, the programs I visited tended to use behavioural and developmental strategies more frequently to address behaviour problems. Foster families I spoke to reported that they did not feel overwhelmed by behaviour difficulties because they “were very well trained” and therefore had confidence that they knew what to do if challenges emerged.

With PFLA individual treatment protocols are developed which focus largely on skill development for both the child and the foster families along with positive behavioural responses to challenging behaviour. All of the children in the PFLA foster program have a therapy plan which will contain a behavioural protocol.

Relaxation program and self control program using cognitive picture rehearsal strategies are often used to address behavioural difficulties. (Both of these therapeutic techniques for people with intellectual disability were pioneered by the Groden Centre). The foster families are all skilled in ensuring that the

Dr Groden demonstrating relaxation training

child in their care practice relaxation every day and they are required to provide ongoing daily documentation of their child’s progress in this area.
**What respite is provided to Therapeutic Foster Families?**

All of the programs have a respite component inherent to the support they provide to foster parents. Respite offered to foster families was almost always family based. The program staff felt that the commitment to use only family based respite with the same respite family, ensured the child was secure as they know where they go each time. Many of the children have been going to the same respite families for many years. These long term relationships also meant that respite families felt confident in their ability to manage the child as the child grows up.

Barnardos Break Away provides every foster family with 35 nights a year respite through their Short Break Program which is also a mainstream respite program offered to any family caring for a child with a disability in the Dudley area. Their foster families may identify a person they know such as a family member to be their Short Break respite provider. The full assessment and approval process needs to be completed before they can become respite providers.

PFLA provides all of its therapeutic foster carers with US $7000 a year which can be used flexibly for respite. A night of respite will cost US $100, the hourly fee is US $10. The PFLA foster families may also use family members, neighbours as their respite providers. If the family wish to take their foster child on a holiday they may be given some money from this fund to assist with the cost. This is seen as a much better option than the child going into respite whilst the family is on holidays. The program finds that many of the parents prefer for the child to accompany them on holidays.

The Kennedy Kreiger program provides a 31 days of respite that can be used flexibly. Emergency respite is provided if needed and like PLFA and Barnardos Break Away they also have a full time respite co-ordinator attached to their program who foster families contact directly.

Foster families did not lose their subsidy payments whilst their child was in respite with any of the programs visited.

**What Training is Provided by the Programs to Foster Parents?**

All of the programs provided comprehensive training about their agencies service philosophy and expectations of therapeutic foster parents. The provision of comprehensive training to foster families around the impact of neglect and trauma on the child’s attachment relationships was major component of all foster programs visited.
Kennedy Kreiger TFC

At TFC all foster parents are required to attend a minimum of 24 hours of training a year. Six hours of this must be training specific to the child in their care. They are also required to attend peer sessions separate to this. Training provided through the Therapeutic Foster Care Program is coordinated by clinical social workers experienced in the delivery of services to children in the foster care system who have a variety of disabilities and medical conditions. Experts presenters, develop the training and technical assistance programs. The topics covered for therapeutic foster families are as follows:

- Supporting foster and adopted children with disabilities
- Impact of attachment and loss on children
- Strategies for helping children with emotional and behavioral problems
- Permanency planning
- Creative program design in foster care: New solutions to recurring problems
- Adoption issues impacting families and children
- Program placement services
- Outcomes and research

Discussion with a group of therapeutic foster parents attached to the program indicated that they feel very confident in how to respond to many behavioural issues that they encounter with their foster child, which they attributed to the high quality of training they receive from the program.

Groden PFLA

Therapeutic Foster parents receive pre-placement training, specific individual instruction relating to the child that will be placed with them and on going regular training sessions. The PFLA foster parents all have a Personal Instruction Plan which is completed by attendance at their group training sessions or by individual instruction with the program staff. The areas need to be completed by all foster parents are as follows:

Overview of treatment Foster Care
History and Philosophy of Groden Centre and PFLA
Organisation Structure & Teamwork
Their foster parents are also required to attend mandatory two hours a month training held by the program and their allowance will be deducted if they do not attend these. PFLA have common competencies they expect of all foster parents which are based on the PRIDE standards. They also use post testing to assess what their foster parents have learnt from their training modules.

**Barnardo’s Break Away**

Barnardo’s foster parents must attend ongoing training which is a rolling program and is very comprehensive. Families must attend the equivalent of three all day sessions a year. Barnado’s Manager Julia Tanner reported ensuring that training is inspiring and relevant to foster parent is essential, hence they will seek high quality presenters.

**What Are Therapeutic Foster Parents Paid?**

In 2004 the UK government established a national minimum allowance for foster carers in England and Wales. Breakaway Barnardo’s Manager Julia Tanner explained that their program recognises that caring for foster children with disabilities is a 24-hour job and they aim to pay an adequate amount to recognise this. They separate their payments into two. One is for the foster parent known as a fee, and the second is for the child and is referred to as a boarding allowance. Their foster parents are classed as self employed. They pay their foster parents a fee of £256 a week and this is not taxed. The Boarding allowance is paid per child to cover costs such as food, clothes and toys. This payment ranges depending on the age of the child from £110-200 per week.

PFLA classify their therapeutic foster families as consultants and they pay them between US$ 21,500-30,00 per annum depending on the needs of the child. This amount is not taxed. This is to cover all expenses associated with caring for the child. All health care, specialist equipment and education costs are provided for by the state.
an extra $7000 respite allowance per child which can only be used to fund respite for the foster family.

Kennedy Kreiger TFC also separate their payments into a salary of US $10,933 per annum along with a boarding allowance (to cover all costs associated with caring for the child) of US $7,620-7,800 per annum per child. A foster parent may have up to two children and if under 12 years of age could receive US $34,272 per annum.

In the US children’s health insurance also covers any specialist therapy needed such as speech and occupational therapy and this insurance is paid for by the local social services department. Any medical or other equipment needed for the child would be provided from this also.

In Finland foster parents are paid a subsidy of approximately €7200 per annum depending on the age of the child. A starting allowance of €2,500 if necessary would also be paid. All costs associated with the child’s health care, schooling (including a hot meal each day at school) and child care are provided by the local municipality.

Professional Foster parents who would be caring for approximately six significantly disabled children in their own home are paid €47,040 per year.

In Netherlands foster families caring for a child with a disability are paid approximately €6,205 a year. All education, health and therapy costs are provided free and a bicycle is supplied every five years.

How are Therapeutic Foster Programs monitored?

The Developmental Disabilities Unit exists with Rhode Island Department of Children Youth and Families. This unit oversees all children with disabilities in foster care. They require reporting on the child every 3 months and there is an annual review the children to ensure their care plans are being adhered to. This was considered to be a very useful unit as staff were very knowledgeable about the disability issues for the child.

In the UK every 6 months each looked after child must have a formal review meeting which is attended by the placement agency, the child’s statutory worker from the local authority, school staff and foster family. The meeting is chaired and supervised by an Independent Reviewer who has the statutory authority to ensure that all goals and decisions relating to the child’s progress whilst in foster care are being properly addressed by the individuals and agencies involved. I was able to attend one of these reviews for a child in the Barnardos
program and it was apparent from the meeting that the level of accountability required from all involved with the child was very high due to the expectations associated with the independent review process.

What other Supports are Provided?

Social and Peer Support

All of the programs visited provide a range of supports designed to bring their foster families together for social connection and peer support such as foster parents dinners, family activity days and support group meetings and newsletters. Kennedy Kreiger TFC have a foster mentor program where more experienced foster carers are connected with their newer foster parents. They have a Parent Staff Advisory Committee which meets regularly to ensure communication strategies are working for foster parents of the agency.

Other therapy

If children require specialist psychotherapy this is arranged by the foster program to be provided through private practitioners. In the US costs for this are covered with by child’s medical insurance. Other therapy such as physiotherapy, speech and occupational therapy is provided through the school system.

Education Support

In the US all children with disabilities are required to have an Individual Education Plan (IEP) under the IDEA Act 1997. Under this legislation children with disabilities are entitled to a free and appropriate public education. To assist foster families with the education of their foster child, Educational Advocates are available through the Groden and Kennedy Kreiger programs. These are attorney’s or consultants who are specifically trained in understanding and interpreting policies around education as it relates to children with disabilities. Bruce Ruby explained access to such education advocates is seen as essential in ensuring that children with disabilities are able to receive the appropriate education placement and levels of specific support needed whilst at school.

The PFLA program staff work closely with schools, sharing the therapeutic plan with the child’s school. If the child’s behaviour becomes problematic for a school then the school is required to ensure that the placement is appropriate for the child and that services and behavioural intervention is put into place. If this cannot happen then a more appropriate school placement will need to be found for the child.
“Zero tolerance policies” around behaviour and suspensions of children with disabilities can’t be used by schools to exclude a child with a disability. For a child with a disability to be suspended or excluded from school, it must be determined that the child’s disability did not effect the child’s understanding of the impact and consequences of the behaviour and that the child’s disability did not impair their ability to control their behaviour.

Most foster parents reported that as a result children with disabilities were not suspended or excluded from school often.

---

**A Therapeutic Program for Families with Children with Disabilities in Finland**

In Finland, foster families caring for a child with a developmental disability or brain injury are eligible to access a specialist residential program provided by the Mannerheim Child Welfare League. I was fortunate to spend time at this extremely impressive center in Finland and to participate in therapy and a supervision session with staff and two foster parents.

Huvitus Rehabilitation and Development Centre, is approximately an hour from Turku in southwestern Finland. The intensive live in stays are available to any family in Finland who has a child with a diagnosed developmental disability, psychosocial problems or brain injury. Foster families are also able to attend.
Huvitus offers the entire family including all siblings, the opportunity to stay in cottages for five days up to four times a year where the emphasis is on building the strengths and resources of the family by developing positive and nurturing interactions between them.

During their five day visit a wide range of activities are provided for families to undertake together. For example, there is a fully equipped music room, a pottery studio with kilns, a printing room, a huge indoor adventure playground with climbing ropes and adventure obstacles, a kitchen for families to cook together a sensory room for relaxation, as well as a sauna.

Print Room, Huvitus

As Huvitus is set in an old orchard surrounded by very picturesque countryside, families are encouraged to take walks and picnics together, horse-ride, kayak or swim when the weather is warmer. Whilst there, families can remain totally focused on themselves and their relationships. Also provided are information sessions during the day for parents where they learn about their child’s particular disability. Groups for siblings are concurrently held were the emphasis is on building the siblings strengths through positive peer interactions.
All therapists at Huvitus are highly skilled and experienced professionals. The extent of supervision and staff development provided for staff was exceptional.

Huvitus accommodates around 600 families a year. Costs including all meals and transport from anywhere in Finland is proved free as part of the program and 80% of each parent’s salary is also paid to enable both parents to take leave from their employment so they can attend Huvitus. Funding for this program is totally provided through Finnish Slot Machine Association to the Mannerhein League.

The staff are multi-professional and provide therapy for families if they are struggling with the child’s behavior. The therapeutic approach used by the Huvitus staff is solution focused and relationship based.

Theraplay is an interactional intervention between the child and foster parents and is used often on a longer term basis with foster families bringing them weekly to Huvitus for individual and family sessions.
A Therapeutic Program for Families in the Bronx, New York

Rose F Kennedy Early Childhood Centre

The Early Childhood Centre is part of the Yeshiva University’s Rose F Kennedy Centre situated in the Bronx, New York. It services families from the area who have children aged 0-3 years. (Early intervention in NYC is 0-3 after this children move to the Department of Education for intervention which is usually always school based.)

It was a privilege to meet the Center’s Director is Dr Susan Chinitz\(^{16}\) who is an eminent psychologist who specialises in infant mental health and developmental disabilities.

Dr Chinitz is also president of the New York Zero-to-Three Network, an organization that promotes the optimal development of young children, their families and their communities. Dr Chinitz explained the work of the Centre and the therapeutic approach used. Her program has 10 Clinicians who provide relationship based therapeutic interventions for young children with developmental and or behavioral concerns and their parents and foster parents.

Their highly experienced family therapists provide dyadic relationship based therapy using the model developed by Mary Dozier of University of Delaware\(^{17}\) designed to develop attachment and self regulation in young children. The Centre provide foster parents with this 10 week program including some home based sessions. Approximately 30-35% of the children they see are in foster care.

The Centre also provides a therapeutic visiting program for birth parents whose children are in foster care. This program was developed to assist birth parents better engage with their children during contact visits. They aim to develop the birth parents interactions and relationship with the child thereby hopefully increasing the likelihood of the child returning to their care. Foster parents are frequently involved in this program as therapeutic visits may occur in their homes under the supervision of a “visit coach.”

---

\(^{16}\) Chinitz, S. Intervention with children with Attachment Disorders Developmental and Behavioural Pediatrics, Vol 16, No 3 1995

PROFESSIONAL FOSTER HOMES IN FINLAND AND NETHERLANDS

Professional foster homes have developed in Finland and in the Netherlands over the last two decades. These are private homes where couples agree to take in children with very severe disabilities (usually who have been in institutional care) and provide them with a long term foster placement. In Finland professional foster homes usually have around 6 children and the foster couple work full time in this role. They are paid a salary of approximately €36,000-47,040 per year. The professional foster parent is paid by the municipality who placed the child with them and they have employee type status with the municipality. In Finland professional foster parents are required to have post graduate qualifications usually in social work, health, education or disability. Professional foster homes have expanded rapidly in Finland throughout the 1980’s. Approximately 16% of children in care are in professional foster homes around 36% are in regular family foster care, with the remainder in either institutional or kin care. Pesapuu indicated that they have some reservations around the consistency of the scrutiny of these homes as this depends in which municipality the foster home is located.

In the Netherlands professional foster homes also grew from the movement to transition children with disabilities out of large institutions into family based living.

Joke and Eddie Nijland and their foster family

Couples, who had been employed originally as carers in large institutions, began to provide long term foster homes for these children so they could move out of the institution.

In the Netherlands I spent time with Joke and Eddie Nijland who are professional foster parents for a group of 6 young people all of whom have an significant intellectual disabilities. Joke and Eddie

---

commenced in this role over 15 years ago when the institution they were working for asked them to take initially one child into their home. They were then assisted by the institution to purchase an adjoining house which was totally renovated and fully integrated into their home. They were paid a salary so they could devote themselves full time to caring for a number of children, which they have done ever since.

Their beautiful home is a warm and very comfortable one in which their 6 foster children (now all young adults ranging in age from 16 to 27 years) have resided now for many years. It was a absolute highlight to spend a day and evening with this dedicated and remarkable foster family and to share with them in a normal day and evening routine. The young people in Eddie and Joke’s care enjoy a wonderful quality of life where they participate fully in normal family routine, enjoy access to community activities and sport and attend school or day programs.

Eddie and Joke are very attached to each of their foster children and view each of the young people in their care as totally part of their family. When they require a break which is once or twice a year, their adult biological son comes and stays at the home to provide the care to the young people. Eddie and Joke have excellent relationships with their foster children’s birth families, and many come and visit their children at the Nijland home.

The progress of all of the young people in the Nijland’s care has been remarkable. All of them came to their home with significant behavioural problems such as severe attachment difficulties, tantrumming, screaming and self injury.

With assistance from the William Strikker PIP program and years of persistence from themselves they proudly informed me that today none of their foster children have any behaviour issues, and none are on medication.

Eddie and Joke are each paid a full time salary of €1700 per month. All costs for the foster children i.e. food, clothes, nappies and ancillaries are paid for by the state. They are also provided with a mini van which is only for use to transport the family.
Joke and Eddie pay for 50% of the running costs associated with their home such as insurance and repairs. A family friend comes once a week to help with cleaning.

They report that the salary means they enjoy a comfortable standard of living but they view themselves as a family not as a group home and stressed that their biggest reward comes from the young people themselves.
I attended and presented a paper at the Foster Family Based Treatment Association (FFTA) Annual Conference. The conference in Houston was attended by 800 therapeutic foster care staff and foster parents. There were 70 presentations & workshops held over the two and a half days. It was a highlight to present on the Alternative Care Disability Support Program and to meet so many of the conference delegates.

With Bruce Ruby of PFLA at Conference Dinner and Woodlands Resort, Texas
RECOMMENDATIONS

It is recommended that:

Therapeutic foster care is a very effective model of foster care for children with disabilities who are unable to remain with their birth family and needs to be developed further in Australia.

Therapeutic foster care programs for children with disabilities need to contain developmental, behavioural and relationship based interventions in order to successfully address the complex behavioural and emotional issues that often exist for foster children.

Relationship based interventions are an important component of therapeutic programs and Video Interaction Guidance and Theraplay® are potentially effective therapeutic techniques which can greatly assist foster families.

As therapeutic foster care programs are highly specialised, program staff need to be appropriately qualified professionals with sound therapeutic skills. Programs should be multi disciplinary.

A practice model be utilised where the approach is family centred and recognises and values the therapeutic foster parent as part of a team.

Therapeutic foster care programs need to contain the components of recruitment, assessment, development, training, matching and sustaining foster families and these components need to be disability specific in order to ensure families are appropriately recruited and properly prepared.

Agencies which have expertise in disability such as autism, intellectual disability or care of medically fragile and physically disabled children be explored as providers of therapeutic foster care programs.

Therapeutic foster care be recognised as requiring a 24/7 commitment and that payment for foster parents be at a rate which recognises this level of commitment. It is recommended strongly that this needs to occur if new foster parents are to be successfully recruited.

Interagency collaboration by foster care programs, especially with the education sector is essential for children with disabilities in foster care.
It is recommended that an independent reviewer from the agency with legal authority for the child be appointed to improve accountability and to ensure that goals are adhered to by the entire team involved with the child, including foster parents. It is recommended that such reviews are held at least annually.

It is recommended that adoption be considered as an option for children with disabilities who cannot be reunified and whose foster family have formally expressed and have demonstrated a long term commitment to the child.