

Achieving Exits to Permanency for Children in Long Term Care

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Despite the federal emphasis on achieving timely permanency for children who enter foster care, some children continue to remain in foster care for extended periods, with approximately 20,000 children a year “aging out” of foster care into adulthood without having achieved permanency in a family setting (Dworsky, 2008). This literature review focuses on the federal Child and Family Services Review measure that measures agency performance related to achieving permanency for children in foster care for long periods of time. The review summarizes the factors associated with timely discharges from care; while each child and family involved with the child welfare system brings a set of unique challenges and characteristics, research points to common individual and system factors that may be associated with long stays in foster care. Broad strategies that may be linked to achieving permanency are described, followed by explicit models developed to increase the likelihood of timely permanency.

Keywords: Child welfare, permanency, outcome, policy

INTRODUCTION

Despite the federal emphasis on achieving timely permanency for children who enter foster care, some children continue to remain in foster care for extended periods of time, with approximately 20,000 children a year “aging out” of foster care into adulthood without having achieved permanency in a family setting (Dworsky, 2008). While the U.S. Department of Health and Human Service, Administration on Children and Families (ACF; U.S. DHHS, 2007) states that “the vast majority of children who are discharged from foster care prior to their 18th birthday and who are legally free for adoption are discharged to a permanent home (including guardianship, adoption, and reunification),” long-term foster care remains a reality for those children who cannot safely reunify with their birth families, who do not have kin available for permanent placement, and for whom adoptive families have not been found. There are multiple factors associated with the failure to achieve timely permanency through reunification or adoption. These correlates were explored in the preceding literature reviews on reunification and adoption timeliness, which identified a series of child, family, and system level factors.

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COMPOSITE MEASURE FOR EXITS TO PERMANENCY/ LONG TERM CARE

The focus of the authors in this literature review is the federal Child and Family Services Review (CFSR) composite measure that seeks to measure agency performance related to achieving permanency for children in foster care for long periods of time. The long-term care composite is the third of four federal measures aimed at assessing the goal of achieving permanency for children in foster care. Like the other permanency measures related to timely reunification, timely adoption, and placement stability, it is a composite measure combining multiple individual indicators, each of which measures a different dimension of the overall domain, into a single composite score. This composite captures information regarding the amount of time children are staying in foster care before they are ultimately placed in future permanent homes or emancipated as legal adults. The three specific indicators that make up the composite measure are:

Component A: Achieving permanency for children in foster care for long periods of time.

- **C3.1:** Of all children in foster care for 24 months or longer on the first day of the year, what percent were discharged to a permanent home by the end of the year and prior to turning 18?
- **C3.2:** Of all children discharged from foster care during the year who were legally free for adoption, what percent were discharged to a permanent home prior to turning 18?

Component B: Growing up in foster care.

- **C3.3:** Of all children in foster care during the year who were either discharged to emancipation or turned 18 while still in care, what percent had been in foster care for 3 years or longer?

As outlined above, the long-term care composite has two conceptual components that are captured by the three indicators (U.S. DHHS-ACF, 2007). Component A focuses on achieving permanency for children who have been in foster care for extended periods of time. Component B focuses on youth who emancipate or age out of foster care, measuring the percentage of these youth who spent three or more years in care.

The individual indicators are assigned different weights in the calculation of this score as follows:

- C3.1 comprises 33% of the total long-term care composite.
- C3.2 comprises 25% of the total long-term care composite.
- C3.3 comprises 42% of the total long-term care composite.

For the purposes of this measure, a child is considered to have achieved permanency if he or she is reunified with the parents/caretakers, living with other relatives, placed in permanent legal guardianship with a kinship caregiver, or adopted. A notable feature of the long-term care composite measure is that it includes kinship guardianship (without adoption) as a permanency outcome, a change from previous evaluation methods in which guardianship was not considered a permanent outcome because it did not entail legal adoption.

FACTORS ASSOCIATED WITH LONG TERM STAYS IN FOSTER CARE

Although the majority of children who enter foster care are reunited with their families of origin, some children and families experience alternative outcomes including: adoption, guardianship, placement with relatives, or long term foster care (CWLA, 2009; DeMarco & Austin, 2002; Pabustan-Claar, 2007). This section summarizes research related to children who remain in long term foster care, identifying the factors associated with timely discharges from care or extended stays in care. While each child and family that becomes involved with the child welfare system brings with them a set of unique challenges and characteristics, evidence indicates that there may be common individual and system factors associated with long stays in foster care. It is important to note that the research evidence does not establish that these individual and system factors cause extended stays in care, merely that a relationship exists between the factor and the duration of stay (Biehal, 2007).

Case/Agency/System-Level Factors

The case-, agency-, and system-level factors associated with long term stays in foster care include: reason for removal, caseworker characteristics, type of permanency plan, and placement characteristics.

Reason for removal. Evidence indicates that, in general, neglect is the most common reason children enter care (Albers, Reilly, & Rittner, 1993; Courtney, 1994). While there is limited research examining whether reasons for removal are associated with longer stays in care, one study found that children placed in care as a result of physical abuse have the shortest stays in care compared to those who experienced neglect or sexual abuse (Benedict & White, 1991).

Caseworker characteristics. Some researchers have examined whether the characteristics of child welfare caseworkers have an impact on timely discharges. In one study researchers found that children with workers who had a degree in social work were more likely to be in a permanent placement within three years compared to those with non-social work degrees (Albers et al., 1993). In another study researchers reported that the attitudes and biases of caseworkers may have an impact on permanency planning, especially for older youth; negative stereotypes about adolescents (e.g., rowdy, hormonal) especially Black male adolescents, led to the conclusion that permanency simply “does not work” for teens (Freundlich & Avery, 2005).

Pursuit of permanency plan. Evidence indicates that the type of permanency outcome pursued may be linked to the time that a child spends in care. For example, in a study of the timing of exits from care researchers found that discharge occurred earliest for children exiting to guardianship, followed by reunification, emancipation, and then adoption (McDonald, Poertner, & Jennings, 2007). In a second study researchers found that families whose formal permanency plan involved reunification had significantly quicker discharges from care than other families (Benedict & White, 1991). There is evidence that children and families are sometimes unaware of any goals or plans for permanency while in foster care, resulting in no clear plan for leaving (Freundlich, Avery, Gerstenzang, & Munson, 2006). Finally, researchers focusing on time spent in care after the termination of parental rights (TPR) have found that almost half the time spent in care occurs after the rights of parents are terminated (Kemp & Bodonyi, 2002; Meezan & McBeath, 2008). This suggests that while enforcement of TPR is intended to expedite permanency for children not returning home to their family of origin, the unintended consequence may be that large numbers of children still linger in foster care without connections to any family (Smith, 2003).

Placement characteristics. Factors related to placement experiences may also be associated with the time it takes to achieve permanency. For example, researchers have found that placement instability (e.g., multiple care settings) is associated with longer-term stays (three years or longer) in care (Albers et al., 1993). In some studies researchers have found that being placed in a congregate care setting (e.g., group home) may also be associated with slower exits from care (Freundlich & Avery, 2005; Wulczyn, 2003). A less explored topic involves the physical location of the foster care placement. Some evidence suggests that greater distance between the foster care placement and home of origin may be associated with slower permanency planning efforts for children (Freundlich & Avery, 2005). The fact that children come from or are placed in an urban area may also be linked with longer stays in foster care (Wulczyn, 2003).

In a number of studies researchers have found that placement in kinship care may be related to longer stays in foster care (Benedict & White, 1991; Berrick, Barth, & Needell, 1994; Courtney & Park, 1996; Smith, Rudolph, & Swords, 2002; Vogel, 1999; Wulczyn & Goerge, 1992). Further investigation into the reasons why children placed with relatives remain in foster care for longer periods reveal that kinship care providers are less likely to adopt the child in their care. However, they often report being willing to care for the child until they are “of age,” and since they are already family to the child, many feel it is already similar to adoption (Berrick et al., 1994). In a multi-state study, researchers found that children placed in the care of relatives in Arizona, Connecticut, and Illinois were less likely to have a timely discharge from care than other children; while in Ohio and Tennessee, children placed with relatives were more likely to have a timely exit from care than other children (Koh, 2008). In a California study researchers compared permanency outcomes for children placed with relatives to children placed in non-kin foster homes and found that children placed with kin tended to stay in care longer (Pabustan-Claar, 2007). This may be explained by the following factors: (1) inadequate services and support for kin caretakers; (2) lack of communication with relatives regarding options for caring for the child (e.g., subsidized guardianship, adoption); and (3) inadequate financial support for children to stay with kin outside of government supported placements (Pabustan-Claar, 2007).

Family-Level Factors

Family-level factors associated with long-term stays in foster care include economic status, substance abuse, and mental health issues.

Economic status. In one study researchers examining family economic status revealed that children from families receiving Aid to Families with Dependent Children (AFDC) were significantly less likely to be discharged to families (biological or adopted) and more likely to be in foster care for three years or longer (Albers et al., 1993). In another study researchers focused on Medicaid enrollment status, finding that children enrolled in Medicaid prior to entering care were less likely to exit care within 12 months (Becker, Jordan, & Larsen, 2007).

Substance abuse/mental health. Children of parents with alcohol or drug addictions tend to have longer stays in care (Benedict & White, 1991; Vanderploeg et al., 2007). Similarly, parents struggling with mental illness face challenges to reuniting with their children that may result in non-reunification and prolonged stays in care for their children (Risley-Curtiss, Stromwall, Hunt, & Teska, 2004).

Child-Level Factors

Child-level characteristics associated with long-term stays in foster care include: age, race and ethnic background, health and disability status, and sexual orientation.

Age. Researchers yield mixed findings regarding age of the child and timely exits from foster care to permanency. For example, some studies have found that older children are more likely to stay in foster care for longer periods (over three years) than younger children (Albers et al., 1993; Park & Ryan, 2009). This may be due to the fact that many permanency plans for older children involve an exit to independent living and not to a family setting (Freundlich & Avery, 2005; Freundlich et al., 2006). However, age at entry and type of permanent placement appear to complicate this effect. For example, some studies have found that children who enter care as older children are more likely to be reunified or adopted in a timely manner, while children who enter at a young age tend to stay in care longer (Albers et al., 1993; Vogel, 1999). Moreover, other evidence indicates that infants who enter care before the age of one are especially likely to experience longer stays in care, compared to all other age groups (Vogel, 1999). Taking a closer look, infants in care have been linked with low likelihoods for reunification with their families, but they are the most likely to be adopted (Barth, 1997). In this study, infants were not found to linger in care as much as toddler age children or children between the ages of three and five (Barth, 1997). Still in other studies researchers have found that older youth, especially those over the age of 15, are less likely to be adopted if not reunited with their family and more likely to stay in care until emancipating from the system (Church, 2006).

Race/ethnic background. The relationship between race and ethnicity and longer stays in care has been a subject of concern in recent years. Multiple studies have found that African American children are over-represented among those who linger in care (Albers et al., 1993; Barth, 1997; McMurtry & Lie, 1992; Park & Ryan, 2009; Schwartz, Ortega, Guo, & Fishman, 1994; Smith et al., 2002; Wulczyn, 2003). African American children under age 10 appear to be especially likely to remain in care three years or longer (Albers et al., 1993). In contrast, researchers in one study reported that race was not a significant predictor of longer stays in care (Vogel, 1999). Researchers examining the experiences of Latino or Hispanic children have produced similarly mixed results. For example, in one study researchers found an equal likelihood of adoption or remaining in care for Latino children who did not reunite with their families (Barth, 1997). In other studies, however, they found a link between Hispanic ethnicity and spending longer periods in out-of-home care (Church, 2006; Courtney & Park, 1996; Park & Ryan, 2009). In one study where researchers compared White children to all non-White children they found that non-White children were less likely to exit foster care within 12 months (Becker et al., 2007).

Health/disability status. Children with health issues or who are disabled are more likely to experience longer stays in foster care compared to other children (Baker, 2007; Benedict & White, 1991). Children with a mental illness, developmental disability, or experiencing a psychiatric crisis have a lower likelihood for exiting care within 12 months (Becker et al., 2007; Park & Ryan, 2009). For African American children in particular, the odds of staying in care longer increase if they have had prior psychiatric episodes (Park & Ryan, 2009).

Sexual orientation. Sexual orientation may be related to duration in care, as child welfare workers are more likely to label youth who identify as lesbian, gay, bisexual, transgender, or queer (LGBTQ) as "difficult," often based on a lack of understanding about how to care for these youth. A study conducted in New York found that the LGBTQ youth in their sample remained in care on average for over four years, despite ASFA's time limits (Mallon, Aledort, & Ferrera, 2002).

PROMISING PRACTICES FOR ACHIEVING TIMELY EXITS TO PERMANENCY

In this section we focus first on identifying broad strategies that may be linked with achieving permanency and shortening the time children stay in care. Then attention is given to explicit models developed to increase the likelihood of timely permanency for children who are not reunited with their families and also not likely to pursue an adoptive placement. The information includes strategies that have been broadly linked to achieving family reunification, rather than focusing on the far more limited set of practices with an extensive research record proving effectiveness. The absence of rigorous research evidence does not necessarily mean that a particular approach has no impact on family reunification, but rather that potential impact cannot be conclusively determined.

Service Models

Public over private sector service delivery. A study conducted in Milwaukee by researchers exploring this issue found that children placed in public foster care homes or homes managed by smaller and newer community-based private agencies were more likely to be discharged to a permanent home sooner than children placed in foster care homes managed by larger and older private agencies (Zullo, 2002).

Collaboration in service provision. A collaborative system of service provision involving the birth family, foster family, child welfare services, and other relevant service providers may help to address the complex challenges faced by families involved with child welfare services (Lee & Lynch, 1998). Involving all parties in the process from the very beginning, through coordination and continual communication, may help to facilitate the successful and timely discharge of children and families from the child welfare system.

Replacement or Reconnection with Birth Families

After TPR, ties between parents and children are often completely severed and all contact lost (Mapp & Steinberg, 2007), yet children are remaining in care for long periods of time following TPR without a permanent family setting (Kemp & Bodonyi, 2002; Smith, 2003). To address this issue, Texas developed the *Replacement with Birth Families Project* to rekindle connections that had been lost between children and their birth families (Mapp & Steinberg, 2007). Designed for children who had been in foster care for three years or longer and had no permanent placement plans, the program placed 14 children with biological parents, with the result that several more re-established communication and a connection with family members that had either been lost or previously unidentified.

Subsidized Guardianship

Guardianship in the child welfare context refers to a permanent relationship between a child and an adult guardian (e.g., relative, friend, foster parent) who is legally responsible for the child's health and welfare (Brooks, 2001). The rights of the child's biological parents do not need to be terminated for a guardianship to be created, and parents retain their right to visit and keep contact with the child (Brooks, 2001; Testa & Rolock, 1999). In this way, permanency occurs for the child by maintaining contact with their family of origin, while living in a stable, permanent environment with a legal guardian. Providing a financial subsidy to guardians allows families to care for the child who otherwise could not afford to do so (Brooks, 2001). ASFA permits states

to subsidize guardianship, but does not provide the state with the financial incentives that are provided for adoptions (Brooks, 2001; Cahn, 1999).

Evidence suggests that when the legal and financial implications of subsidized guardianship are fully explained and relative caretakers are further supported with post-discharge services, they will often agree to provide care on a more permanent basis (Testa, 2004; Testa & Rolock, 1999). A study with kinship caregivers revealed that, although most would not be comfortable with adoption due to their beliefs that this would signify “giving up” on the parents of the child, most would be willing to take on guardianship that was financially subsidized (Testa, Shook, Cohen, & Woods, 1996). A rigorous evaluation of a demonstration project piloting a subsidized guardianship option for families identified as ineligible for family reunification or adoption found that permanency rates increased for children in care (Testa, 2001, 2002). Among relatives who agreed to subsidized guardianship, grandmothers were the most likely to take on the role of guardian to the child (Testa, 2001). However, findings did not indicate a decrease in the time it took to exit to permanency (Testa, 2002).

Youth-Driven Permanency

Some researchers suggest that an effective strategy to ensure timely and successful permanency placements for older children and adolescents is to involve youth in the plan for their discharge from foster care (Charles & Nelson, 2000; Freundlich & Avery, 2005). The youth perspective on permanency places emphasis on relational permanency (meaningful and supportive emotional attachments) over physical or legal permanency (Sanchez, 2004). Involving youth in permanency planning might include asking them to identify potential adults with whom they could live if reuniting with their family is not an option. Involvement in permanency decisions is particularly important for youth who identify as LGBTQ, as their unique needs may be inadequately addressed in foster care settings (Jacobs & Freundlich, 2006).

The Babies Can't Wait Initiative

The Babies Can't Wait Initiative (BCWI) is a collaborative movement that began in 2001 in New York City to enhance communication and coordination between the child welfare system and the courts in order to better address the needs of infants in foster care (Dicker & Gordon, 2004). Activities of BCWI included:

- Reviewing the laws that relate to infants in foster care to gain a greater understanding of the system and ensure that the needs of infants were being met.
- Identifying and bringing together local stakeholders, including service providers and community members.
- Raising awareness among judicial leadership of the needs of infants in foster care.
- Building a knowledge base by:
 - Providing a series of lunch time training sessions for those involved in child welfare court processes.
 - Developing a brief checklist and handbook for judges and service providers.
 - Distributing local community resource information regarding health and social services for infants.

Effectiveness. At this time, there is no research evidence regarding the efficacy of BCWI. However, anecdotal evidence indicates that the program has a positive impact on its local community through increased collaboration and coordination between service systems (Dicker & Gordon,

2004). Infants involved in the pilot program experience increased attention to meeting their health needs in a timely manner. The program has expanded beyond New York City to other parts of New York State along with plans to expand nationally.

Implementation. The costs associated with implementing BCWI involve: training resources; time required to initiate and plan for collaboration and coordination between agencies; and materials for developing checklists, handbooks, or other resources. For more information contact Sheryl Dicker, JD, at sdicker@courts.state.ny.us.

Court Appointed Special Advocates

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

Effectiveness. Evaluations of CASA programs provide generally favorable evidence on the positive impact of CASA volunteers in child welfare cases. However, it is difficult to specify how CASA involvement affects child welfare outcomes because CASA volunteers are not involved in all child welfare cases, are assigned at various points-in-time of the case, and are not randomly assigned to cases when they do get involved. A systematic review of the literature found convincing evidence of a link between CASA involvement and positive permanency outcomes (Youngclarke et al., 2004). Specifically, several studies found that children involved with CASA or another court appointed advocate were more likely to be adopted or reunited with their families compared to children without such involvement (Abramson, 1991; Youngclarke et al., 2004). One study found that children with CASA involvement had significantly fewer placements while in care and spent a significantly shorter average length of time in care (Calkins & Millar, 1999). In fact, children with a CASA volunteer had approximately one-third fewer placements and spent an average of eight fewer months in care than children without an assigned CASA volunteer (Calkins & Millar, 1999). However, there is contrary evidence indicating that CASA involvement may not make a significant difference in outcomes for children in foster care (Litzelfelner, 2000).

Implementation. The CASA organization bears all costs for training, providing volunteers, and necessary resources. For more information contact the National CASA Association, staff@nationalcasa.org or <http://www.nationalcasa.org/index.asp>, or the California CASA Association, staff@californiacasa.org or <http://www.californiacasa.org/index.htm>.

Kentucky Adoptions Opportunities Project

The Kentucky Adoptions Opportunities Project (KAOP) is a multi-system permanency planning approach involving the collaboration of the child welfare system, the courts, and the county attorney's office (Martin, Barbee, Antle, & Sar, 2002). The broad goal of KAOP is to expedite permanency planning (within 12 months of petitioning for a placement) for children deemed as "high risk" for lingering in the child welfare system. KAOP seeks to achieve this goal through the use of: (1) risk assessment and concurrent planning; (2) consistent child representation in court; and (3) early foster care placement in a foster/adoptive or kinship home. Risk assessments are conducted utilizing a structured assessment instrument, and concurrent planning is integrated with Kentucky's solution-based casework model (Martin et al., 2002). Consistent child representation in court is facilitated by designating one dedicated attorney to the project in each county.

Effectiveness. The evaluation of the KAOP pilot produced generally positive findings (Martin et al., 2002). Evidence suggested that cases and court hearings progressed in a timely manner at the start, but began to slow down toward the end of the study period. Specifically, permanency planning hearings and periodic reviews were often delayed, and thereby delayed the achievement of permanency. However, children in the KAOP group did experience significantly shorter lengths of time in care before achieving permanency, compared to the general foster care population in their region. Children involved in KAOP in urban areas remained in care 11.6 (vs. 31.8) months, while KAOP children in rural areas stayed in care 16.9 (vs. 24.7) months.

Implementation. Resources to implement KAOP involve training staff, taking time to bring together and educate stakeholders who will participate in the project, and additional time that may be needed for certain activities that may be new to the case process, such as risk assessments. For more information, contact Anita P. Barbee, PhD, apbarb01@louisville.edu, or Becky Antle, PhD, blfree01@louisville.edu.

Multidimensional Treatment Foster Care/Early Intervention Foster Care

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

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

Clinical and treatment components involve:

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

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

Effectiveness. MTFC has been rigorously evaluated in various settings and with diverse populations. While only results relevant to timely exits to permanency are presented here, more detailed information is available on the MTFC website.

In two evaluations where researchers compared child welfare outcomes for pre-school age children in foster care who received MTFC-P with children who received traditional foster care services they found that MTFC-P had a positive impact (Fisher et al., 2005; Fisher, Kim, & Pears, 2009). While researchers in neither study found a significant difference in the number of attempts made to place children in permanent placements, in one study they found that children who received MTFC-P achieved a significantly higher number of successful permanent placements (Fisher et al., 2009), and in the second study they found a significantly lower number of failed placements (Fisher et al., 2005). Of the successful permanent placements, MTFC-P appeared to be especially effective in facilitating successful adoptions (Fisher et al., 2009). Looking at time to permanency, in the earlier study they found no significant difference in time spent in care between the MTFC-P and non-MTFC-P groups (Fisher et al., 2005). However, in the 2009 study they found that a significantly higher number of children in the MTFC-P group experienced a successful permanent placement within 24 months of entering care, compared to the non-MTFC-P children (Fisher et al., 2009).

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

- 1 Full time program supervisor,
- 1 Half time individual therapist,
- 1 Half time family therapist,
- 1 Half time skills trainer,
- 1.75 FTE foster parent recruiter, trainer, and PDR caller,
- 1 Foster family per placement, and
- Psychiatric services on an hourly fee basis.

The full start-up process takes approximately one year and begins with a site visit from TFC Consultants, Inc. to describe MTFC, identify possible staff and participants, and develop an implementation plan and timeline. This is followed with a four-day staff training session at the model site in Oregon. Participating foster parents attend a two-day training session at the site

where the program is being implemented. On-going consultation and support are provided as well. For more information, contact TFC Consultants, Inc., <http://www.mtfc.com/index.html>.

Structured Decision Making Case Management System

Structured Decision Making (SDM) is a comprehensive case management model used by a child welfare system to assist caseworkers in conducting assessments and making well-informed decisions (CEBC, 2008a). The model is intended to allow caseworkers to utilize objective assessment procedures at critical decision points during the case in order to improve decision making (CEBC, 2008a). Beginning with the opening of a case, workers assess the risks and strengths of a family through the use of a standardized assessment tool and develop a case plan for the family based on results of the assessment (Johnson & Wagner, 2005). The case plan identifies specific services for the family, along with explicit expectations for visitation between child and parents (Johnson & Wagner, 2005). Subsequent reviews and adjustments of the plan are made throughout the life of a case with the use of standardized assessment tools (Johnson & Wagner, 2005). SDM is currently employed in 30 different child welfare jurisdictions throughout the U.S. (Children's Research Center, 2009).

Effectiveness. Evidence supporting the effectiveness of SDM in a variety of uses continues to grow (Children's Research Center, 2009); our focus in this review is on its use in promoting timely exits to permanency. Michigan began reforming its child welfare case management system in the mid-1990s, incorporating elements of SDM into its new model for case management shortly after the passage of ASFA (Johnson & Wagner, 2005). A study was conducted comparing the outcomes of children who received SDM case services to children who received "services as usual" (Johnson & Wagner, 2005). The results indicated that by the end of the 15-month study period, children served by the SDM model achieved permanency at significantly higher rates than children in the comparison group. Children in the SDM group also had significantly higher rates of adoption and family reunification and lower rates of re-entry into foster care after being reunited, though differences in re-entry rates were not statistically significant.

Implementation. Costs associated with implementing SDM are minimal, as existing agency resources are usually all that is needed (CEBC, 2008a). Onsite staff training may be required (2–4 days), and the use of an information management system is highly recommended. More information is located at: http://www.nccd-crc.org/crc/crc/c_sdm_about.html.

Wraparound Services

Wraparound services were specifically designed to meet the needs of children with behavioral problems, mental health problems and delinquency who are involved in multiple systems of care (CEBC, 2008b). Wraparound services are also referred to as individualized care (Evans, Armstrong, & Kuppinger, 1996). The program engages family members, service providers, community supports, and other important adults in the child's life in order to collaborate on an individualized plan of care (CEBC, 2008b). Wraparound expands on existing positive assets of the family, the child, and the community to build relationships, strengthen natural support systems, keep the child in a stable community placement, and avoid institutional care. The values embedded in the Wraparound framework require that services are "individualized, family-driven, culturally competent, and community-based" (CEBC, 2008b, para. 3). The program includes the following four phases: (1) engagement and team preparation, (2) initial plan development, (3) implementation, and (4) transition (CEBC, 2008b).

Effectiveness. Wraparound service programs vary widely in their planning, scope, and implementation, making it difficult to compare the results of evaluations (Clarke & Clarke, 1996; Walker & Schutte, 2005). Efforts to explicitly define the model for the purpose of research and evaluation are still evolving (Ferguson, 2007). The limited evaluation evidence generally indicates a positive impact on timely exits to permanency. For example, in one study where researchers evaluated the Fostering Individualized Assistance Program (FIAP) and compared the outcomes of children in foster care who received FIAP with children who received traditional foster care services found that children in the FIAP group were significantly more likely than the non-FIAP group to be in a permanent placement by the end of the study period (Clark, Lee, Prange, & McDonald, 1996). Moreover, the study targeted children who, at the start of the study, had already been in out-of-home care for an average of 2.6 years, making the findings from this evaluation especially relevant to achieving timely permanency. Another study that also focused on children who had already experienced extended stays in out-of-home care (averaging over three years) found that 11 of 33 children who received wraparound services had their permanency plans changed from long-term foster care to placement with a relative (Bruns, Rast, Peterson, Walker, & Bosworth, 2006).

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

CONCLUSION

In addition to providing an overview of the CFSR composite measure that pertains to long-term foster care, this review also summarizes findings from current research related to long-term stays in foster care. First, multi-level factors that are correlated in the literature with long-term stays in foster care were identified and discussed. Next, the review identified promising practices and interventions that show potential to reduce the duration of stays in foster care and promote exits to permanency.

With this information compiled, the fundamental question that arises involves translating this information from research into salient practice steps. In other words, what application does the research literature have to the practitioners working to achieve positive outcomes for children and families? Improving performance on reducing long-term foster care stays for children matters to child welfare practitioners on many levels. On an administrative level, child welfare agencies are evaluated by the federal government for their performance on outcomes including long-term care and exits to permanency. This federal oversight and evaluation (and its connection to funding) means that child welfare agencies have a keen interest in improving their performance on these measures. However, the more immediate issue for practitioners involves improving outcomes for the clients that they serve.

The translation of research into practice is dependent on a critically reflective perspective among practitioners in the field. In order for the research presented here to have a positive impact on the outcome in question, the practice community needs to critically reflect on the findings as a first step in using the information to inform their work with clients. In assessing how the information might be used by agencies to inform practice, some initial questions are identified as a way to promote a dialogue among practitioners:

- Are there ways that collaborations between the agency, birth families, extended families, courts, and service providers might be enhanced to promote timely exits to permanency?

- Are permanency goals being clearly outlined and consistently pursued by agency staff on every case?
- Are existing resources, such as CASA, being maximized?
- Are older youth being involved in their own permanency planning?
- Do agency workers receive training to confront negative attitudes and stereotypes about which children are likely to attain permanency?
- Are families made explicitly aware of the goals of permanency planning?

The road forward to improving child outcomes in relation to permanency lies in continued research to test the effectiveness of promising practices, along with continued collaborative dialogue with child welfare practitioners on implementing evidence-informed practice.

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