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Assessing the Efficacy of Pre-Service Trainings for Treatment Foster Parents

Amy Strickler

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ASSESSING THE EFFICACY OF PRE-SERVICE TRAININGS FOR TREATMENT
FOSTER PARENTS

A Dissertation

Submitted to the School of Education

Duquesne University

In partial fulfillment of the requirements for
the degree of Doctor of Philosophy

By

Amy Strickler

May 2015

Copyright by

Amy Strickler

May 2015

DUQUESNE UNIVERSITY
SCHOOL OF EDUCATION
Department of Counseling, Psychology and Special Education

Dissertation

Submitted in Partial Fulfillment of the Requirements
For the Degree of Doctor of Philosophy (Ph.D.)

Executive Counselor Education and Supervision Program

Presented by:

Amy Strickler
B.S., University of Pittsburgh, 2005
M.S.Ed., Duquesne University, 2009

March 10, 2015

ASSESSING THE EFFICACY OF PRE-SERVICE TRAININGS FOR TREATMENT

FOSTER PARENTS

Approved by:

_____, Chair
Matthew J. Bundick, Ph.D.
Assistant Professor of Counselor Education
Department of Counseling, Psychology, and Special Education
School of Education
Duquesne University

_____, Member
Lisa Lopez Levers, Ph.D.
Professor of Counselor Education
Department of Counseling, Psychology, and Special Education
School of Education
Duquesne University

_____, Member
Annette C. Trunzo, Ph.D.
Director of Organizational Performance
Pressley Ridge

ABSTRACT

ASSESSING THE EFFICACY OF PRE-SERVICE TRAININGS FOR TREATMENT FOSTER PARENTS

By

Amy Strickler

May 2015

Dissertation supervised by Matthew J. Bundick, Ph.D.

This quasi-experimental study examined the effectiveness of two pre-service trainings: Model Approach to Partnerships in Parenting (MAPP, $n = 81$) and Pressley Ridge's Treatment Foster Care pre-service training (PR-TFC, $n = 71$) on treatment foster parents' parenting attitudes, readiness to provide treatment foster care, and attitudes toward providing treatment foster care. ANCOVAs revealed the PR-TFC group experienced significantly more change than the MAPP group in two parenting constructs, and the MAPP group experienced significantly more change than the PR-TFC group in one parenting construct. This study revealed no significant differences between groups in the amount of change in personal dedication to provide foster care or willingness to foster children with emotional and behavioral issues. However, a chi-square test of association showed licensing rates were significantly higher for the PR-TFC group than the MAPP

group. This study also included a follow-up component for participants from the PR-TFC group who were licensed and had a child placed in their home. Repeated measures ANOVAs found significant increases for the PR-TFC group from posttest to follow-up and pretest to follow-up for personal dedication to fostering, but no significant changes in their willingness to foster. A description of treatment foster parent attitudes toward providing treatment foster care after a child was placed in the home is also provided. Practical implications of these results and recommendations for future research are discussed.

DEDICATION

This dissertation is dedicated to a fearless, strong, and inspiring woman, my Nana.

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Chapter One: Introduction

Overview

Increasingly states, federal agencies, and foundations have started to promote the use of evidence-based practices (EBPs) that have been shown to be effective when implemented in child welfare and mental health organizations (Bruns, Hoagwood, & Hamilton, 2008; Chambers, Ringeisen, & Hickman, 2005). In addition, child welfare and mental health organizations are expected to reduce the costs of care yet provide high quality, effective services to an increasing number of children with emotional and behavioral diagnoses, with the majority of these children residing in out-of-home placements (Chambers et al., 2005). In the United States, there are approximately 500,000 children entering out-of-home care each year, and this high number places stress on local child welfare and mental health organizations to find alternatives to costly, out-of-home services such as residential treatment facilities (Chamberlain, 2002; United States Department of Health and Human Services [U.S. DHHS], 2013).

In response to multiple funding entities looking to replace residential treatment with more effective community-based services, treatment foster care has been viewed as a viable alternative to address the mental health needs of children while remaining in a family setting at a reduced cost (Bryant & Snodgrass, 1990; Chamberlain, 2002). Treatment foster care (TFC) is a compilation of aspects from regular foster care and residential treatment centers, falling in between these two service systems, as more intensive than foster care and less intensive than residential treatment centers (Bryant & Snodgrass, 1990; Chamberlain, 2002). In the TFC model, trained treatment foster parents work with children who are placed in their homes and are expected to use therapeutic

strategies designed to decrease problematic behaviors and increase appropriate behaviors (Bryant & Snodgrass, 1990; Chamberlain, 2002). Treatment foster parents are responsible for developing and sustaining strong therapeutic alliances with youth, thus making them the key front-line implementers of the program (Chamberlain, 2002). Due to these added responsibilities as treatment agents, treatment foster parents receive additional compensation, training, and ongoing support in order to increase their commitment and competence in their therapeutic role (Chamberlain & Mihalic, 1998; Dorsey et al., 2008).

Due to their high level of involvement as treatment agents, the training of treatment foster parents is an important aspect of the treatment foster care model. Although federal policy and state statutes require prospective foster parents to be trained, the components of these trainings vary widely (Dorsey et al., 2008; Foster Care Independence Act of 1999, P. L. 106-109). Even though there is an acknowledgement of the importance of foster parent training, little research indicates the effectiveness of these training programs, specifically for treatment foster parents. In addition, many states do not differentiate training for treatment foster parents from training for regular foster care parents (Dorsey et al., 2008). In research studies, foster parents have often cited the lack of training as one of the reasons for dropping out of their role as foster parents; conversely, more foster parent training has been associated with better relationships between treatment foster parents and supervisors (Chamberlain, Moreland, & Reid, 1992; Murray, Southerland, Farmer, & Ballentine, 2010). Once trained, retaining quality foster parents becomes paramount to mental health organizations, because this not only helps to reduce costs of providing the service, but also improves outcomes for children in their

care (Chamberlain et al., 1992; Festinger & Baker, 2013). In addition, high foster parent turnover rates ranging from 20% to 40% per year results in added time, resources, and money for mental health organizations to recruit and train additional foster parents (Festinger & Baker, 2013). Foster parents who are terminated may also experience negative feelings including anger, shame, and sadness, making them unlikely to foster again; and children who have placement disruptions experience separation, change, and loss (Festinger & Baker, 2013).

Preparing foster parents in their therapeutic role has been seen as a possible solution to address the issues with retaining foster parents (Festinger & Baker, 2013). In addition, increasing foster parents' willingness to foster children with emotional and behavioral issues, foster parents' dedication to providing foster care, and foster parent satisfaction have all been shown to increase the retention of foster parents (Cox, Cherry, & Orme, 2011; Denby, Rindfleisch, & Bean, 1999; Orme et al., 2006). The use of effective training programs in TFC programs may lead to increased treatment foster parent satisfaction, licensing rates, retention, and placement stability and permanency for youth placed in their home (Piescher, Schmidt, & LaLiberte, 2008).

Youth residing in foster care are considered a vulnerable population due to their exposure to maltreatment such as neglect and the traumatic experience of removal from their biological parents, and this loss of access to existing attachment figures is best resolved if youth are able to develop healthy attachments with their alternative caregivers (Bruskas, 2008; Oosterman, Schuengel, Slot, Bullens, & Doreleijers, 2007). In addition, compared to youth who are in not foster care, youth in foster care are at a greater risk for a variety of negative outcomes with decades of research demonstrating a strong

association between placement disruptions in foster care and poor outcomes such as mental health issues associated with grief, loss, and traumatic experiences (Grogan-Kaylor, Ruffolo, Ortega, & Clarke, 2007; Rubin, O'Reilly, Luan, & Localio, 2007).

There is a systemic effect of providing high quality foster care to youth while in care due to the increased negative outcomes for youth who leave foster care and transition into adulthood, such as increased mental health issues, involvement in criminal activities, and high unemployment rates (Ancil, McCubbin, O'Brien, Pecora, & Anderson-Harumi, 2007). Equipping foster parents with interventions to help with forming healthy attachments and providing stability for youth should be prioritized in order to facilitate permanent long-lasting placements so that youth in foster care experience improved well-being outcomes now and in the future (Rubin et al., 2007). Therefore, there is a need to determine the effectiveness of treatment foster parent trainings in order to respond to the needs of children placed in their home, as well as the lack of research currently available on training characteristics and outcomes that prepare treatment foster parents for their professional role as therapeutic change agents.

Statement of the Problem

Although there has been an increase in the support of using EBPs, there are several mechanisms for identifying appropriate evidence-based models which adds to the difficulty for mental health organizations to evaluate all available research on these models (Bruns et al., 2008). However, there are efforts to alleviate this problem in the mental health field, such as using the California Evidence-Based Clearinghouse (CEBC), which reviews child welfare interventions across the United States that have been researched, synthesizes the evidence, assigns ratings based on the available research, and

makes this information publicly available by posting it online. Table 1 shows the rating scale the CEBC uses to review programs, with lower scores representing a greater level of research support.

Table 1

The California Evidence-Based Clearinghouse's Scientific Rating Scale

Numerical Rating	Description
1	Well-Supported by Research Evidence
2	Supported by Research Evidence
3	Promising Research Evidence
4	Evidence Fails to Demonstrate Effect
5	Concerning Practice
NR	Not Able to be Rated

Note. Adapted from “Scientific Rating Scale” by the California Evidence Based Clearinghouse for Child Welfare, 2015, Retrieved from <http://www.cebc4cw.org/ratings/scientific-rating-scale/>.

When searching for research on the effectiveness of foster parent training programs, the CEBC (2013) confirms the lack of evidence of effectiveness. For example, there are currently only three training programs available for foster parents that have empirical evidence of effectiveness: FosterParentCollege.com, Keeping Foster Parents Trained and Supported (KEEP), and Together Facing the Challenge. The CEBC (2013) has assigned these programs with modest, less confident scientific ratings (e.g., a two or three), meaning that the evidence for their effectiveness is not as substantial as other programs that receive more confident scientific ratings, either due to the study design or sample size.

In addition, only one of these programs is designed specifically for treatment foster parents (e.g., Together Facing the Challenge), and none of them are offered as pre-service courses that would be completed before a child is placed in the home (CEBC, 2013; Dorsey et al., 2008). There are two programs, the Model Approach to Partnerships in Parenting (MAPP), and Foster Parent Resources for Information, Development, and Education (PRIDE) that are viewed as gold standards for the field for pre-service courses, and the Department of Human Services mandates their use in half of the states (Dorsey et al., 2008). However, the CEBC (2013) has not been able to rate these programs due to a lack of sufficient high quality studies demonstrating their effectiveness, and, “both have been criticized for their relatively substantial attention to procedures and policies and relatively brief attention to issues involved in effectively meeting the needs of troubled youth (particularly their scant focus on managing difficult behaviors)” (Dorsey et al., 2008, p.1406).

Additionally, Dorsey et al. (2008) conducted a comprehensive literature review of peer-reviewed articles on foster parent training; 79 articles were initially found, but only 30 articles were retained that included outcome measures assessing either foster parent behavior/success or child-level behavior/success. Also, 11 of the articles were written more than 20 years ago, included very small samples, were quasi-experimental in nature, and assessed a limited range of outcomes (Dorsey et al., 2008). These outcomes ranged from foster parent knowledge, behavior, attitudes, or satisfaction with foster parenting, to child behavioral outcomes (Dorsey et al., 2008). However, these outcomes were mostly collected following the completion of the training, with little or no follow up assessments at other time points. Although increases in knowledge or attitudes may have an impact

on foster parent behaviors, follow-up studies are needed that directly examine the continuation of these outcomes, and the positive impact on child-related outcomes (Dorsey et al., 2008). Through review of the literature on foster parent training and search for evidence-based training programs listed on clearinghouse websites, there are currently few data on trainings specifically for treatment foster parents, with the majority of evidence for treatment foster care coming from Chamberlain's (2002) research that is based on the Multidimensional Treatment Foster (MTFC) model (Dorsey et al., 2008).

Although Chamberlain's MTFC model has substantial evidence of effectiveness, there are only 35 MTFC programs in the United States, meaning that with over 1,500 TFC programs nationwide, MTFC only represents approximately 2% of all TFC programs (CEBC, 2013; Chamberlain, 2002; Dorsey et al., 2008). In addition, the MTFC model is costly to implement, with an estimated \$118,000 in the first year for start-up costs, to \$10,000 per year to support continued certification, replacement training, consultation, and fidelity monitoring activities (Blueprints for Healthy Youth Development, 2013). High costs for implementation and sustainability put use of the model out of reach for many mental health organizations, even those which desire to implement an EBP. The limited research available outside of the MTFC model does not provide information about whether similar outcomes could be achieved if organizations use a different, less costly TFC model (Dorsey et al., 2008). Therefore, it is imperative to determine training components, desired outcomes, and treatment foster parent competencies ideal for preparing treatment foster parents *before* placing a child in their home for TFC programs that may not have the financial or organizational infrastructure to implement the MTFC model.

Purpose of the Study

The purpose of this study was to examine the effectiveness of pre-service trainings on treatment foster parents' attitudes toward parenting, readiness to provide treatment foster care, and attitudes toward providing treatment foster care. In order to address the areas of interest and the specific research questions, permission to access de-identified, archival data was requested and granted by the Director of Organizational Performance at Pressley Ridge (A. C. Trunzo, personal communication, August 11, 2014). The dataset included demographic information, training outcomes, and scores from standardized assessments from prospective treatment foster parents who completed a training designed specifically for treatment foster parents (Pressley Ridge's Treatment Foster Care [PR-TFC] pre-service training) or a training developed for regular foster parents (Model Approach to Partnerships for Parenting [MAPP]). Data were collected at three time points for both training groups: before the pre-service training, immediately after completing the last pre-service training unit, and approximately three¹ months after a child was placed in the treatment foster parent's home. The following research questions were addressed in this study:

1. Does pre-service training affect treatment foster parents' parenting attitudes toward children?
2. Does pre-service training affect treatment foster parents' readiness to provide treatment foster care?

¹ The initial evaluation design was to conduct follow-up after the child was in the treatment home for approximately three months. However, data analysis revealed that this timeframe was conducted an average of 2.35 years after a child was placed in the home.

3. Does pre-service training affect treatment foster parents' readiness to provide treatment foster care *after* a child is placed in the home?
4. Does pre-service training predict treatment foster parents' attitudes toward providing treatment foster care *after* a child is placed in the home?

Potential Significance

The focus of this study stems from the increased attention on implementing EBPs in treatment foster care, and the lack of research on pre-service training programs that prepare treatment foster parents for their professional role as therapeutic change agents. This is the first study to examine the effectiveness of a pre-service training that was designed specifically for treatment foster parents, thus adding to the evidence base for treatment foster care and pre-service trainings. The developers of treatment foster care models state that treatment foster parents need more enhanced trainings than regular foster parents, but no studies have compared these two types of trainings (Chamberlain & Mihalic, 1998; Dorsey et al., 2008). This study includes a sample that received a training designed specifically for treatment foster parents, and a sample that received a training designed for regular foster parents. These results can be used for several purposes including providing evidence to funders and child welfare departments about the need for specialized trainings for treatment foster parents.

This study used standardized assessments to examine foster parent competencies such as parenting attitudes and fostering readiness. The use of standardized assessments to measure foster parent competencies as a screening method for potential foster parents is a new direction for the field (Orme et al., 2006). The standardized assessments were completed at three time points: before the pre-service training, immediately after the pre-

service training, and approximately two years after a child was placed in the home. This is the first study to examine whether foster parent competencies can be increased through training, and how they may or may not change when a child is placed in the home. This knowledge may help foster parent recruiters understand that even though foster parents may report few foster parent competencies before they attend training, effective trainings may increase their competencies, thus making them a viable option as foster parents. Showing the utility of standardized assessments also may help mental health organizations see how to use data to drive decision making about recruitment instead of using past experiences of what they think works.

The results from this study around the effectiveness of pre-service trainings also have both financial and programmatic implications. Due to the relationship between effective pre-service trainings and decreased foster parent turnover (Piescher et al., 2008), having evidence for effective pre-service trainings will help to reduce costs for organizations, because they will not need to focus efforts on constant recruitment and training of prospective foster parents. Reducing foster parent turnover will also result in improved quality of services, because youth in their homes will experience placement stability in the treatment home instead of experiencing disruptions and loss if foster parents decide to leave the organization.

The potential significance of increased knowledge about the essential treatment foster parent competencies will help to inform pre-service training practices, and may help to provide a clearer definition for policies and procedures on preparing treatment foster parents for their therapeutic roles. Policies may change that require the use of an evidence-based practice to train prospective treatment foster parents, which would put

organizations in a difficult situation to purchase a new training program. However, the use of an evidence-based pre-service training will help organizations focus on increasing efforts around the areas that work and decreasing efforts in areas that do not work. This reduction of ineffective practices also equates to a reduction in finances that are needed for a treatment foster care program to function, thus potentially improving sustainability of the program and increasing the potential to have a positive impact on children with emotional and behavioral problems.

This study could also provide a research design for future studies that examine pre-service trainings. Other mental health organizations that are interested in evaluating pre-service trainings would be able to use the research design and instruments in this study without having to spend time and resources creating their own design. Additional research on pre-service trainings means there would be more options for treatment foster care programs to choose pre-service trainings that fit with their mission, values, and available resources.

Theoretical Foundation

Treatment foster care programs typically encompass a variety of theoretical approaches due to the focus on individualizing services that address the youth's unique needs (Meadowcroft, Thomlison, & Chamberlain, 1993). However, the most common theoretical frameworks most often associated with TFC programs are cognitive/behavioral, and social learning theories; with a newer concept around therapeutic alliance (Dore & Mullin, 2006; Meadowcroft et al., 1993; Southerland, Mustillo, Farmer, Stambaugh, & Murray, 2009). Behaviorism is the compilation of stimulus, response, and reinforcement; and forms the basis of training for treatment foster

parents on how to understand behavior, to employ reinforcement schedules, and to use rewards and punishments (Skinner, 1974; Dore & Mullin, 2006). In addition, youth in TFC typically receive behaviorally focused treatments such as points-and-level systems to increase positive behavior and the loss of their privileges as punishment for negative behavior (Chamberlain, 2003; Dore & Mullin, 2006). The point-and-level system is commonly used in educational and child welfare settings, and is similar to a token economy in which targeted behaviors are shaped through providing positive reinforcement in the form of points, and as youth comply with the behavior management plan, they receive points and progress through levels (Skinner, 1974; Chamberlain, 2003). As youth advance through the levels, privileges are offered, and a loss of points results in a loss privileges, demotion to a lower level, or an addition of a punishment such as having to complete a chore (Chamberlain, 2003).

Social learning theory expands behaviorism that is based on direct reinforcement alone to include a social element that relies on modeling (Bandura, 1977). Children learn to model appropriate and inappropriate behaviors through live models (Bandura, 1977). Treatment foster parents act as the child's live model by modeling appropriate behavior, and they focus on the social element that is involved in learning new behaviors. Both behaviorism and social learning theory are classic approaches to changing behavior in TFC programs (Bandura, 1977; Skinner, 1974). However, the therapeutic alliance provides the foundation for the effectiveness of these approaches, as therapeutic change requires a strong therapeutic relationship between the treatment foster parent and youth (Bordin, 1979; Chamberlain, 2003). The therapeutic alliance is an agreement on goals

and tasks, and the formation of a therapeutic bond that facilitates the change process (Bordin, 1979)

Research has shown the therapeutic relationship is associated with positive outcomes regardless of treatment modality and child development level (Shirk & Karver, 2003), and has recently been used to examine associations with treatment foster care outcomes (Rauktis, Andrade, Doucette, McDonough, & Reinhart, 2005; Southerland et al., 2009). Studies of youth with emotional and behavioral disorders who showed improvement in therapeutic alliance also had more improvement in externalizing symptoms (Hogue, Dauber, Stambaugh, Cecero, & Liddle, 2006; Rauktis et al., 2005). Therefore, the quality of the relationship between the treatment parent and youth is an important mechanism for positive youth outcomes in TFC (Southerland et al., 2009). The theoretical framework for this study postulates that if treatment foster parents are trained in the proper use of behavior management techniques, the ways to model appropriate behavior, and the importance of building a strong therapeutic alliance; they will experience an increase in their parenting attitudes, fostering readiness, and attitudes toward providing treatment foster care.

Summary of Methodology

A quasi-experimental design was used to compare the use of Pressley Ridge's Treatment Foster Care (PR-TFC's) pre-service training with training-as-usual that was designed for foster parents (Model Approach to Partnerships for Parenting [MAPP]). The project was completed through an inter-agency collaboration between Pressley Ridge and Easter Seals/UCP of North Carolina and Virginia (Easter Seals) between 2010 and 2014. The initial purpose of collecting and evaluating the data obtained from surveys

was for internal quality improvement activities. For this study, a secondary data analysis of de-identified data was conducted to examine the effectiveness of pre-service trainings on treatment foster parents' attitudes toward parenting, readiness to provide treatment foster care, and attitudes toward providing treatment foster care.

Participants included a purposive sample of prospective treatment foster parents ($N = 152$) who completed pre-service training with Easter Seals. The prospective treatment foster parents completed standardized assessments before the pre-service training, immediately after the pre-service training, and approximately two years after a child was placed in the home. The instruments measured parenting attitudes and beliefs, personal dedication to provide foster care, willingness to provide foster care to children with emotional and behavioral difficulties, and overall satisfaction with providing treatment foster care. De-identified archival data were used to examine the responses of prospective treatment foster parents on several instruments across multiple time points. The changes in their responses on the standardized instruments were compared by training group using ANCOVAs that controlled for gender, age, prior parenting experience, and pretest scores. Repeated measures ANOVAs were used to compare changes on their standardized instruments across time for those treatment foster parents who were eligible for follow-up² (e.g., licensed as treatment foster parents and had a child placed in their home). Treatment foster parent attitudes based on training group were also examined.³

² Between-group comparisons of scores were not completed by training group due to the small number in the comparison group (MAPP) at follow-up.

³ Inferential statistics were not conducted due to the small number of participants who were in the comparison group (MAPP) at follow-up.

Definition of Key Terms

To provide an understanding of the main ideas that are conveyed within this dissertation, the following definitions for treatment foster care, pre-service training, and treatment foster parents were used:

Treatment Foster Care (TFC)–TFC has been referred to as special foster care, treatment family care, professional parenting, therapeutic foster care, foster family-based treatment (Bishop-Fitzpatrick, Jung, Nam, Trunzo, & Rauktis, 2014; Meadowcroft et al., 1993; Reddy & Pfeiffer, 1997). Multiple definitions of TFC exist, the Foster Family-Based Treatment Association (FFTA), an organization that represents TFC programs across North America, defines TFC as:

A distinct, powerful, and unique model of care that provides children with a combination of the best elements of traditional foster care and residential treatment centers. In [TFC] the positive aspects of the nurturing and therapeutic family environment are combined with active and structured treatment. [TFC] programs provide, in a clinically effective and cost-effective way, individualized and intensive treatment for children and adolescents who would otherwise be placed in institutional settings. (Romanelli, LaBarrie, Hackler, & Jensen, 2008, p. 6)

Pre-Service Training– FFTA’s *Program Standards for Treatment Foster Care* (2013) provides the definition for pre-service training as:

Prior to the placement of children and youth in their homes, Treatment Parents shall satisfactorily complete primarily skill-based training consistent with the Program’s treatment methodology and the service needs of the children and youth. Treatment Parents will also receive an orientation to foster care services. The number of hours of training required should be commensurate with state/provincial and accrediting body requirements and be sufficient to ensure all material is covered adequately. (p. 31)

Treatment Foster Parent– FFTA’s *Program Standards for Treatment Foster Care* (2013) provides the definition for treatment foster parents:

The role of the Treatment Parent is central to Treatment Foster Care. Treatment Parents are viewed as colleagues and as part of the professional team. Although all Treatment Parents are foster parents, not all foster parents are Treatment Parents. Treatment Parents serve both as caregivers for children and youth with treatment needs (the fostering role) and as active agents of planned change (the treatment role). (p. 25)

Chapter Two: Literature Review

The first section of the literature review examines the history and development of treatment foster care to provide an understanding of the service's origins and the placement of treatment foster care in the foster care and residential treatment continuum of care. The second section provides information around treatment foster care program characteristics, models, and outcomes to highlight that the common element of TFC models includes pre-service trainings for treatment foster parents. The third section focuses on pre-service trainings; their foundation, existing pre-serving training programs, pre-service training outcomes, and the use of standardized assessments to measure foster parent competencies.

The Development of Treatment Foster Care

The focus on treatment foster care as a viable option for serving children with severe emotional disorders came as a result of the deinstitutionalization movement that started in the early 1950's (Bryant & Snodgrass, 1990). Deinstitutionalization is most commonly defined as the replacement of long-stay psychiatric hospitals with smaller, less isolated community-based alternatives for the care of clients with mental illness (Lamb & Bachrach, 2001). The deinstitutionalization movement was based on three assumptions: community-based care would be more humane, more therapeutic, and more cost-effective than hospital-based care (Bachrach, 1978; Thornicroft & Bebbington, 1989). There also were several trends in the mental health field that supported the deinstitutionalization movement: creation of legislature, advancements in psychopharmacology treatments, social movements supporting a recovery-oriented paradigm, studies on the cost effectiveness of providing community-based services, the focus on providing community-

based alternatives instead of restrictive placements, and shifts in treating the ecology of the child (Hawkins, 1989; Trunzo, Bishop-Fitzpatrick, Strickler, & Doncaster, 2012). These practical and theoretical shifts provided a rationale for the creation of community-based programs such as treatment foster care.

Legislature. In 1961, the Joint Commission on Mental health was credited for starting the deinstitutionalization movement through the publication of a report, spurred by the Mental Health Study Act (P.L. 84-182), that called for a national program and policies to treat people with mental illness in community-based settings (Action for Mental Health, 1961). In 1963, President John Kennedy revealed his plan for reforming the nation's care of the mentally ill by replacing state hospitals with community care and also called for increased funds and training to meet these goals (Whitaker, 2002). In the same year, the Community Mental Health Centers Construction Act (P.L. 88-164) and its succeeding amendments required grantees to provide community-based services and to offer grant funding that would help community mental health centers (CMHCs) in serving all members of the community, regardless of their ability to pay, thereby forming a mental health safety net (Wagenfeld, Murray, Mohatt, & DeBruyn, 1994). With the election of Ronald Reagan in the 1980's, the Omnibus Budget Reconciliation Act (OBRA) of 1981 (P.L. 97-35) was created and there was a shift in control to contract with CMHCs to provide services to the people who were deinstitutionalized and other populations with mental illness (Bachman, 1996). The most popular policy created in the 1980's that is still in effect today is the Child and Adolescent Service System Program (CASSP), created by the National Institute of Mental Health (NIMH), that supports alternatives to institutional care and the integration of a system of care for children

(Burns, 2002). Throughout the years, several key policies and legislations have been created in support of CMHCs to provide services to people with mental illness, but these policies would not have been widely supported without the advancements in psychopharmacological treatments.

Psychopharmacological advancements. During the creation of policies and legislation that supported deinstitutionalization, there were major advancements in psychopharmacology creation for the treatment of mental health disorders, specifically in the 1950's, the introduction of chlorpromazine for the treatment of schizophrenia and other neuroleptics made Kennedy's plan to deinstitutionalize more feasible (Whitaker, 2002). However, two decades ago, the use of medications to treat children's emotional and psychiatric disorders was considered controversial until several studies were published that showed an improved quality of life for children and enabled them to remain in the community in the least restrictive and most natural living arrangement possible (Campbell & Cueva, 1995; Duchnowski, Kutash, & Friedman, 2002; Jensen, Hoagwood, & Petti, 1996). Despite the controversies in the history of psychopharmacology creation and the varied effects on the client's mental health (worsening or improving), the present viewpoint is that effective medication is a critical component of community-based treatment and may even make the difference in avoiding a restrictive placement (Duchnowski et al., 2002; Whitaker, 2002). As clients were better able to manage their mental health symptoms due to their medication, they were better able to advocate for equal rights and treatment as citizens of their communities.

Recovery-oriented paradigm. A product of the creation of legislature and psychopharmacology advancements was the support for a recovery-oriented paradigm

that quickly emerged through social movement groups and advocates for empowering the rights of clients with mental illness. This political grassroots movement usually comprised of people who had experienced psychiatric treatments or hospitalization and were determined to develop the least restrictive psychiatric treatments and to secure full citizenship rights for people labeled as mentally ill (Chamberlain, 1990). There also was another source of support for the recovery-oriented movement, professional and mental health advocates who enacted psychiatric rehabilitation initiatives that shaped the emergence of community resources and best practices in treatment for people with psychiatric disabilities by recognizing the value of the community and that people are not defined by their mental illness (Jacobson & Curtis, 2000). These social and professional movements for a recovery-orientated model supported both the efforts of treating clients with mental health issues with integrity and in a community-based setting in a more therapeutic and cost-effective way.

Cost effectiveness studies. The support for more cost-effective services that could be offered in the community was another trend that supported the deinstitutionalization movement and the creation of CMHCs. The necessity for cheaper alternatives was due to the number of patients in state hospitals reaching the highest point with 559,000 people out of the total national population of 165 million, and calculations projected that the costs of state mental hospital systems would soon exceed acceptable levels (Lamb & Bachrach, 2001; Shadish, 1984). In addition, a study conducted by the Joint Commission on Mental Health Services in 1969 found that not only were the services for children inadequate, but that only a fraction of children in need were being served with a significant amount of resources spent on the diagnostic process

(Duchnowski et al., 2002). As a result, there was a need to provide lower cost community-based treatments to more children instead of higher cost hospitalizations to only a few children. The demands for alternatives to hospitalizations warranted the creation of lower cost community-based programs that could serve children with serious emotional disturbances.

Community-based alternatives. In response to these trends towards deinstitutionalization, a variety of community-based treatments were created with treatment foster care emerging as a viable alternative to high-cost hospitalizations. Since inception, treatment foster care has been referred to as special foster care, specialized foster care, treatment family care, and professional parenting, all of these terms refer to the same service that was first seen in the United States in the mid-1970's as an alternative to placing children in institutional settings (Meadowcroft et al., 1993). Treatment foster care programs have foundations from a variety of developmental approaches such as foster family care, residential treatment centers, and parent training programs (Hawkins, 1989). These program components, shifts in treatment philosophies, and pressures from legislature to reduce restrictiveness and costs of programming helped to shape the development of treatment foster care programs.

Psychiatric hospitals and residential treatment centers also facilitated the emergence of treatment foster care in order to fill a gap in services for, "...children who no longer required institutional care but who were unlikely to find stability on their own or regular foster care" (Bryant & Snodgrass, 1990, p. 3). Therefore, the influence of foster family care on treatment foster care programs has been the most obvious association, because most programs are conducted under foster family care regulations

and are viewed as slightly intensified versions of regular foster care (Bryant, 1981). In addition, the residential treatment center's milieu programming in which staff are supervised by mental health professionals and where settings resembled homelike environments both contributed to the characteristics of the treatment foster care model (Hawkins, 1989). Treatment foster care is therefore a compilation of aspects from regular foster care and residential treatment centers, falling in between these two service systems, as a step-up in the level of restrictiveness from regular foster care and a step-down in the level of restrictiveness from residential treatment centers (Bryant & Snodgrass, 1990; Chamberlain, 2002).

Youth. There are three primary systems that provide care for children in the United States: the child welfare, mental health, and juvenile justice systems (Weithorn, 1988). Foster care in the child welfare system focused on providing a safe and stable home for youth, residential treatment in the mental health system was reserved for youth who required treatment in a highly structured and contained setting, and the juvenile justice system provided congregate care with the primary goal to protect the community and to punish the offender (Dore & Mullin, 2006). Although each of these systems have historically focused on meeting different aspects of children's needs, they started to increasingly share concerns regarding the emotional and behavioral disturbances of youth in their care (Dore & Mullin, 2006). In the child welfare system, there was the realization that early life trauma of abuse and neglect and the later maladjustments of youth necessitated the need for a more therapeutic level of foster care (Dore & Mullin, 2006). TFC was designed to address the needs of children whose difficulties or circumstances placed them at risk of multiple placements or more restrictive placements

such as a hospital, secure residential center, or youth juvenile setting (Webb, 1988). These groups of children were classified as those who experienced trauma, neglect, or abandonment; children with mental health problems; children with antisocial behavior and offending; and children with serious medical conditions (Turner & Macdonald, 2011).

Reports from early specialized foster care programs supported this information, because the majority of their population of children was emotionally or behaviorally disturbed (Webb, 1988). During the 1960's, a number of epidemiological and longitudinal studies attempted to identify factors that placed children at high risk for an emotional or behavioral disorder; these factors were classified as located in the child, the primary caregiver, and in the family/environmental context (Dore, 1999). There is not one single factor that places children at risk for emotional or behavioral issues, an interaction of those three factors contributes to an increased risk for children (Dore, 1999). However, research around children's mental health issues in the 1980's had found that less than half of the children who had a mental health problem received any form of treatment, and the ones who received treatment often received inappropriate services (Saxe, Cross, & Silverman, 1988). At that time, treatment resources were focused on a small number of children who were in inpatient psychiatric facilities, state mental hospitals, or other residential treatment (Saxe et al., 1988).

The deinstitutionalization policies were successful in reducing adolescent admission rates to state and county mental hospitals, but the admission rates to psychiatric hospitals increased four-fold between 1980 and 1984 due, in part, to lax admission requirements (Weithorn, 1988). It was also found that changes made during

placements in psychiatric hospitals or residential treatment placements frequently did not generalize to the individual's home situation (Webb, 1988). In addition, foster care does not typically provide interventions to address the complex emotional, psychological and behavioral needs of children; nor do they provide the caregivers with the skills and support services that are needed to implement these interventions (Turner & Macdonald, 2011). Treatment foster care programs addressed this problem by providing the learning experience in an environment similar to the one the youth is expected to use their new learning, which was expected to enhance generalization and reduce behavioral or emotional issues (Webb, 1988). It was also recognized that children's mental health problems were due to the interactions between intra-individual difficulties and environmental conditions; therefore, treatment must address conditions in the family, school, neighborhood, and child which requires the coordination of multiple services (Saxe et al., 1988). This knowledge around the interaction between individual and environmental conditions also spurred the creation of ecological treatment approaches such as treatment foster care.

Ecological treatment shift. The shift in treatment philosophies was integral in the creation of treatment foster care models; for example, there was increasing recognition that treatment should focus on the entire ecology of the child and that therapeutic accomplishments can occur with little direct involvement of a mental health professional (Hawkins, 1989). These tenets are evident in the programs established by Nicholas Hobbs and his colleagues that are referred to as *Project Re-Education for Children with Emotional Disturbance*, or Re-ED, where specially trained educators developed academic, behavioral, and ecological interventions to improve the functioning

of children with emotional and behavioral problems (Hobbs, 1966). Hobbs' Re-ED model, guided by social learning theory, outlined psychoeducational interventions for children who had emotional disorders with the goal for children to relearn how to function while interventions addressed functioning in all domains of the children's lives (Duchnowski et al., 2002). In support of the ecological and paraprofessional approach, there was the discovery and further studies on the therapeutic role that biological parents could play in children's lives when offered the appropriate training (Hawkins, 1989). The foster parents in the earlier years of treatment foster care were expected not only to care for the child, but also to provide more intensive treatment. There was then the realization that additional supervision and training was needed to help these foster parents with the emotional and behavioral issues of the child (Bryant & Snodgrass, 1990). With the shift in treating the ecology of the child and the role of foster parents as providing treatment, the model of treatment foster care was unique compared to regular foster care and residential treatment centers.

As part of the deinstitutionalization movement, the aim was to reduce the stays in hospitals and the restrictiveness of this living environment that removed people from their community with a high cost to the government. Therefore, treatment foster care was seen as a service that was minimizing in the level of restrictiveness, because the child was placed in a home with a family (Hawkins, 1989). The family setting of treatment foster care answered the public sentiment for keeping even the most difficult children within family settings while also responding to the fiscal constraints that were burdening state and county governments (Meadowcroft et al., 1993). Therefore, because treatment foster care was less expensive compared to other more restrictive levels of care, the

development of treatment foster care was encouraged and early program leadership found that referrals from public agencies were ample and the programs could be kept viable once established (Hawkins, 1989). The creation of the treatment foster care model addressed both the push from funding sources to reduce costs and restrictiveness of hospitalizations as well as providing the therapeutic aspect of remaining in a family setting.

Throughout the history of the deinstitutionalization movement there were both practical and theoretical developments that helped in the creation of the treatment foster care model. As trends towards deinstitutionalization progressed, key policies and legislations were created to support CMHCs while the advancements in psychopharmacological treatments made symptom management and creation of community-based programs more feasible. Social and professional movements for a recovery-oriented model advocated for client integrity and less restrictive services that were more cost effective to provide. In response to these trends, treatment foster care became a sustainable option to address the mental health needs of children while remaining in a family setting at a reduced cost to funders. The treatment foster care model addressed the concerns about the restrictiveness of the living environment, the cost to provide services, the integrity of the services provided, and the increasing need for helping children with emotional or behavioral issues.

Treatment Foster Care Programs

Program characteristics. The Foster Family-Based Treatment Association (FFTA) first established program standards in 1991, and within three years these standards were being used as guidelines in the development and implementation of

treatment foster care programs (Meadowcroft et al., 1993). FFTA's 2013 *Program Standards for Treatment Foster Care* operationalize TFC by defining the essential elements of the model, and provide guidelines around 79 standards in regards to the program, treatment parents, and the youth and families served. Although not all TFC programs meet the *Program Standards*, TFC programs typically adhere to four core principles: (a) treatment parents are the primary change agents and care is provided in their home, (b) treatment parents receive advanced training, support, and increased stipends, (c) treatment parents implement interventions instead of agency-employed therapists, and (d) agency staff are consultants instead of direct service providers (Bishop-Fitzpatrick et al., 2014; Reddy & Pfeiffer, 1997). Within these principles, interventions are individualized to meet the needs of youth who need intensive treatment such as residential treatment, but would benefit from a nurturing family environment and a positive therapeutic alliance with the treatment parent (Farmer, Burns, Dubs, & Thompson, 2002; Reddy & Pfeiffer, 1997).

Current legislature. The Federal Foster Care Program, authorized by title IV-E of the Social Security Act, helps to provide safe and stable out-of-home care for children until children can be safely returned home. TFC programs are provided funding under this act and other child welfare funding streams, meaning that youth who receive Medicaid are eligible to receive this service typically until the age of 21. Despite the benefits of TFC, current law does not provide a standard definition of TFC under Medicaid, which impaired TFC quality and access. Recently, the Quality Foster Care Services Act of 2014 (S. 1992) was submitted to amend the Social Security Act to provide a standard definition of treatment foster care services in Medicaid. This

inclusion of a definition for TFC will help to promote accountability for states offering TFC, identify funding options, and help to establish foster parent training and standards (“The Quality Foster Care Services Act”, n.d., para. 4).

Theoretical framework. As mentioned previously, the trademark of TFC is the ability to individualize services that fit the needs of the youth in care and their families (Meadowcroft et al., 1993). However, theoretical frameworks most often associated with TFC programs (in order from most to least common) are cognitive/behavioral, social learning, systems/ecological, family systems, or psychodynamic theories (Dore & Mullin, 2006; Meadowcroft et al., 1993). The most common approaches used in TFC (e.g., behaviorism and social learning theory) will be reviewed with an addition of a contemporary approach based on the therapeutic alliance.

Behaviorism. B. F. Skinner (1974) is best known for defining operant conditioning whereby behaviors are dependent upon what happens after the response and are based on rewards and punishment. For example, children can be taught that a desirable behavior of completing their homework will result in a reward from parents, and this will increase the likelihood of children completing their homework. Alternatively, the removal of something children enjoy to do can decrease or prevent undesirable behaviors (Skinner, 1974). In this case, children can lose the privilege to watch television if they continue to use inappropriate language. Schedules of reinforcement are used to positively reinforce behaviors that are desirable and to punish behaviors that are not desirable (Skinner, 1974). This theory provides the basis for the training of treatment foster parents in the ways to reinforce positive behaviors in children to promote increases in their appropriate behavior, and to reduce the instances of negative

behaviors (Dore & Mullin, 2006). Youth in treatment foster care programs typically receive behaviorally-based treatments, usually operating on a point-and-level system where the youth earns points for positive behaviors and privileges are removed for misbehaviors (Bryant & Snodgrass, 1990; Chamberlain, 2003; Dore & Mullin, 2006).

Social learning theory. Social learning theory proposes that behavior is explained in relation to a continuous reciprocal interaction of personal and environmental determinants (Bandura, 1977). Therefore, social learning theory expands traditional learning theory that is based on direct reinforcement alone to include a social element that involves learning through observation, intrinsic reinforcement, and specific factors that influence modeling and imitation of behavior (Bandura, 1977). Bandura (1977) suggests that people learn and imitate behaviors that they have observed in other people, often without direct reinforcement through the use of live models. An example of live modeling was Bandura's Bobo doll experiment, which focused on the negative side of learning and imitating behaviors, where children observed an adult act violently towards a Bobo doll, and then in turn the children began to imitate the aggressive actions when they were allowed to play with the doll later (Bandura, Ross, & Ross, 1961). Therefore, Bandura felt that children could learn to model appropriate or inappropriate behaviors through the use of a live model. This theory fueled the creation of parent training programs that focused on training parents to be live models for their children and to reinforce new desirable behaviors (Bandura, 1977; Kaminski, Valle, Filene, & Boyle, 2008). Social learning theory aligns with the role of a treatment foster parent acting as the live model so the child can learn to imitate their appropriate behaviors. Therefore, pre-service training programs typically focus on teaching foster parents the importance of

modeling appropriate behavior for youth in their care and are based on research that parents can be trained in this type of therapeutic role (Almeida, Hawkins, Meadowcroft & Luster, 1989; Hawkins, 1989).

Therapeutic alliance. The main role of a treatment foster parent is to function as the change agent for the youth in the treatment home, and establishing a positive relationship with the youth is considered an essential process of the TFC model (Chamberlain, 2003). A key factor in being a change agent is the ability to form a strong therapeutic alliance with the person in treatment (Bordin, 1979). The therapeutic alliance between a client and the change agent is defined as a mutual understanding and agreement about change goals, the necessary tasks to move toward these goals, and the establishment of a therapeutic bond (Bordin, 1979). Therapeutic alliance has been widely studied in adults, and meta-analyses suggest the therapeutic alliance is one of the most consistent predictors of treatment outcomes instead of the therapist's theoretical intervention (Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000).

For children, the therapeutic relationship is modest, yet consistently, associated with outcomes regardless of treatment modality and child development level (Shirk & Karver, 2003). More recently, therapeutic alliance theory has been used to examine the process factors that influence treatment foster care outcomes, such as improved functioning for youth (Rauktis et al., 2005; Southerland et al., 2009). In addition, studies of youth with emotional and behavioral disorders who showed improvement in therapeutic alliance also had more improvement in externalizing symptoms (Hogue et al., 2006). Rauktis et al. (2005) found similar findings that even though youth with externalizing symptoms had lower alliance scores; they showed improved therapeutic

alliance scores after six months in a treatment foster care program. Therefore, training treatment foster parents in the ways to build quality relationships with youth is one of the mechanisms for potentially improving emotional and behavioral functioning for youth (Southerland et al., 2009).

Specific treatment foster care models. There are several specific TFC models available such as the Parent-Therapist Program, Alberta Parent Counsellors Program, Kent Family Placement Project, Pressley Ridge's TFC Program (formerly known as Pressley Ridge Youth Development Extension [PRYDE]), Multidimensional Treatment Foster Care (MTFC), and Casey Family Programs that are located across the United States, Canada, and United Kingdom (Bishop-Fitzpatrick et al., 2014; Hudson, Nutter, & Galaway, 1994). Despite the availability of specific models, the information about these models is based on a small number of programs such as Chamberlain's MTFC model and Meadowcroft's PR-TFC model (Bishop-Fitzpatrick et al., 2014; Farmer et al., 2002).

MTFC. Patricia Chamberlain and colleagues established the MTFC model in 1983 for adolescents who had severe and chronic problems with delinquency (Chamberlain & Reid, 1998; Chamberlain, 2003). The model was later adapted and evaluated with adolescents who were returning from placement in state hospitals, adolescents in foster care, and preschoolers in foster care (Chamberlain, 2003; Fisher, Gunnar, Chamberlain, & Reid, 2000). The MTFC model aims to create supports for youth so they can have positive community living experiences and to prepare their parents to use skills to ensure youth maintain treatment gains when they return home (Chamberlain, 2003). The interventions include family and individual therapy, skill training, and academic supports (Chamberlain, 2003). In addition to the core elements of

TFC programs, there are four key elements of treatment: (a) youth are provided with a consistent reinforcing environment with mentoring and encouragement, (b) there is a clear structure and limits with defined consequences that are delivered in a teaching-oriented way, (c) youth are provided with close supervision, and (d) helping youth avoid negative peer influences and develop relationships with positive peers (Chamberlain, 2003). To accomplish these goals, daily data are collected from treatment foster parents using the Parent Daily Report Checklist (Chamberlain, 2003).

MTFC outcomes. The first study to assess the effects of specialized foster care (SFC), which later became MTFC, was a randomized control trial comparing outcomes of youth who were placed in SFC or treatment as usual (residential treatment centers or group homes) (Chamberlain & Reid, 1991). Results of this study showed that youth who were in SFC were placed faster than the treatment as usual group, and spent longer in their placements even though this difference was not significant (Chamberlain & Reid, 1991). In addition, the Parent Daily Reports indicated a 50% reduction in problem behaviors for the SFC group (Chamberlain & Reid, 1991). However, this initial study used a small sample size ($n = 10$ in each group), and the SFC group reported more emotional issues during the study. The next study involved youth in regular foster care and demonstrated that retention rates of parents in foster care was increased, and foster parents' reports on child problems on the Parent Daily Report Checklist were reduced by providing enhanced training (based on MTFC training concepts in behavior management) and support as well as an increase in monthly stipend as compared to groups who received no additional training or support (Chamberlain et al., 1992).

To examine the effectiveness with the juvenile justice population, a randomized control trial was used to compare MTFC with community Group Care (GC) among juvenile delinquents who had been removed from their home (Chamberlain & Reid, 1998). The boys in the MTFC group ran away less frequently, completed their programs more often, and were locked up in detention less frequently (Chamberlain & Reid, 1998). These youth also reported they committed fewer delinquent acts and fewer violent crimes, and they spent more days living with their families at follow-up after a year (Chamberlain & Reid, 1998). The limitation of this study is that only boys were included in the sample. In a follow-up from this study, the MTFC program had a positive effect on the youth by preventing subsequent violent behavior in the boys after two years of entry into the study (Eddy, Whaley, & Chamberlain, 2004). The same study design was used to examine outcomes for girls referred from juvenile justice. A randomized control trial comparing girls in MTFC to group care found that MTFC was more effective than the control group in reducing incarceration and delinquency rates, and the MTFC girls spent fewer days in locked settings at follow-up after a year (Leve, Chamberlain, & Reid, 2005). In the follow-up to this study, the girls in MTFC demonstrated maintenance of the program in preventing delinquency as measured by a decrease in days in locked settings, number of criminal referrals, and self-reported delinquency after two years of entry into the study (Chamberlain, Leve, & DeGarmo, 2007). The publication and dissemination of the research results using rigorous research designs helped to aid in the selection of MTFC as a Blueprint Program by the Colorado Center for the Study and Prevention of Violence, the Centers for Disease Control, and the Office of Juvenile Justice and Delinquency Prevention (Chamberlain, 2003). In addition, MTFC received the strongest

rating on the CEBC (2013) website meaning that it is the only program model available for treatment foster care that is well supported by research evidence.

PR-TFC. Pressley Ridge, a nonprofit mental health organization, developed the PR-TFC model in 1981 and the model is currently being used in Pressley Ridge’s 15 TFC programs in six states (Hawkins, Meadowcroft, Trout, & Luster, 1985; Meadowcroft & Grealish, 1990; Trunzo et al., 2012). The PR-TFC model was originally referred to as the Pressley Ridge Youth Development Extension (PRYDE) program which focused on using treatment foster parents as primary change agents, and reunifying youth with their families at time of discharge from the program (Hawkins et al., 1985; Hasselman & Rautkis, 2004). Due to PR-TFC’s similarities with MTFC, it is important to provide a comparison of the models’ components outlined in Table 2 (MTFC information was synthesized in a presentation by Farmer & Murray, 2009). These similarities in treatment approaches may suggest that comparable results could be achieved using PR-TFC’s model; however, more research is needed in order to confirm this statement.

Table 2

Similarities and Differences between MTFC and PR-TFC

Model Component	MTFC	PR-TFC
Service Coordination/Case Management	Yes	Yes
Treatment Parents as key providers/change agents	Yes	Yes
Team approach to treatment	Yes	Yes
Respite provided	Yes	Yes
Work with youth’s family	Yes	Yes
Reduce association with deviant peers	Yes	Yes
Intensive supervision/support	Yes	Yes
Proactive approach to behavior problems	Yes	Yes
Preparing for transition to adulthood	Not systematic	Yes
Addressing previous trauma and sequelae	Not systematic	Yes

Note. Adapted from “Together Facing the Challenge: Preliminary Findings from a Randomized Control Trial of Therapeutic Foster Care” by E. M. Z. Farmer and M.

Murray, 2009, Paper presented at the 22nd Annual Research Conference, A System of Care for Children's Mental Health: Expanding the Research Base, Tampa, FL.

In addition to the core principles of TFC models, three basic tenets underlie the PR-TFC model: (a) children's troubled behavior can change, (b) treatment foster parents can learn to change children's behavior, and (c) treatment involves teaching youth the skills necessary for effective living (Hasselman & Rauktis, 2004; Trunzo et al., 2012). The model is based on the Nicholas Hobbs' Re-Education model and is designed to provide individualized services for youth with emotional and behavioral disorders in treatment homes at a reduced cost to funders (Hobbs, 1966; Almeida et al., 1989). Treatment foster parents are expected to implement interventions such as active teaching, skill-based interventions, and the use of a daily list of objectives to encourage and reward individualized behaviors through a points system (Almeida et al., 1989; Bishop-Fitzpatrick et al., 2014; Trunzo et al., 2012).

Youth who are served in PR-TFC typically present with externalizing disorders such as Attention deficit hyperactivity disorder (ADHD), on average have two clinical diagnoses, and half of them are receiving the service as a step down in level of restrictiveness (e.g., moving from residential treatment center to treatment foster care) (Bishop-Fitzpatrick et al., 2014; Trunzo et al., 2012). Youth also experience behavioral problems in their day-to-day functioning at home, in school, and/or in the community as measured by having a score in the severe impairment range on the Child and Adolescent Functional Assessment Scale (CAFAS) (Bishop-Fitzpatrick et al., 2014; Hodges, 2005). They also have a history of residential stability or are at risk for residential stability, and

they are involved with two or more public service systems (e.g., juvenile justice, child welfare, substance abuse) (Bishop-Fitzpatrick et al., 2014; Trunzo et al., 2012).

PR-TFC outcomes. Early results of the PR-TFC program showed 82% of youth were discharged to their homes, and of these youth only one had re-entered the child welfare system six months after discharge (Hawkins et al., 1985). Although similarities exist between the MTFC and PR-TFC model, unlike the MTFC model, the PR-TFC model has not been evaluated using rigorous research designs, and has relied more on outcome evaluation results to provide practice-based evidence of effectiveness in improving youth functioning and discharging youth to the least restrictive living environment (Hawkins et al., 1985; Mason et al., 2003). However, a recent article examined the effectiveness of the PR-TFC model in improving functioning for youth using an analytic sample of 612 youth who had discharged from PR-TFC programs over a three year period (Bishop-Fitzpatrick et al., 2014). Using structural equation modeling, it was shown that youth enrolled in PR-TFC programs improved in functioning from entry to discharge and their functioning at discharge was predicted by days in TFC treatment and age at time of entry (Bishop-Fitzpatrick et al., 2014). This study provides additional practice-based evidence for the effectiveness of the PR-TFC programs using a large sample of youth who had discharged from the program; however, the study design did not include a comparison group and only reported data from admission to discharge. Therefore, due to the lack of studies using rigorous research designs, the PR-TFC model currently has not been able to be rated on the CEBC (2013) website.

Treatment Foster Care Outcomes

Rigorous research on TFC has suggested the program model can have a positive impact on youth with behavioral and emotional issues in MTFC programs (Chamberlain, 1994; 2002; Chamberlain & Reid, 1991). However, additional research with other TFC models needs to examine whether similar results can be obtained in TFC programs that do not utilize the MTFC model (Bishop-Fitzpatrick et al., 2014; Farmer et al., 2002). For example, Bishop-Fitzpatrick et al. (2014) summarized three studies that evaluated the efficacy of TFC programs. The first study found that across the major models of TFC, youth in treatment foster homes experienced improvements while in treatment homes (Hudson et al., 1994). The second study, a meta-analysis of 40 outcome studies, found large effects for increasing permanency and children's social skills across treatment foster care programs, and medium effects for reducing the restrictiveness of placements at discharge, improving psychological adjustments, and decreasing behavior problems (Reddy & Pfeiffer, 1997). The third study, a systematic review of available treatment foster care program, found only five studies that used rigorous research designs, with the majority of the studies including Chamberlain's research (Turner & Macdonald, 2011).

Although the results indicate that TFC is a promising intervention for children and youth with emotional and behavioral problems or youth involved in the juvenile justice system, the evidence base is not robust and more research is needed in this area (Bishop-Fitzpatrick et al., 2014; Turner & Macdonald, 2011). A common theme across all treatment foster programs, and a core requirement of the program, that has been associated with improved outcomes for youth and retention of treatment foster parents is the pre-service training provided to prospective treatment foster parents (FFTA, 2013;

Piescher et al., 2008). Pre-service trainings for treatment foster parents have similar foundations with parent training programs, as the role of a treatment foster parent is similar to that of a parent with the main goal of helping to change behavior of the youth.

Parent Training Characteristics

During the 1950's and 1960's, there was a growing understanding that parents contribute to their children's behaviors, and that parents also can be trained in a therapeutic role in order to provide behavior change for their children (Hawkins, 1989; Kaminski et al., 2008). This knowledge about the capacity for parents to provide behavior change in their children provided the foundation for many training programs for parents, and is seen as a popular approach to improving parent-child interactions and reducing child maltreatment with approximately 800,000 parents receiving such training each year (Besser, Falk, Arias, & Hammond, 2009). Therefore, traditional parent training program characteristics and outcomes have influenced treatment foster parent training programs as these training programs have similarities, and have been in place longer (Hawkins, 1989; Kaminski et al., 2008).

There are three general assumptions about characteristics parent training programs should include: instruction in child development and appropriate parenting skills, use of a manual or curriculum, and the provision of ancillary services; all of which are supposed to influence the outcomes of the program (Kaminski et al., 2008). In a meta-analysis of 128 parenting programs with reported outcomes, predominant outcomes included positive changes in parenting knowledge, attitudes, self-efficacy, behaviors, or skills, and to a lesser amount, improved child behaviors (Kaminski et al., 2008). Decades of research also show that programs in which parents actively acquire parenting skills

through mechanisms such as homework, modeling, or practicing skills directly with their own children or through role-playing with peers are more effective than passive approaches that only provide information through books, lectures, or videos (Besser et al., 2009; Kaminski et al., 2008). Therefore, training programs that move beyond traditional didactic instruction and instead incorporate concepts of adult learning principles and opportunities for experiential activities are more effective than passive learning strategies, with group trainings being seen as less costly and more effective than individual trainings (Besser et al., 2009).

Although similarities exist between parent training programs and treatment foster parent training specifically around assessing parenting knowledge and attitudes, the structure and characteristics of treatment foster parent training differs due to the professional role that treatment foster parents play in serving as the implementers of the TFC program model and the primary change agents for youth placed in their homes (Meadowcroft & Grealish, 1990). Therefore, different training guidelines and outcomes associated with parent training programs are necessary for treatment foster parents so they can be prepared for handling the emotional and behavioral needs of children placed in their home, as well as the added responsibilities of their professional role.

Foster Parenting Training Characteristics

With regard to treatment foster parent pre-service training, the Foster Family-Based Treatment Association (FFTA, 2013) published a set of *Program Standards for Treatment Foster Care*; however, the training standards are limited with suggestions around training content, and they only recommend the required hours to be commensurate with state/provincial and accrediting body requirements, with no guidance

on specific training outcomes before a child is placed in the home. And, although US federal policy requires training of prospective foster parents, the policy only provides general guidelines for training content and does not address implementation procedures or recommendations for the skills foster parents need to demonstrate before a child is placed in the home (Foster Care Independence Act of 1999, P. L. 106-169). Therefore, program staff offer trainings on different topics and focus on particular domains; however, Chamberlain's MTFC model has influenced the specific training constructs for pre-service trainings (Dorsey et al., 2008).

Existing Foster Parent Training Programs

MTFC. The MTFC model includes 20 hours of pre-service training using a manual, and involves current TFC parents, role-plays, home practice exercises, and traditional didactic-style interaction (Chamberlain, 1994; Chamberlain & Mihalic, 1998; Dorsey et al., 2008). For the MTFC model, the pre-service training includes five core areas: an overview of the MTFC model, using a four-step approach to analyze behavior, procedures for using a three-level point system, working with the child's biological family, and explaining MTFC policies and procedures (Dorsey et al., 2008; Fisher & Chamberlain, 2000). The MTFC model is based on social learning theory where the youth's behavior is explained in relation to a continuous reciprocal interaction of personal and environmental determinants (Bandura, 1977).

The MTFC pre-service training complements the model by teaching treatment foster parents ways to modify and teach appropriate behavior through positive reinforcement and punishment using the relationship with the child (e.g., therapeutic alliance) and family environment as catalysts for change (Chamberlain, 1994;

Chamberlain & Mihalic, 1998). Although the MTFC model influences foster parent satisfaction and children's behavior and delinquency, the effectiveness of the MTFC pre-service training program has yet to be established (CEBC, 2013; Dorsey et al., 2008).

KEEP. The less intensive version of MTFC, KEEP, has been studied and involves weekly 90-minute group support sessions over 16 weeks, with main concepts of the model presented through role-plays and videotapes that focus on the foster parent's role as the key change agents in helping youth (Chamberlain et al., 2008; Chamberlain et al., 2006; Price et al., 2008). The program promotes child cooperation, behavioral modification and limit setting, encouraging success in school, and managing the stress of providing foster care by supporting foster parents in the application of these concepts (Chamberlain et al., 2008; Chamberlain et al., 2006; Price et al., 2008).

Supporting evidence for the effectiveness of the KEEP program shows foster parents reported higher levels of positive reinforcement, lower levels of undesirable child behaviors, fewer placement disruptions, and fewer foster parents dropping out of providing care; moreover, the children in foster care were twice as likely to be reunited with a parent, a relative, or adopted compared to the control group (Chamberlain et al., 2008; Chamberlain et al., 2006; Price et al., 2008). Therefore, due to multiple studies demonstrating the program's effectiveness, CEBC (2013) rated the KEEP program as a promising practice; however, studies that evaluate this program's effectiveness as a pre-service training for treatment foster parents have yet to be published (Dorsey et al., 2008).

FosterParentCollege.com. A program that is also designed to provide ongoing support and training to foster parents is the FosterParentCollege.com program, where

foster parents can take up to 38 parent training courses online or through DVD's that are self-paced and take about one to two hours to complete each course (Delaney, Nelson, Pacifici, White, & Smalley, 2012; Pacifici, Delaney, White, Cummings, & Nelson, 2005; Pacifici, Delany, White, Nelson, & Cummings, 2006). Courses are based on attachment theory with the focus on teaching foster parents the process of parent-child bonding and encompass topics that help foster parents deal with serious child behavior issues (e.g., anger outbursts, child abuse and neglect, lying), building relationships (e.g., strengthening communications), and understanding children with mental health diagnoses (e.g., ADHD, Autism) (Delaney et al., 2012; Pacifici et al., 2005; Pacifici et al., 2006).

Supporting evidence for this program evaluates only one or two of the courses, and there has not been a formal evaluation of the entire training program (Delaney et al., 2012; Pacifici et al., 2005; Pacifici et al., 2006). For example, an evaluation of the *Anger Outburst* course showed that foster parents had increased knowledge and confidence in dealing with foster children's anger issues compared to the wait-list control group (Pacifici et al., 2005). Another research study evaluated two training courses (*Lying* and *Sexualized Behavior*) and found that foster parents increased their knowledge for both courses, but changes in knowledge were only significant for the *Lying* course (Pacifici et al., 2006). Recently, Delaney et al. (2012) evaluated the *Child Abuse and Neglect* course for use as a pre-service training versus a traditional in-person session and found that foster parents' knowledge of child abuse and neglect increased more than the in-person comparison group, and foster parents were more satisfied with the online training course; however, the rest of the pre-service training courses were provided in person and were not evaluated for effectiveness. Although the CEBC (2013) rated this program as a

promising practice, this fragmented evaluation approach does not provide evidence for the overall effectiveness of the entire training program, especially in a pre-service format.

Together Facing the Challenge. The only training program developed and evaluated specifically for treatment foster parents is the Together Facing the Challenge program, yet it has also not been evaluated for use in a pre-service format (CEBC, 2013; Farmer, Burns, Wagner, Murray, & Southerland, 2010). The treatment parent training consists of six sessions, one session per week for a total of 12 hours on topics that include: building relationships, setting expectations, using effective parenting to enhance cooperation, implementing consequences, preparing children for the future, and taking care of oneself (Murray et al., 2010). Supervisors in TFC programs also receive 12 hours of training prior to the training sessions on topics in which treatment foster parents are trained, and ways in which they can support them in their role (Murray et al., 2010).

Supporting evidence for this training program includes one randomized-control trial that showed youth whose treatment foster parents received this training program, compared to the treatment as usual group, experienced more improvement in their symptoms, behaviors, and strengths at six months, and these improvements remained significant at 12 months (Farmer et al., 2010). Due to the fact that this study used a rigorous research design with a comparison group, included a follow-up component, and treatment effects were maintained, the CEBC (2013) rated this program as supported by research evidence, which is stronger than the promising practice rating both KEEP and FosterParentCollege.com received. However, there were no assessments that would provide results on increased knowledge of treatment foster parents' or change in their parenting behaviors due to the additional training they received.

The KEEP program, FosterParentCollege.com, and Together Facing the Challenge may be helpful in supporting ongoing training needs of treatment foster parents, but more research is needed to determine the effectiveness of using these programs as pre-service training programs, as well as evaluating other training programs designed specifically for foster parents as pre-service courses.

PRIDE. The Child Welfare League of America (CWLA, 1996) developed the Foster Parent Resources for Information, Development, and Education (PRIDE) program, and this program is widely used for pre-service training in 30 states and 19 countries. The PRIDE program covers topics including attachment, planning for permanency, loss, strengthening and maintaining family relationships, discipline through using token economies, and general foster care information (CWLA, 1996). The entire program provides a structured process for recruiting, training, and selecting foster and adoptive parents (CWLA, 1996). The training component involves nine three-hour sessions that are delivered to foster parents over a two-and-a-half month period through use of individual manuals, videos, self-instruction, and homework (CWLA, 1996).

However, the CEBC (2013) has not been able to rate the PRIDE program due to the lack of empirical evidence for its effectiveness. One evaluation study found that foster parents increased their knowledge about working with foster children after completing the training (Christenson & McMurty, 2007). Another study followed up with the original training class, and found that the knowledge the foster parents gained was still significant a year and a half after completing the training program (Christenson & McMurty, 2009). However, neither of these studies included a rigorous research

design that involved a control group that would determine if the PRIDE program was more effective than a comparable training program.

MAPP. If mental health organizations do not use the PRIDE program for pre-service training, the other option the Department of Human Services supports is the Model Approach to Partnerships in Parenting (MAPP) program (Dorsey et al., 2008). The Child Welfare Institute initially developed the MAPP program to provide foster parent training over a 10-week period (Lee & Holland, 1991). However, the MAPP program has gone through several revisions based on inconclusive evidence to support its effectiveness as a foster parent training program (Lee & Holland, 1991; Puddy & Jackson, 2003).

For example, in a small pilot study of the original MAPP curriculum, foster parents were predicted to demonstrate more appropriate developmental expectations, lower emphasis on physical punishment, improved understanding of appropriate parent-child roles, and greater empathy toward children's needs compared to the control group (Lee & Holland, 1991). In comparison to the control group of untrained foster parents, there was no statistically significant difference between the groups for the four predictions (Lee & Holland, 1991). This study relied on a very small sample size ($N = 29$), was quasi-experimental, and did not assess all components of the training curriculum (Lee & Holland, 1991). In addition, Lee and Holland (1991) concluded that there was "...no available systematic presentation of a theoretical foundation for MAPP and no apparent logical or empirical justification for its assumptions, components, or methods" (p.172).

After this pilot study was conducted, the MAPP curriculum was changed to Model Approach to Partnerships in Parenting/Group Selection and Participation in Foster and/or Adoptive Families (MAPP/GPS) to include a theoretical basis, goals, objectives, and specific skill areas for foster parents (Puddy & Jackson, 2003). The training program still consisted of 10 weeks, with 30 hours of trainings using lectures, group discussion, role-playing exercises, and guided imagery (Puddy & Jackson, 2003). New goals for MAPP/GPS were to teach foster parents twelve skills to aid in effective communication, management of child behaviors, and assurance of health and safety of the foster child (Puddy & Jackson, 2003). In an evaluation of the twelve skills identified in the MAPP/GPS program, Puddy and Jackson (2003) found that the program was ineffective in increasing foster parents' knowledge in 8 of the twelve skills compared to the control group, and actually decreased their knowledge in effective communication and behavior management skills. They concluded that, "...the findings indicate that the MAPP/GPS training program is problematic and does not adequately prepare foster parents for the challenges of parenting foster children" (Puddy & Jackson, 2003, p. 1002).

For example, the four areas in which trained foster parents increased their skills compared to the control group were areas that do not represent actual parenting knowledge and techniques, because they are issues that are relevant to working with the foster care system (e.g., working in partnerships, making an informed decision to foster) (Puddy & Jackson, 2003). Therefore, they recommended that the program is best used as a decision tool to decide whether to become a foster parent rather than a foster parent training program (Puddy & Jackson, 2003).

Rhodes, Orme, Cox, and Buehler (2003) evaluated the MAPP/GPS training, but focused more on demographic variables that influenced retention rates of foster parents such as education, family income, marital status, employment status, having parenting and foster parenting experience, belonging to a place of worship, working in a helping profession, being European American, and having social support from family and friends. They found that 48% of families who started the pre-service training did not complete it, and that 46% of families who did complete the training either had discontinued or planned to discontinue foster parenting six months after the training (Rhodes et al., 2003). In addition, families with more psychosocial problems and fewer resources had a greater likelihood of not continuing as foster parents after completing the pre-service training (Rhodes et al., 2003). However, due to lack of a control or comparison group, the impact on retention rates of foster parents cannot be directly attributed to ineffectiveness of the pre-service training or certain demographic variables. Due to the lack of evidence to support its effectiveness as a training program, the CEBC (2013) has not been able to give a rating for MAPP/GPS. Therefore, review of the available literature confirms there are currently no pre-service training programs both designed and evaluated specifically for treatment foster parents.

PR-TFC. Another intervention is the Pressley Ridge-Treatment Foster Care (PR-TFC) pre-service training designed specifically for treatment foster parents, and although the skill-based components of the training program may be an encouraging approach to prepare treatment foster parents for their therapeutic role, no research has been published on the effectiveness of this training program on preparing treatment foster parents. The PR-TFC pre-service training program has a similar training structure and learning

constructs as MTFC's pre-service training, because the program models are comparable and were both started in the 1980's (Chamberlain, 1990; Chamberlain & Reid, 1994; Hawkins et al., 1985).

An important component of the PR-TFC model is the PR-TFC pre-service training; a competency-based program rooted in social learning theory and behavior management techniques that contains 12 units and takes 2 ½ hours to present each unit (Burge, 2006). Integrated multimedia resources include PowerPoint slides, video vignettes on DVD that demonstrate therapeutic skills taught during training, experiential activities (e.g., role plays), homework, and reading assignments for parents in a manual (Burge, 2006). Some key concepts of the training modules include: professional parenting roles, understanding child development and behavior, developing healthy relationships, therapeutic communication, changing behavior, skill teaching, conflict resolution, and understanding and managing crisis (Burge, 2006). The PR-TFC pre-service training has clear objectives and requirements, a set of core values and guiding principles, promotes a common language and identity, and provides measurable treatment parent competencies (Burge, 2006). Knowledge questionnaires developed specifically for the training, standardized attitudinal measures, and organization-developed skills observation forms help to determine whether potential treatment foster parents are learning the skills from the training, increasing their child rearing and parenting attitudes, increasing their willingness and dedication to provide treatment foster care, and after they are licensed, whether they are using their therapeutic skills when a child is placed in the home.

PR-TFC vs. MAPP. For the purpose of this study, it is important to distinguish the similarities and differences between the two trainings that were given to prospective treatment foster parents. The key training components are outlined in Table 3 and show that MAPP focuses on child welfare practices and decision making to become foster parents whereas PR-TFC focuses on empowering treatment parents as change agents and teaching them skills to help manage behaviors of youth in their care. The amount of training and focus on alliance building are similar for both training programs.

Table 3
Training Components of MAPP and PR-TFC

Training Component	MAPP	PR-TFC
Underlying theories	<ul style="list-style-type: none"> • Role theory • Adult learning theory 	<ul style="list-style-type: none"> • Social learning theory • Behaviorism • Therapeutic alliance
Underlying beliefs	<ul style="list-style-type: none"> • Alliance model of child welfare practice • Safety, well-being, and permanence • Strengths approach 	<ul style="list-style-type: none"> • Treatment parent as change agent • Children’s troubled behavior can change • Treatment parent teaches youth skills necessary for effective living
Training length	30 hours, 10 units	30 hours, 12 units
Concepts	<ul style="list-style-type: none"> • Know their own family • Communicate effectively • Know the children • Build strengths; meet needs • Work in partnership • Be loss and attachment experts • Manage behaviors • Build connections with birth family • Build self-esteem • Assure health and safety • Assess impact of foster care on own family 	<ul style="list-style-type: none"> • Introduction to TFC: History and Mission • Professional Parenting I: Roles and Responsibilities • Professional Parenting II: Roles and Responsibilities • Understanding child development • Developing healthy relationships • Therapeutic communication • Understanding behavior • Changing behavior

- Make an informed decision to foster
- Skill teaching
- Conflict resolution
- Understanding crisis
- Managing crisis

Note. MAPP information adapted from “The Development of Parenting Skills in Foster Parent Training,” by R. Puddy and Y. Jackson, 2003, *Children and Youth Services Review*, 25(12), p. 995.

Foster Parent Competencies

Standardized attitudinal measures are gaining momentum in the mental health field as an approach to assess key competencies found to increase foster parent’s ability to provide treatment foster care (Orme et al., 2006). Casey Foster Family Programs, the leading foundation that focuses primarily on foster care, has done extensive research around the competencies and assessments that can be used to screen potential foster parents before placing children in the home that would help to reduce instances of child maltreatment or placement disruptions (Orme et al., 2006). A popular approach foster care programs use is the Casey Home Assessment Protocol-Self-Report (CHAP-SR) that provides screening tools to assess the 10 competencies identified as pertinent areas for providing safe foster placements for youth, with recommended self-report measures to assess eight out of the 10 competencies (Orme et al., 2006). These competencies include: engagement in fostering, family history, physical and mental health, family functioning, parenting style, family resources, social supports, cultural competencies, fostering readiness, and capacity for meeting fostering challenges (Orme et al., 2006). The PR-TFC pre-service program is designed to address all of these competencies with specific focus on using standardized attitudinal measures that assess parenting styles, capacity for meeting foster challenges, and fostering readiness.

Due to the similarities of parent training with treatment foster parent training, Casey Foster Family Programs has identified foster parents' parenting style as an important competency to assess in order to ensure that children with emotional and behavioral problems are not placed in a home where parents might not practice healthy parenting approaches (Orme et al., 2006). Appropriate parenting styles for treatment foster parents refers to parenting behaviors and attitudes, such as use of non-physical punishment, appropriate expectations for children based on their developmental levels, and having empathy for children (Bavolek & Keene, 1999; Orme et al., 2006). In addition, foster parents' parenting style can be related to their capacity to meet the challenges of fostering due to their abilities to effectively deal with children's difficult behaviors (Orme et al., 2006). According to Orme et al. (2006) foster parents should demonstrate knowledge of age appropriate behaviors, understanding of reasons for a child's behavior, and a commitment to work with the child due to the connection between these skills, and providing safe living environments for youth in placement.

Another important competency is fostering readiness with an emphasis on the willingness and dedication to provide foster care to children with emotional and behavioral problems due to connections between these attitudes and increased placement success and stability (Cox et al., 2011). For example, Orme et al. (2006) found that a greater willingness to foster children with emotional and behavioral problems follows from a greater personal dedication to fostering and leads to more satisfaction with fostering, a greater potential to foster in general, and a smaller number of placement disruptions. In addition, a greater personal dedication to foster follows from more parental acceptance of children, and leads to greater potential to promote foster child

development, and greater intention to foster in the long range (Orme et al., 2006).

However, the sample included in this research included current foster parents, with no current studies examining whether completion of pre-service training influences foster parents' willingness and dedication to provide treatment foster care.

By using the CHAP-SR competencies as a guiding approach for screening prospective foster parents, mental health organizations can use a systematic approach to assess treatment foster parents' attitudes about parenting, their willingness and dedication to provide foster care, and their capacity for meeting fostering challenges in order to inform the need for additional resources, supports, and training (Orme et al., 2006). In addition to using standardized attitudinal measures for screening, they can be used to determine if the added resources and training given to treatment foster parents is effective in cultivating development of these competencies before a child is placed in the home, which would help reduce placement disruptions and improve child well-being. To date, no one has published research on the use of these screening assessments in evaluating the effectiveness of training programs for measuring increases in treatment foster parents' readiness to provide treatment foster care.

Chapter Three: Methodology

The purpose of this study was to examine the effectiveness of pre-service trainings on treatment foster parents' attitudes toward parenting, readiness to provide treatment foster care, and attitudes toward providing treatment foster care for those who completed the Model Approach to Partnerships in Parenting (MAPP) pre-service training compared to those who completed Pressley Ridge's Treatment Foster Care (PR-TFC) pre-service training. In order to address the areas of interest and the specific research questions, de-identified archival data were obtained from prospective treatment foster parents who completed assessments before the pre-service training, immediately after the pre-service training, and approximately two years after a child was placed in the home. The instruments measured parenting attitudes and beliefs, personal dedication to provide foster care, willingness to provide foster care to children with emotional and behavioral difficulties, and overall satisfaction with providing treatment foster care.

Research Questions

The following research questions were addressed in this study:

1. Does pre-service training affect treatment foster parents' parenting attitudes toward children?
2. Does pre-service training affect treatment foster parents' readiness to provide treatment foster care?
3. Does pre-service training affect treatment foster parents' readiness to provide treatment foster care *after* a child is placed in the home?
4. Does pre-service training predict treatment foster parents' attitudes toward providing treatment foster care *after* a child is placed in the home?

Hypotheses

From the review of the findings from previous research (e.g., Dorsey et al., 2008; Festinger & Baker, 2013; Orme et al., 2006; Piescher et al., 2008), the alternative hypotheses examined in this study were:

H₁: There is a significant increase in appropriate parenting and child rearing attitudes for participants who complete the PR-TFC training than participants who complete the MAPP training.

H_{2a}: There is a significant increase in the personal dedication to provide foster care service for participants who complete the PR-TFC training than participants who complete the MAPP training.

H_{2b}: There is a significant increase in the willingness to foster children with behavioral and emotional difficulties for participants who complete the PR-TFC training than participants who complete the MAPP training.

H_{2c}: There are significantly more participants who become licensed as treatment foster parents for those who complete the PR-TFC training than those who complete the MAPP training.

H_{3a}: After a child is placed in the home, participants who completed the PR-TFC training will report significantly more personal dedication to provide foster care service than participants who completed the MAPP training.

H_{3b}: After a child is placed in the home, participants who completed the PR-TFC training will report significantly more willingness to foster children with behavioral and emotional difficulties than participants who completed the MAPP training.

H4: The PR-TFC group will be a significant predictor of treatment foster parents' overall satisfaction with providing treatment foster care after a child is placed in the home.

Research Design

A quasi-experimental evaluation design was initially used to compare the use of Pressley Ridge's Treatment Foster Care (PR-TFC's) pre-service training with training-as-usual that was designed for foster parents (Model Approach to Partnerships for Parenting [MAPP]). Use of a comparison group helps to strengthen the internal validity of the study, because this research design allows the researcher to detect any effects of the intervention (Babbie, 2010). The project was completed through an inter-agency collaboration between Pressley Ridge and Easter Seals/UCP of North Carolina and Virginia (Easter Seals) between 2010 and 2014. The initial purpose of collecting and evaluating the data obtained from surveys was for internal quality improvement and program evaluation activities.

The initial evaluation design was a multiple baseline methodology approach where the offices in North Carolina provided MAPP and PR-TFC training in two waves, with all offices starting with MAPP training initially, then half of the offices starting with PR-TFC training in wave one, and the other half starting PR-TFC in wave two approximately six weeks later. This is a common design used in social service fields due to the practicality especially when random assignment is not feasible, and if withdrawal of an intervention would be considered unethical (Gast & Ledford, 2014). However there were several offices that did not follow this evaluation design and did not implement the PR-TFC training, so only those offices that implemented both MAPP and then PR-TFC

were used in this study. The purpose of only including offices that implemented both MAPP and PR-TFC in this study is to reduce confounding variables that may have an influence on the results (e.g., demographics of participants trained in the offices, staff that provided trainings). For this study, exemption from Duquesne University's Institutional Review Board was received, and data were de-identified by an Evaluation Assistant within Pressley Ridge so the researcher did not know the identity of research participants.

Sample

A purposive sample of treatment foster parents ($N = 152$) who completed pre-service training with Easter Seals was used in this study. This sample size is sufficient for running the intended analyses due to the comparable sizes of participants in each of the groups (PR-TFC vs. MAPP). Comparable sample sizes are considered robust and preferred when analyzing data, because they mitigate violations of assumptions for statistical tests. This sample represents the intended population due to the interest in examining the effectiveness of the pre-serving training programs for preparing treatment foster parents in their therapeutic roles.

Data Collection

Data were collected at three time points for both training groups: before the pre-service training (pretest), immediately after completing the last pre-service training unit (posttest), and approximately two years after a child was placed in the treatment foster parent's home (follow-up) for those treatment foster parents who were licensed and had a child placed in their home at any point after becoming licensed. The dataset contained demographic variables (e.g., sex, age, race, education level, employment status), training

outcomes (e.g., licensed as treatment foster parents, child placed in home) and scores from four instruments.

Instruments

Adult-Adolescent Parenting Inventory-2 (AAPI-2). The AAPI-2 is a 40-item survey designed to assess parenting and child rearing attitudes of adult and adolescent parents. Based on known parenting and child rearing behaviors of abusive parents, responses to the inventory provide an index of risk for practicing behaviors known to be attributable to child abuse and neglect (Bavolek & Keene, 1999). Participants reported on a Likert scale (1 = *strongly agree* and 5 = *strongly disagree*) to the following statements: “Children should keep their feelings to themselves”, and “Spanking teaches children right from wrong.” One purpose of the AAPI-2 is to screen and train prospective foster parent applicants in order to identify appropriate parenting attitudes and practices to increase the quality of placements (Bavolek & Keene, 1999). The assessment has two parallel forms (Form A and Form B) that can be used as a pre and posttest to measure treatment effectiveness, and they provide total scores and sten scores for five subscales: expectations of children, parental empathy towards children’s needs, alternatives to corporal punishment, parent-child role responsibilities, and children’s power and independence (Bavolek & Keene, 1999). Sten scores were developed to determine high, medium, and low risk to abuse, and were based on norms generated from a population of 713 adult parents who have not participated in formal parenting programs. This population represents the normal or non-abusive parent population. Cronbach’s alphas are high ranging from .88 to .97 (Bavolek & Keene, 1999).

Validity research with the AAPI-2 indicates: abusive parents express significantly more abusive attitudes than non-abusive parents, males regardless of status (abusive or non-abusive) express significantly more abusive parenting attitudes than females, and responses to the inventory discriminate between the parenting behaviors of known abusive parents and the behaviors of non-abusive parents (Bavolek & Keene, 1999; Conners, Whiteside-Mansell, Deere, Ledet, & Edwards, 2006). The AAPI-2 also collects the following demographic information: age, gender, race, marital status, number of children, education level, employment status, household income, military background, and history of abuse.

AAPI-2 scoring. The AAPI-2 was scored using the Assessing Parenting website that provides raw scores and sten scores for each construct (Family Development Resources, 2007). Responses for each item were also downloaded and available in the database. There was no missing data as the website does not allow assessments to be entered without all of the questions completed. Scoring can be complex due to the reverse-scored items and different questions that comprise of the constructs for the two different forms. Using the AAPI-2 online development handbook (Bavolek & Keene, 2010), questions for each construct were reverse-scored, summed, and double-checked against the construct scores that were generated from the Assessing Parenting website (Family Development Resources, 2007). The reason for re-constructing the construct scores from participants' individual scores was for the ability to compute reliability coefficients for each construct, which requires knowing which questions constitute each construct. In addition, change scores were calculated by subtracting the posttest score from the pretest score for each construct for all participants in order to determine any

movement in scores from before the training and after the training. Higher posttest scores indicate more appropriate parenting attitudes, and a lower risk for child maltreatment as participants are intended to respond 5= *strongly disagree* to negatively worded statements about children and respond 1= *strongly agree* to positively worded statements about children that are then reverse-scored (Bavolek & Keene, 1999). Therefore, a positive change score indicates an improvement in parenting attitudes at the end of pre-service training.

Personal Dedication to Fostering Scale (PDFS). The PDFS is an 18-item scale designed to measure professional commitment, moral/ethical consciousness, receptivity, and responsiveness to foster children. Items were modified from the Human Caring Inventory for Social Workers (Ellett, 2000). Participants reported on a 4-point Likert scale how much they agreed or disagreed with statements such as: “I would delay my personal plans to assist a foster child who needs my help”, and “I would want to be a foster parent even if I did not get paid.” The PDFS provides a summary report that shows whether a potential foster parent’s raw score indicates low, medium, or high potential to provide foster care (Orme et al., 2006). The normative sample is from 304 foster mothers and 111 foster fathers who were licensed to provide foster care (Orme, Cherry & Cox, 2006; Orme et al., 2006). The rationale to use licensed foster parents was due to the aspirations of potential foster parents to become licensed themselves; and in reality there are more foster mothers than foster fathers (Orme et al., 2006). The interquartile ranges are used to determine their level of potential for providing foster care: low, medium, or high. The interquartile ranges are different for males and females.

The PDFS has strong reliability ($\alpha = .80$), and validity of the assessment was assessed using regressions and exploratory factor analysis (Orme et al., 2006). The results show strong support that PDFS scores predict more available time to foster, more cultural receptivity to fostering, greater willingness to foster children, greater potential to foster, and greater intention to foster in the long range (Orme et al., 2006).

PDFS scoring. A formula in Figure 1 was used to compute raw scale scores for the PDFS (Orme et al., 2006). This formula results in a range from 0 to 100 and was used by the developers because of its ease in interpretation for agency staff who use the assessment. One item on the PDFS is reverse-scored and this item was recoded before scoring. Missing values for items (pretest = 0.49%, posttest = 0.60%, follow-up = 0.60%) were estimated using a mean score substitution based on the participant's responses of completed items before scaled scores were computed. The scoring manual recommends to use this option only for participants who have at least 15 out of the 18 responses completed. Interquartile ranges for males and females were used to determine potential (e.g., high, medium, or low) to provide foster care based on the PDFS scores. Change scores were also calculated to determine movement in scores from before the training, after the training, and at time of follow-up. Higher scores indicate more personal dedication to provide foster care so a positive change score indicates an improvement in personal dedication to provide foster care after the training and at time of follow-up.

$$S = \frac{(M - 1)(100)}{K - 1}$$

where: S = the scale score

M = the mean item score

K = the largest possible value for an item response

Figure 1. Formula for computing scaled scores for PDFS & WFS. From *Casey Home Assessment Protocol (CHAP) Technical Manual (2nd ed.)* by J. G. Orme, M. E. Cox, K. W. Rhodes, T. M. Coakley, G. S. Cuddeback, and C. Buehler, 2006, Knoxville: University of Tennessee, Children’s Mental Health Services Research Center.

Willingness to Foster Scale (WFS). The WFS is a 70-item scale designed to measure willingness to foster different types of children such as: children with emotional and behavioral problems, children with special needs, children five and under, children six and over, and children of a different race, religion, culture, or sexual orientation. Participants responded to statements on a 4-point Likert scale about their level of willingness to foster different types of children such as: “Child who threatens others”, and “Child who doesn’t feel guilty after misbehaving.” Only the 40-question subscale addressing foster parent’s willingness to foster children with emotional and behavioral issues (WFS-EB) was used in this study. The WFS provides a summary report that shows whether a potential foster parent’s raw score indicates low, medium, or high potential to provide foster care (Orme et al., 2006). The normative sample is the same sample used for the PDFS (Orme et al., 2006). Cronbach’s alphas for the five subscales ranged from marginal to excellent, with the emotional-behavioral ($\alpha = .96$), special needs ($\alpha = .90$), and children less than 5 ($\alpha = .89$) having excellent reliability, children older than 6 has good reliability ($\alpha = .77$), and different race, religion, culture, and sexual orientation subscale has marginal reliability ($\alpha = .66$).

Validity of the assessment was assessed using regressions and exploratory factor analysis with the results showing strong support for the predictive validity of the WFS as an indicator of the potential to provide successful foster care. For example, the WFS predicted more satisfaction with fostering, greater potential to foster in general, larger total number of children fostered, and smaller number of children placed somewhere else at the request of foster parents (Orme et al., 2006).

WFS scoring. The WFS is scored the same way as the PDFS using the formula for computing scaled scores in Figure 1 and has a potential range of 0 to 100. Before the scaled score was computed, missing values for items (pretest = 0.81%, posttest = 0.87%, follow-up = 0.63%) were estimated using a mean score substitution based on the participant's responses of completed items. The scoring manual recommends to use this option only for participants who have at least 32 out of the 40 responses (80%) completed for the WFS Emotional/Behavioral (WFS-EB) subscale. Interquartile ranges for males and females were used to determine potential (e.g., high, medium, or low) to provide foster care based on the WFS-EB. Change scores were also calculated to determine movement in scores from before the training, after the training, and at time of follow-up. Higher scores indicate more willingness to provide foster care to children with emotional or behavioral issues so a positive change score indicates an improvement in their willingness to provide foster care to these types of children after the training and at time of follow-up.

Foster Parenting Satisfaction Survey (FPSS). This 65-item survey instrument was developed to determine the factors that influence satisfaction and retention of foster parents (Denby et al., 1999). A revised 40-question survey was used in the evaluation

project to evaluate overall satisfaction with providing treatment foster care, and consists of three sections: Opinions about Fostering, Experiences with Agency and Training Experience, and Stress, Support and Satisfaction. Treatment foster parents rate how much they disagree or agree on a 7-point Likert scale for the first two sections of the survey, sample items include: “Staff treat me like a team member”, and “I feel competent to handle the types of children placed in my home.” For the final domain, the treatment foster parent rates how often they feel supported on a 5-point Likert scale (1 = *never* and 5 = *very often*) addressing areas such as: “How often does staff help you complete the difficult tasks of being a foster parent?” and “How often does staff provide you with needed after hours support?” The final three questions on the survey address overall satisfaction using a 4-point Likert scale (1 = *not at all satisfied* and 4 = *very satisfied*), likelihood to continue providing foster care in one year using a 3-point Likert scale (1 = *not at all likely* and 3 = *very likely*), and likelihood to recommend the agency to someone using the same 3-point Likert scale as the previous item.

Construction of survey items was based on information collected during in-depth interviews with 15 randomly selected closed foster homes (Denby et al., 1999). Themes that emerged from inductive analysis of the 15 interviews defined constructs that guided question construction for the survey instrument (Denby et al., 1999). Additional items were derived from a review of studies that used diverse outcome variables such as continuance, dropping out, supply of homes, and exit rates (Denby et al., 1999). Factors that influenced satisfaction were examined using the FPSS and the intent of licensed foster parents to continue to foster (Denby et al., 1999). Factors exerting the strongest influence on satisfaction were: feeling competent to handle children who were placed,

wanting to take in children who needed loving parents, no regrets about investment in foster children, foster mother's age, and agency social workers providing information and showing approval for a job well done (Denby et al., 1999). Factors exerting the strongest influence on the intent to continue to foster include: overall satisfaction, readiness to phone the social worker, number of foster boys in the home, being treated like one needed help oneself, and the agency being privately owned (Denby et al., 1999). Psychometric information for the survey was later examined with a sample of foster parents, and found a five-factor solution that accounted for 35% of the variance and reliability alphas that ranged from .73 to .89 (Rodger, Cummings, & Leschied, 2006). However, this study used a revised survey that Pressley Ridge has been using internally since 2009 to evaluate treatment foster parent satisfaction that has not been validated.

FPSS scoring. There were several reverse-scored items that were re-coded before data were analyzed. Missing items (0.27%) were dropped using pairwise deletion, and data for other items were used to calculate averages for each of the domains with higher scores indicating more favorable responses. In addition, percentages were calculated for the last three questions on the survey to determine the amount of foster parents who responded more favorably to questions about overall satisfaction, likelihood to be a foster parent a year from now, and likelihood to refer someone to become a foster parent.

Instrument Administration

As shown in Table 4, the instruments were not all administered to prospective treatment foster parents at the same time points throughout the study. These differing time points have an effect on the data analysis plan.

Table 4

Instrument Administration Time Points

Instrument	Time points		
	Pre	Post	Follow-Up
AAPI-2	X	X	
PDFS	X	X	X
WFS-EB	X	X	X
FPSS			X

Data Analysis

The dataset was initially in a Microsoft Excel file, and there were several safeguards to prevent data entry errors, such as formatted cell values for the PDFS and WFS (e.g., the cell would only allow entries of 1 through 4 for the PDFS and WFS), and locked cells that prevented any modification or deletion of formulas. The Excel file was converted into SPSS 22.0, and pre-analysis data screening and data analyses were completed.

Pre-screening demographic variables. The following demographic variables were collected and examined to determine if there were differences between the two training groups (PR-TFC vs. MAPP): gender, race, marital status, education, employment, and income. Because these variables were categorical, chi-square tests of association were used to determine if they were significantly different between training groups. Continuous variables including age of the treatment foster parent and number of children were examined using one-way ANOVAs to compare means between the two training groups to determine if any differences existed. Number of children was recoded from a continuous variable into a categorical variable entitled *prior parenting experience* as the intent was to examine if any prior parenting experience had an influence on the

scores instead of the number of children. A chi-square test of association was conducted to determine if any significant differences existed between the two training groups for prior parenting experience.

Pre-screening instrument scores. The total scores for all instruments and time points were converted to z -scores in order to determine if any univariate outliers existed by training group. Any z value greater than +3.00 or less than -3.00 was considered an outlier since approximately 99% of the scores will lie within three standard deviations of the mean (Mertler & Vannatta, 2002). Normality using skewness and kurtosis values above +1 or below -1 were examined to determine the distribution shape of scores, and normal Q-Q plots were also examined for each of the scores to determine how the scores fit along a straight line. Linearity was assessed through examining scatterplots of the scores, and homoscedasticity was assessed using Levene's test of homogeneity of variance.

Identifying covariates. Controls were included in the data analysis design in order to statistically remove bias due to initial differences in the training groups (Field, 2013). Therefore, adjustments were made so that the training groups were initially the same on the covariates so that treatment effects were easily detected, thus improving power (Field, 2013). Covariates included in the design were: gender, age, prior parenting experience, and pretest scores. Gender has been shown to significantly impact AAPI-2 scores with males expressing significantly more abusive parenting attitudes than females; and the WFS and PDFS scores have shown to differ based on gender (Bavolek & Keene, 1999; Orme et al., 2006). Age and prior parenting experience have also been shown to influence parenting attitudes (Bavolek & Keene, 1999; Orme et al., 2006). The use of

pretest scores as a covariate is recommended when analyzing change scores so that groups are similar in terms of their starting point for scores especially since randomization did not occur (Hedeker & Gibbons, 2006).

Statistical analyses. For the first two research questions examining parenting attitudes and readiness to provide treatment foster care, analysis of covariance (ANCOVAs) was conducted to determine if the improvement in scores is significantly different between the two training groups. Change scores were used instead of examining posttest scores due to the intent to determine if the pre-service training changes attitudes and readiness scores for treatment foster parents. A chi-square test examined licensing status by training group as another indicator for readiness to provide treatment foster care. The third research question was addressed by conducting repeated measures ANOVAs due to the interest in comparing PDFS and WFS scores across three time points: pretest, posttest, and follow-up, and has greater power than a one-way ANOVA because subjects serve as their own controls (Gravetter & Wallnau, 2010). The fourth research question was addressed through use of a bivariate regression to examine whether the training group predicts attitudes toward providing treatment foster parents, because a regression provides a way to predict values of one variable from another (Field, 2013).

Human Participants and Ethics Precautions

Due to the nature of this study being related strictly to secondary analysis of data already collected, there were no interactions with research participants. When exemption was received from Duquesne's Institutional Review Board, the data were de-identified by an Evaluation Assistant within Pressley Ridge so the researcher did not know the identity

of these participants. There was no risk involved with this study as results are reported in aggregate with no identifying information associated with the results.

Chapter Four: Results

The purpose of this study was to examine the effectiveness of pre-service trainings on treatment foster parents' attitudes toward parenting, readiness to provide treatment foster care, and attitudes toward providing treatment foster care for those who completed the Model Approach to Partnerships in Parenting (MAPP) pre-service training compared to those who completed Pressley Ridge's Treatment Foster Care (PR-TFC) pre-service training. Specifically, this study examined if treatment foster parents' attitudes toward parenting improve on the Adult-Adolescent Parenting Inventory-2 (AAPI-2) after pre-service training depending on the type of pre-service training received. This study also examined if readiness to provide treatment foster care improves on the Personal Dedication to Fostering Scale (PDFS) and Willingness to Foster Scale-Emotional/Behavioral (WFS-EB) by training group, both in terms of change from before to after the pre-service training as well as after a child is placed in a treatment home. Licensing status by training group was examined as another indicator of a treatment foster parents' readiness to provide treatment foster care. The study also examined treatment foster parent attitudes toward providing treatment foster care on the Foster Parent Satisfaction Survey (FPSS) after a child was placed in the home. The results from this study are presented through the use of tables, and results from statistical analyses are highlighted in the narrative.

Descriptive Analysis of Sample

Demographic variables. Of the 189 initial participants in the dataset, 152 had complete or partial files (e.g., only missing one assessment out of the four) and were included in the analyses. Demographic differences between those who had missing data

(e.g., missing all of their pretest or posttest assessments), and those who had complete/partial files were conducted using chi-square analyses and ANOVAs to detect differences in gender, race, marital status, education, employment, income, age, and number of children. Using an alpha level of .05, there were no significant differences between the two training groups who had complete/partial versus incomplete files on demographic information. Therefore the sample in this study ($N = 152$) consisted of prospective treatment foster parents who resided in North Carolina, and who either received MAPP training ($n = 81$) or PR-TFC training ($n = 71$). These two training groups are considered equal using the ratio of 1 to 1.5, ($81/71 = 1.14 < 1.5$). There were no significant differences between the two training groups (PR-TFC vs. MAPP) on gender, race, marital status, education, employment, income, and prior parenting experience as evidenced by nonsignificant chi-square tests. To analyze continuous demographic variables, one-way ANOVAs compared age and number of children between the PR-TFC and MAPP group, and there were no significant differences in their means. Therefore, the two training groups were not significantly different based on their demographic variables.

Table 5 provides demographic information for each training group (PR-TFC vs. MAPP) by variable type for categorical variables. Table 5 shows the majority of participants, regardless of training group, were mostly Black females who were married, experienced post-secondary education either through attending some college or graduating from college, employed full-time, made above \$25,000, and had prior parenting experience. Participants were on average in their mid-to-late 40s (MAPP [$M = 46.90$, $SD = 12.05$] and PR-TFC [$M = 48.34$, $SD = 13.00$]), and had an average of two children (MAPP [$M = 1.87$, $SD = 1.52$] and PR-TFC [$M = 2.17$, $SD = 1.77$]).

Table 5

Demographics by Pre-Service Training Group (Categorical Variables)

	Number (%)	
	MAPP (n = 81)	PR-TFC (n = 71)
Gender		
Male	27 (33%)	27 (37%)
Female	54 (67%)	45 (63%)
Race		
Black	58 (72%)	49 (69%)
White	21 (26%)	22 (31%)
Native American	1 (1%)	0 (0%)
Unknown/Missing Data	1 (1%)	0 (0%)
Marital Status		
Married	37 (46%)	41 (58%)
Unmarried Parents	6 (6%)	2 (3%)
Single	15 (19%)	15 (21%)
Separated	8 (10%)	4 (6%)
Divorced	11 (14%)	8 (11%)
Widowed	3 (4%)	1 (1%)
Unknown/Missing Data	1 (1%)	0 (0%)
Education Level		
10 th Grade	1 (1%)	0 (0%)
11 th Grade	2 (2%)	1 (1%)
High School Graduate	26 (32%)	22 (31%)
Some College	25 (31%)	20 (28%)
College Graduate	16 (20%)	22 (31%)
Post-Graduate or Above	11 (14%)	5 (1%)
Unknown/Missing Data	0 (0%)	1 (1%)
Employment		
Unemployed	8 (10%)	11 (15%)
Not Employed Due to Disability	4 (5%)	1 (1%)
Retired	4 (5%)	9 (13%)
Employed Part Time	11 (14%)	10 (14%)
Employed Full Time	53 (65%)	39 (56%)
Unknown/Missing Data	1 (1%)	1 (1%)
Income		
Under \$15,000	6 (7%)	5 (7%)
\$15,001-\$25,000	15 (19%)	14 (20%)
\$25,001-\$40,000	28 (35%)	20 (28%)
\$40,001-\$60,000	11 (14%)	16 (23%)
Over \$60,000	14 (17%)	14 (20%)
Unknown/Missing Data	7 (8%)	2 (2%)

Prior Parenting Experience		
Yes	61 (75%)	59 (83%)
No	20 (25%)	12 (17%)

AAPI-2 scores. There were 146 participants who had complete AAPI-2 pre and post scores (MAPP [$n = 80$]; PR-TFC [$n = 66$]). Pre-screening of the data was completed by construct, time, and training group. The separation of the scores into the five AAPI-2 constructs is due to past research that typically examines these constructs separately instead of a total score (Bavolek & Keene, 1999; Conners et al., 2006). Pre-screening of outliers using z -scores found outliers below -3 for four of the five AAPI-2 constructs, and kurtosis values above 1 for two of the AAPI-2 constructs. In viewing the scatterplots for linearity, there were no concerns as they represented elliptical shapes, and Levene's test was only significant for one construct. However, because the training groups are comparable in size this violation can be ignored (Gravetter & Wallnau, 2010).

Assumptions unique to the ANCOVA were tested to determine if a linear relationship existed between the covariates and dependent variables, and if there was homogeneity of regression slopes. There were no violations to these assumptions through examining the bivariate scatterplots of the covariates and dependent variables, and through using the custom model to examine the interaction between the covariates and independent variable, and finding a nonsignificant interaction (Field, 2013). In addition, even though there were five dependent variables (AAPI-2 construct change scores) the reason a MANCOVA was not conducted on the change scores was due to the fact that the five constructs' change scores were not moderately correlated with each other, and so a MANCOVA would not be a powerful test in this situation (Field, 2013). Because there were no skewness issues and there were no outliers below -4 , the

ANCOVA was run with the outliers included and not included, and the results remained the same; therefore, all participants' scores were included in the ANCOVA results.

Internal consistency reliability was conducted using Cronbach's alphas to understand the correlation of the observed scale with different items on the same test, and to determine whether the items generally agree with the composite score of the construct (Garson, 2013). Evaluating internal consistency is important because a more reliable scale improves the power of the study when measurement error is low (Garson, 2013). Table 6 provides Cronbach alpha's by construct and time (Form A = pretest, Form B = posttest), and it should be noted that alphas were also initially run by training group and found to be comparable. Cronbach alphas were all acceptable (~.70) except for Construct E, which may be due to the small number of items in the scale and/or the fact that this construct had three reverse-scored items which are sometimes challenging for participants to interpret (Barnette, 2000).

Table 6

Psychometric Properties for AAPI-2 by Construct and Time

	α		N of items	Potential Range
	Form A	Form B		
Construct A: Expectations of Children	.77	.66	7	7–35
Construct B: Parental Empathy Toward Children	.72	.77	10	10–50
Construct C: Alternatives to Corporal Punishment	.83	.75	11	11–55
Construct D: Parent-Child Family Roles	.75	.73	7	7–35
Construct E: Children's Power and Independence	.44	.47	5	5–25

Table 7 provides average scores for each training group by construct and time with higher scores at posttest indicating more appropriate parenting attitudes. Change

scores are also provided, and a positive score indicates an increase in appropriate parenting attitudes from before the pre-service training to after pre-service training.

Table 7

AAPI-2 Means (SD) by Construct, Time, and Pre-Service Training Group

	MAPP (<i>n</i> = 80)			PR-TFC (<i>n</i> = 66)		
	Pre	Post	M_{Δ}	Pre	Post	M_{Δ}
A. Expectations of Children	21.30 (4.49)	21.65 (4.34)	0.35 (3.90)	20.50 (4.36)	22.38 (3.87)	1.88 (3.24)
B. Parental Empathy Toward Children	38.75 (5.20)	42.81 (4.34)	4.06 (4.58)	37.83 (4.75)	40.62 (5.34)	2.79 (4.56)
C. Alternatives to Corporal Punishment	40.30 (7.47)	42.88 (5.39)	2.58 (5.26)	41.05 (6.06)	44.20 (6.13)	3.15 (5.24)
D. Parent-Child Family Roles	26.15 (5.37)	25.18 (4.59)	-0.98 (3.91)	25.61 (4.76)	26.00 (4.64)	0.39 (3.85)
E. Children's Power and Independence	19.16 (2.69)	20.14 (2.53)	0.98 (2.98)	19.23 (2.29)	19.41 (2.60)	0.18 (2.12)

Note: M_{Δ} = Mean change scores.

PDFS scores. There were 148 participants who had complete pre and post scores on the Personal Dedication to Fostering Scale (PDFS): MAPP (*n* = 79), and PR-TFC (*n* = 69). Pre-screening of the data was completed by pretest and posttest scores, and training group. Pre-screening of outliers using *z*-scores found outliers below -3, and skewness values below -1 for both training groups at both time points. Linearity was assessed through viewing scatterplots, and there were no concerns as they represented elliptical shapes; and Levene's test was not significant.

ANCOVA assumptions for linearity and homogeneity of regression of slopes were also tested, and there were no violations through examining the scatterplots of the covariates and dependent variables, and finding a nonsignificant interaction using the custom model of the ANCOVA (Field, 2013). Because the training groups were

comparable in size, the ANCOVA was run with the outliers removed and included, and the results remained the same; therefore all participants' scores were included in the analysis. To assess internal consistency reliability, Cronbach alphas were computed, and were high and comparable between training groups (PDFS pretest $\alpha = .87$; PDFS posttest $\alpha = .91$). Change scores were also calculated for each group, and the average change on the PDFS for each training group is: MAPP ($M_{\Delta} = 1.70$, $SD = 17.99$), and PR-TFC ($M_{\Delta} = 1.04$, $SD = 13.87$). Positive scores are interpreted as an improvement in participants' personal dedication to provide foster care. Table 8 provides the average scores for each training group by time with a potential range of 0 to 100, and according to the CHAP technical manual, these average scores indicate the foster parents in both training groups had medium potential to provide foster care both before and after the pre-service training.

Table 8

PDFS Means (SD) by Time and Pre-Service Training Group

	MAPP ($n = 79$)	PR-TFC ($n = 69$)
PDFS Pretest Score	77.79 (15.26)	76.52 (12.25)
PDFS Posttest Score	79.50 (14.05)	77.56 (13.25)

WFS-EB scores. There were 149 participants who had complete WFS pre and post scores on the Willingness to Foster Scale Emotional/Behavioral subscale (WFS-EB): MAPP ($n = 79$), and PR-TFC ($n = 70$). Pre-screening of the data was completed by pretest and posttest scores, and training group. Pre-screening of outliers using z -scores found no outliers above +3 or below -3, and no skewness or kurtosis values above +1 or below -1 for both training groups at both time points. The scatterplots revealed linearity was sufficient as they represented elliptical shapes; and Levene's test was not significant.

The assumptions unique to ANCOVA were assessed (linearity and homogeneity of regression slopes), and there were no violations after viewing scatterplots of the covariates and dependent variables, and also finding a nonsignificant interaction in the custom model of the ANCOVA (Field, 2013). To assess internal consistency reliability, Cronbach alphas were computed, and were very high (WFS-EB pretest $\alpha = .97$; WFS-EB posttest $\alpha = .97$). Change scores were also calculated for each group, and the average change on the WFS-EB subscale for each training group is: MAPP ($M_{\Delta} = -2.72$, $SD = 14.12$), and PR-TFC ($M_{\Delta} = 0.08$, $SD = 15.74$). Positive scores can be interpreted as an improvement in the participant's willingness to foster children with emotional or behavioral issues. Table 9 provides the average scores for each training group by time with a potential range of 0 to 100, and according to the CHAP technical manual, these average scores indicate the foster parents in both training groups had medium potential to provide foster care both before and after the pre-service training.

Table 9

WFS-EB Means (SD) by Time and Pre-Service Training Group

	MAPP ($n = 79$)	PR-TFC ($n = 70$)
WFS-EB Pretest Score	56.59 (19.88)	51.16 (18.81)
WFS-EB Posttest Score	53.87 (19.42)	51.23 (17.72)

Training outcomes. The licensing status was collected for each participant after pre-service training concluded, and for those who were licensed only, whether a child was placed in the home. Table 10 provides licensing status, and child placement numbers and percentages for each training group. The majority of participants who were licensed and had a child placed were from the PR-TFC training group. Of the participants who

did not become licensed, there were two reasons provided for why the participants did not become licensed: *family decision* (e.g., the family decided not to continue as foster parents) or *agency decision* (e.g., the agency staff felt the foster parent was not suitable to provide foster care service). Ninety four percent of MAPP participants and 62% of PR-TFC participants made the family decision not to become licensed.

Table 10

Training Outcomes by Pre-Service Training Group

	Number (%)	
	MAPP (<i>n</i> = 81)	PR-TFC (<i>n</i> = 71)
Licensed		
Yes	16 (20%)	36 (51%)
No	65 (80%)	35 (49%)
Child Placed for Licensed Only		
Yes	12 (75%)	28 (78%)
No	4 (15%)	8 (12%)

Follow-up sample. The initial evaluation design included a follow-up component that was to be completed after a child was placed with the treatment foster parents for approximately three months. Therefore, only those who were licensed as treatment foster parents and had a child placed in their homes were eligible for the follow-up component. As can be seen in Table 10 above, there were a small number of training participants who became licensed and had a child placed for each group. The follow-up interviews were completed via the phone or through the mail. There were only six -licensed treatment foster parents who completed follow-up from the MAPP group (follow-up response rate = 50%), and 22 licensed treatment foster parents from the PR-TFC group (follow-up response rate = 79%). In addition, the average follow-up times for both MAPP ($M = 2.87$ years, $SD = 0.43$), and PR-TFC ($M = 2.19$ years, $SD = 0.59$)

programs greatly exceeded the planned follow-up time of three months. This extended timeframe for completing the follow-up component was due to restructuring of leadership at Easter Seals and the lack of resources (e.g., time and staff) to identify participants eligible for follow-up and to complete the follow-up interviews (A. C. Trunzo, personal communication, January 2, 2015).

Follow-up demographics. The sample included in the follow-up component ($n = 28$) consisted of licensed treatment foster parents who had a child placed in their home any time after the pre-service training occurred, and who either received MAPP training ($n = 6$) or PR-TFC training ($n = 22$). Table 11 provides the descriptive information for each training group (PR-TFC vs. MAPP) by variable type, and shows the majority of participants, regardless of training group, were mostly Black females who experienced post-secondary education either through attending some college or graduating from college, employed, made above \$25,000, and had prior parenting experience. Average age for the group was in the late 40s and early 50s: MAPP ($M = 48.86$, $SD = 5.26$), and PR-TFC ($M = 51.26$, $SD = 10.74$), and average number of children was two: MAPP ($M = 1.50$, $SD = 1.98$), and PR-TFC ($M = 2.64$, $SD = 2.26$).

Table 11

Follow-Up Demographics by Pre-Service Training Group (Categorical Variables)

	Number (%)	
	MAPP ($n = 6$)	PR-TFC ($n = 22$)
Gender		
Male	2 (33%)	9 (41%)
Female	4 (67%)	13 (59%)
Race		
Black	6 (100%)	13 (59%)
White	0 (0%)	9 (41%)
Marital Status		

Married	2 (33%)	14 (64%)
Single	2 (33%)	4 (18%)
Separated	1 (17%)	1 (4%)
Divorced	1 (17%)	3 (14%)
Education Level		
High School Graduate	2 (33%)	4 (18%)
Some College	1 (17%)	6 (27%)
College Graduate	2 (33%)	11 (50%)
Post-Graduate or Above	1 (17%)	0 (0%)
Unknown/Missing Data	0 (0%)	1 (5%)
Employment		
Unemployed	0 (0%)	4 (18%)
Retired	0 (0%)	7 (32%)
Employed Part Time	1 (17%)	1 (5%)
Employed Full Time	5 (83%)	10 (45%)
Income		
\$15,001-\$25,000	1 (17%)	5 (23%)
\$25,001-\$40,000	5 (83%)	6 (27%)
\$40,001-\$60,000	0 (0%)	3 (14%)
Over \$60,000	0 (0%)	8 (36%)
Prior Parenting Experience		
Yes	3 (50%)	19 (86%)
No	3 (50%)	3 (14%)

Follow-up PDFS scores. Pre-screening of the Personal Dedication to Fostering Scale (PDFS) data was completed by pretest, posttest, and follow-up scores, and by training group. Pre-screening of outliers using *z*-scores found no outliers above +3 or below -3, and no skewness or kurtosis issues. Linearity was assessed through viewing scatterplots, and there were no concerns as they represented elliptical shapes; and Levene's test was not significant. Table 12 shows the average scores by time and training group, and PDFS scores range from 0 to 100 with higher scores indicating more personal dedication to provide fostering. There was one participant from the PR-TFC training group that did not have all three time points completed for the PDFS; this participant was excluded from analyses of PDFS scores.

Table 12

Follow-Up PDFS Means (SD) by Time and Pre-Service Training Group

	MAPP (<i>n</i> = 6)	PR-TFC (<i>n</i> = 21)
PDFS Pretest Score	53.28 (34.08)	77.69 (8.07)
PDFS Posttest Score	73.59 (10.00)	79.37 (10.01)
PDFS Follow-Up Score	73.46 (8.17)	85.94 (7.06)

Follow-up WFS-EB scores. Pre-screening of the Willingness to Foster Scale-Emotional Behavioral subscale (WFS-EB) data was completed by pretest, posttest, and follow-up scores, and by training group. Pre-screening of outliers found no *z*-scores that would be considered outliers above +3 or below -3, and no skewness or kurtosis issues. Linearity was assessed through viewing scatterplots, and there were no concerns as they represented elliptical shapes; and Levene's test was not significant. Table 13 shows the average scores by time and training group, and WFS-EB scores range from 0 to 100 with higher scores meaning more willingness to provide foster care to children with emotional or behavioral issues. There was one participant from the PR-TFC training group that did not have all three time points completed for the WFS-EB; this participant was excluded from analyses of WFS-EB scores.

Table 13

Follow-Up WFS-EB Means (SD) by Time and Pre-Service Training Group

	MAPP (<i>n</i> = 6)	PR-TFC (<i>n</i> = 21)
WFS-EB Pretest Score	50.81 (21.16)	54.66 (54.66)
WFS-EB Posttest Score	40.34 (12.39)	47.28 (14.68)
WFS-EB Follow-Up Score	44.37 (13.72)	54.34 (12.70)

Follow-up FPSS scores. The Foster Parent Satisfaction Survey (FPSS) was only completed at follow-up. Pre-screening of the survey data was completed by training group; and no outliers, normality, or linearity issues were found. Average scores were calculated for each domain, and are provided in Table 14 by training group, with higher scores indicating more favorable responses. For domains one and two, the scale used in the survey ranged from 1 = *strongly disagree* to 7 = *strongly agree*. For domain three, the scale used ranged from 1 = *never* to 5 = *very often*. In addition, the percentage of foster parents who indicated they were *very satisfied* in response to their overall satisfaction was: MAPP (17%), and PR-TFC (55%). Foster parents who responded *very likely* to the questions about continuing as a foster parent in one year and referring someone to become a foster parent were: MAPP (50% for both questions), and PR-TFC (64% for both questions).

Table 14

Follow-Up FPSS Means (SD) by Pre-Service Training Group

	MAPP (<i>n</i> = 6)	PR-TFC (<i>n</i> = 22)
1. Opinions about Fostering	5.17 (0.67)	5.68 (0.82)
2. Experiences with Agency and Training	4.98 (0.91)	5.89 (0.69)
3. Stress, Support, and Satisfaction	3.97 (0.55)	4.05 (0.65)

Results by Research Questions and Hypotheses

This study aimed to examine the effectiveness of pre-service trainings on treatment foster parents' attitudes toward parenting, readiness to provide treatment foster care, and attitudes toward providing treatment foster care. This study examined change scores from the AAPI-2 to determine if parenting attitudes improve depending on the type of pre-service training received. This study also examined if readiness to provide

treatment foster care changes on the PDFS and Willingness to Foster Scale-Emotional/Behavioral WFS-EB by training group both before and after the pre-service training as well as after a child was placed in a treatment home. Licensing status by training group was also examined as another indicator of readiness to provide treatment foster care. The study also examined FPSS scores after a child was placed in the home in order to examine treatment foster parent attitudes toward providing treatment foster care after a child was placed in the home.

Research Question 1. Changes in Parenting Attitudes

Research Question #1. Does pre-service training affect treatment foster parents' parenting attitudes toward children?

- Hypothesis #1: There is a significant increase in appropriate parenting and child rearing attitudes for participants who complete the PR-TFC training than participants who complete the MAPP training.

One-way between subjects ANCOVAs controlling for age, gender, prior parenting experience, and pretest AAPI-2 scores were conducted to determine if the change scores for each construct were significant by training group.

AAPI-2 Construct A: Expectations of children. The covariate age significantly influenced the AAPI-2 change score for *Expectations of Children*, $F(1, 139) = 5.05, p = .03$, and the covariate of the pretest AAPI-2 score for *Expectations of Children* also significantly influenced the AAPI-2 change score for *Expectations of Children*, $F(1, 139) = 39.84, p \leq .001$. There was also a significant effect of the training group on the change in *Expectations of Children* scores after controlling for age, gender, prior parenting experience, and pretest score, $F(1, 139) = 5.68, p = .02, \eta_p^2 = .04$. The adjusted means for

the training groups and change score for *Expectations of Children* indicate that PR-TFC participants ($M_{\Delta} = 1.76$) experienced significantly more change than the MAPP participants ($M_{\Delta} = 0.49$) on their expectations of children.

AAPI-2 Construct B: Parental empathy toward children. The covariate of the pretest AAPI-2 score for *Parental Empathy Toward Children* significantly influenced the AAPI-2 change score for *Parental Empathy Toward Children*, $F(1, 139) = 48.01, p \leq .001$. There was also a significant effect of the training group on the change in *Parental Empathy Toward Children* after controlling for age, gender, prior parenting experience, and pretest score, $F(1, 139) = 5.98, p = .02, \eta_p^2 = .04$. The adjusted means for the training groups and change score for *Parental Empathy Toward Children* indicate that MAPP participants ($M_{\Delta} = 4.23$) experienced significantly more change than the PR-TFC participants ($M_{\Delta} = 2.59$) on their empathy toward children.

AAPI-2 Construct C: Alternatives to corporal punishment. The covariate gender significantly influenced the AAPI-2 change score for *Alternatives to Corporal Punishment*, $F(1, 139) = 5.75, p = .02$, and the covariate of the pretest AAPI-2 score for *Alternatives to Corporal Punishment* also significantly influenced the AAPI-2 change score for *Alternatives to Corporal Punishment*, $F(1, 139) = 65.97, p \leq .001$. There was not a significant effect of the training group on the change in attitudes toward *Alternatives to Corporal Punishment* after controlling for age, gender, prior parenting experience, and pretest score, $F(1, 139) = 1.40, p = .24$. The adjusted means for the training groups and change score for *Alternatives to Corporal Punishment* indicate that MAPP participants ($M_{\Delta} = 2.47$) did not experience significantly more change than the

PR-TFC participants ($M_{\Delta} = 3.12$) on their attitudes toward alternatives to corporal punishment.

AAPI-2 Construct D: Parent-child family roles. The covariate gender significantly influenced the AAPI-2 change score for *Parent-Child Family Roles*, $F(1, 139) = 5.65, p = .02$, and the covariate of the pretest AAPI-2 score for *Parent-Child Family Roles* also significantly influenced the AAPI-2 change score for *Parent-Child Family Roles*, $F(1, 139) = 57.40, p \leq .001$. There was also a significant effect of the training group on the change in attitudes toward *Parent-Child Family Roles* after controlling for age, gender, prior parenting experience, and pretest score, $F(1, 139) = 4.77, p = .03, \eta_p^2 = .03$. The adjusted means for the training groups and change score for *Parent-Child Family Roles* indicate that participants who received PR-TFC training ($M_{\Delta} = 0.32$) experienced significantly more change than those who received MAPP training ($M_{\Delta} = -0.89$) on their attitudes toward parent-child family roles.

AAPI-2 Construct E: Children's power and independence. The covariate of the pretest AAPI-2 score for *Children's Power and Independence* significantly influenced the AAPI-2 change score for *Children's Power and Independence*, $F(1, 139) = 46.80, p \leq .001$. There was no significant effect of the training group on the change in attitudes toward *Children's Power and Independence* after controlling for age, gender, prior parenting experience, and pretest score, $F(1, 139) = 3.65, p = .06$. The adjusted means for the training groups and change score for *Children's Power and Independence* indicate that participants who received MAPP training ($M_{\Delta} = 0.97$) did not experience significantly more change than those who received PR-TFC training ($M_{\Delta} = 0.25$) on their attitudes toward children's power and independence.

Research Question 2. Changes in Readiness to Provide Treatment Foster Care

Research Question #2. Does pre-service training affect treatment foster parents' readiness to provide treatment foster care?

- Hypothesis #2a: There is a significant increase in the personal dedication to provide foster care service for participants who complete the PR-TFC training than participants who complete the MAPP training.

A one-way between subjects ANCOVA controlling for age, gender, prior parenting experience, and pretest PDFS scores was conducted to determine if the change scores for the PDFS were significant by training group.

PDFS change. The covariate prior parenting experience significantly influenced the PDFS change score, $F(1, 141) = 5.81, p = .02$, and the covariate of the pretest PDFS score also significantly influenced the PDFS change score, $F(1, 141) = 84.42, p \leq .001$. There was no significant effect of the training group on the change in personal dedication to fostering after controlling for age, gender, prior parenting experience, and pretest score, $F(1, 141) = 0.56, p = .46$. The adjusted means for training group and change score for PDFS indicate that MAPP participants ($M_{\Delta} = 2.15$) did not experience significantly more change than the PR-TFC participants ($M_{\Delta} = 0.56$) on their personal dedication to provide foster care scores.

- Hypothesis #2b: There is a significant increase in the willingness to foster children with behavioral and emotional difficulties for participants who complete the PR-TFC training than participants who complete the MAPP training.

A one-way between subjects ANCOVA controlling for age, gender, prior parenting experience, and pretest WFS-EB scores was conducted to determine if the change scores for the WFS-EB were significant by training group.

WFS-EB change. The covariate age significantly influenced the WFS-EB change score, $F(1, 142) = 7.72, p = .01$, and the covariate of the pretest WFS-EB score also significantly influenced the WFS-EB change score, $F(1, 142) = 41.87, p \leq .001$. There was no significant effect of the training group on the change in the willingness to provide foster care to children with emotional and behavioral issues after controlling for age, gender, prior parenting experience, and pretest score, $F(1, 142) = 0.38, p = .56$. The adjusted means for training group and change score for WFS-EB indicate that PR-TFC participants ($M_{\Delta} = -0.71$) did not experience significantly more change than the MAPP participants ($M_{\Delta} = -1.99$) on their willingness to provide foster care to children with emotional and behavioral issues. The negative change scores indicate that the scores decreased from before the training to after the training; therefore participants' willingness to provide foster care to children with emotional and behavioral issues decreased after receiving pre-service training although not significantly.

- Hypothesis #2c: There are significantly more participants who become licensed as treatment foster parents for those who complete the PR-TFC training than those who complete the MAPP training.

A chi-square test of association was performed to examine the relationship between training group and licensing status at the end of the pre-service training as an indicator of treatment foster parents' readiness to provide treatment foster care.

Licensing status. The relationship between training group and licensing status was significant, $\chi^2(1, N = 152) = 16.10, p < .001$, meaning PR-TFC participants were more likely to be licensed than MAPP participants. To determine the strength of this association, the phi coefficient indicates a medium effect between training group and licensing status ($\phi = .33, p < .001$).

Research Question 3. Changes in Readiness to Provide Treatment Foster Care After Child Placement

Research Question #3: Does pre-service training affect treatment foster parents' readiness to provide treatment foster care *after* a child is placed in the home?

- Hypothesis #3a: After a child is placed in the home, participants who completed the PR-TFC training will report significantly more personal dedication to fostering than participants who completed the MAPP training.

A repeated measures ANOVA was conducted to determine if the training group's scores change on the PDFS from pre, post, and follow-up. Due to the small number in the MAPP training group ($n = 6$), there will be no between-group comparison for training groups and only the PR-TFC participants ($n = 21$) group's scores will be compared across time by gender.

PDFS follow-up. Mauchley's Test of Sphericity indicated that the assumption of sphericity had not been violated, $\chi^2(2) = 1.09, p = .58$. There was a significant effect of time on personal dedication to fostering scores for the PR-TFC group, $F(2, 38) = 7.72, p = .004, \eta_p^2 = .25$. Post-hoc paired samples t-tests were conducted using Bonferonni adjustment ($.05/3 = .017$) to determine where the significant changes in scores occurred. There was a significant change in PDFS scores from post to follow-up, $t(20) = -2.84, p$

=.01, $d = 0.76$, and from pre to follow-up $t(20) = -3.86$, $p = .001$, $d = 1.06$, but not significant from pre to post $t(20) = -0.37$, $p = .72$.

- Hypothesis #3b: After a child is placed in the home, participants who completed the PR-TFC training will report significantly more willingness to foster children with behavioral and emotional difficulties than participants who completed the MAPP training.

A repeated measures ANOVA was conducted to determine if the training group's scores change from pre, post, and follow-up on the WFS-EB. The MAPP training group was also excluded from this analysis due to the small number of participants ($n = 6$).

Therefore, only results for PR-TFC participants ($n = 21$) will be compared across the three time points by gender.

WFS-EB follow-up. Mauchley's Test of Sphericity indicated that the assumption of sphericity had not been violated, $\chi^2(2) = .70$, $p = .71$. There was a significant effect of time on willingness to provide foster care to children with emotional and behavioral issues for the PR-TFC group, $F(2, 38) = 3.97$, $p = .03$, $\eta_p^2 = .17$. Post-hoc paired samples t-tests, using Bonferonni adjustment ($.05/3 = .017$), were conducted to determine where the significant changes in scores occurred. There were no significant changes in WFS-EB scores from pre to post due to the Bonferonni adjustment, $t(20) = 2.59$, $p = .02$, from pre to follow-up $t(20) = 0.12$, $p = .91$, and not significant from post to follow-up, $t(20) = -2.12$, $p = .05$. It should be noted the paired samples t-tests show the PR-TFC group had lower scores (e.g., lower willingness) from pre to post, and from pre to follow-up, as can be seen from the positive t-value.

Research Question 4. Prediction of Attitudes Toward Providing Treatment Foster Care

Research Question #4: Does pre-service training predict treatment foster parents' attitudes toward providing treatment foster care *after* a child is placed in the home?

- Hypothesis #4: The PR-TFC group will be a significant predictor of treatment foster parents' overall satisfaction with providing treatment foster care after a child is placed in the home.

Due to the small number in the MAPP training group ($n = 6$), a bivariate regression comparing the two training groups on their Foster Parent Satisfaction Survey scores was not conducted. In addition, no further analyses were conducted using this survey due to the uncertainty about the psychometric properties of the survey.

Summary

This study examined change scores of prospective treatment foster parents ($N = 152$) to determine if parenting attitudes and readiness to provide treatment foster care increased depending on the type of pre-service training received (MAPP vs. PR-TFC). Licensing status by training group was also examined as another indicator of readiness to provide treatment foster care. Readiness to provide treatment foster care was also examined with a follow-up sample for participants who were licensed and had a child placed in their home. The study also assessed FPSS scores after a child was placed in the home to examine treatment foster parent attitudes toward providing treatment foster care. The results of this study suggest pre-service trainings designed specifically for treatment foster parents such as PR-TFC may influence their parenting attitudes, readiness to

provide treatment foster care, and attitudes about providing foster care compared to trainings designed for foster parents such as MAPP.

To examine changes in parenting attitudes toward children, one-way between subjects ANCOVAs controlling for age, gender, prior parenting experience, and pretest AAPI-2 scores on the five AAPI-2 construct change scores were conducted and found the PR-TFC group experienced significantly more change than the MAPP group for two AAPI-2 constructs: *Expectations of Children* and *Attitudes Toward Parent-Child Family Roles*. The MAPP group changed significantly more on *Parental Empathy Toward Children* than the PR-TFC group. Neither group changed significantly more than the other on the two remaining constructs: *Alternatives to Corporal Punishment* and *Attitudes Toward Children's Power and Independence*.

To assess readiness to provide treatment foster care, a one-way between subjects ANCOVA controlling for age, gender, prior parenting experience, and pretest PDFS score was conducted and found no significant changes between the training groups on their personal dedication to fostering. The other measure of readiness was examined by conducting a one-way between subjects ANCOVA controlling for age, gender, prior parenting experience, and pretest WFS-EB score and found no significant change between the training groups on their willingness to provide foster care to children with emotional and behavioral issues. The last indicator of readiness to provide treatment foster care was examined by conducting a chi-square test of association examining the relationship between licensing status and training group, and found PR-TFC participants were more likely to be licensed than MAPP participants.

To evaluate readiness for providing treatment foster care for the follow-up sample of licensed treatment foster parents who had a child placed in their home, a repeated measures ANOVA was conducted to determine if the training group's scores change on the PDFS from pre, post, and follow-up for the PR-TFC group only ($n = 21$) due to the small number in the MAPP training group ($n = 6$). There was a significant effect of time on personal dedication to fostering scores for the PR-TFC group. Post-hoc paired samples t-tests revealed a significant change in PDFS scores for the PR-TFC group from post to follow-up, and from pre to follow-up, but not significant from pre to post. A repeated measures ANOVA was conducted to determine if the training group's scores change from pre, post, and follow-up on the WFS-EB. The MAPP training group was also excluded from this analysis due to the small number of participants ($n = 6$). There was a significant effect of time on WFS-EB scores for the PR-TFC group, but the post-hoc analyses by the three time points were not significant due to the Bonferonni adjustment.

No analyses were completed on the FPSS, which was intended to measure treatment foster parent attitudes toward providing treatment foster care at time of follow-up. The lack of analysis was due to the small number in the MAPP training group and concerns about the psychometric properties of the survey. Therefore, a prediction of attitudes toward providing treatment foster care based on the training received was not conducted.

Chapter Five: Discussion

The purpose of this study was to examine the effectiveness of pre-service trainings on treatment foster parents' attitudes toward parenting, readiness to provide treatment foster care, and attitudes toward providing treatment foster care for those who completed the Model Approach to Partnerships in Parenting (MAPP) pre-service training compared to those who completed Pressley Ridge's Treatment Foster Care (PR-TFC) pre-service training. This study examined if treatment foster parents' attitudes toward parenting changes on the Adult-Adolescent Parenting Inventory-2 (AAPI-2) after pre-service training depending on the type of pre-service training received. This study also examined differences in the degree to which readiness to provide treatment foster care changes on the Personal Dedication to Fostering Scale (PDFS) and Willingness to Foster Scale-Emotional/Behavioral (WFS-EB) by training group. Licensing status by training group was examined as another indicator of a treatment foster parents' readiness to provide treatment foster care.

The study also included a follow-up component for treatment foster parents who were licensed at the end of the training and had a child placed in their home. Their readiness across time (pretest, posttest, and follow-up) was examined using the PDFS and WFS-EB. The study also examined treatment foster parent attitudes toward providing treatment foster care on the Foster Parent Satisfaction Survey (FPSS) at follow-up.

Summary of the Study

This study aimed to provide evidence of the effectiveness of pre-service trainings for treatment foster parents in order to fill the gap in research on pre-service training programs that prepare treatment foster parents for their professional role as therapeutic

change agents. Because this study included a comparison of pre-service trainings for treatment foster parents, the intent is to add to the evidence base for both pre-service trainings and about treatment foster parents in general. The hypotheses of this study indicated that a pre-service training designed specifically for treatment foster parents (PR-TFC) would provide a significant increase in parenting attitudes, readiness to provide foster care, and attitudes toward providing foster care than the comparison group that received a pre-service training designed for foster parents (MAPP).

The results of this study indicate the PR-TFC group experienced significantly more change than the MAPP group in their expectations of children and attitudes toward parent-child family roles. However, the MAPP group experienced significantly more change than PR-TFC in their empathy toward children. In regards to readiness to provide foster care, there were no significant differences between the groups in the amount of change they experienced in their personal dedication to provide foster care and their willingness to foster children with emotional and behavioral issues. However, licensing rates for the PR-TFC group were significantly greater than the MAPP group and provide another indicator of their readiness to provide treatment foster care. Readiness to provide foster care was also addressed at follow-up for treatment foster parents who were licensed and had a child placed at some point in their home in order to compare changes from pre, post, and follow-up. There were a very small number of MAPP participants so no between-group comparisons were conducted. However, the PR-TFC group was compared over time and found their personal dedication to provide foster care significantly increased from post to follow-up, and from pre to follow-up. There were no significant changes in their willingness to provide foster care over the three time points.

The attitudes toward providing foster care also was not addressed using statistical analyses, because the MAPP training group had such a small number who were licensed and had a child placed in their home.

Conclusions

The conclusions and interpretations of results from this study are organized by the main constructs that were examined in this study: changes in parenting attitudes, changes in readiness to provide foster care at the end of pre-service training, changes in readiness to provide foster care after a child was placed in the home, and attitudes toward providing treatment foster care. These results will be illuminated through the theoretical framework of the study, previous research findings that support or contradict the current results, and practical implications of these results.

Changes in parenting attitudes. Treatment foster parents who have healthy attitudes about parenting are desirable for the success of the treatment foster care model, because they are the main change agents for youth who will be placed in their home. Social learning theory supports their role as change agents as youth will learn appropriate behavior through viewing their treatment foster parents' behavior and reactions to situations (Almeida et al., 1989). There is also the importance of ensuring the safety and well-being of children placed in a treatment home, and understanding whether treatment foster parents' possess appropriate parenting attitudes is one way to safeguard youth from unhealthy parenting approaches (Orme et al., 2006). Also, parenting style is related to treatment foster parents' capacity to handle the challenges of dealing with children's difficult behaviors (Orme et al., 2006). Therefore, the use of the AAPI-2 to assess parenting attitudes may lead to ensuring safe and stable placements of youth in treatment

homes, and the AAPI-2 is sensitive to change as it has been used to assess changes in parenting attitudes after parenting education is provided (Bavolek & Keene, 1999).

The results of this study found the PR-TFC group experienced significantly more change than the MAPP group in their expectations of children and attitudes toward parent-child family roles after pre-service training. Expectations of children is a common concern among reported cases of child abuse and neglect as parents who have inappropriate expectations often misperceive the skills and abilities of children (Bavolek & Keene, 1999). Understanding child development in order to know the needs and capabilities of children at different stages of their growth has been shown to improve parenting expectations (Kaminski et al., 2008), and is a training unit in PR-TFC's pre-service training. In addition, reversing parent-child roles is another common behavior among abusive parents, because children begin to assume behaviors that are traditionally associated with the parent role (Bavolek & Keene, 1999). Therefore, developing clear and defined roles between the foster parent and child is essential, and there are two units on professional parenting in PR-TFC's curriculum that help to define the parenting role for treatment foster parents. The results suggest that having training units dedicated specifically to children's development and parental roles provides treatment foster parent with information that significantly changes their attitudes in these areas. Interestingly, the MAPP training group's average change score was negative, meaning they experienced a decrease in scores in this construct, suggesting that their understanding of parent-child family roles may have become less clear throughout the training.

In contrast, the MAPP group experienced significantly more change than the PR-TFC group in their empathy toward children after the pre-service training. Parental

empathy toward children requires the ability to place the child's needs as a priority, and to create an environment that promotes the child's emotional and physical development (Bavolek & Keene, 1999). Although both training curriculum address these areas, MAPP curriculum has units about knowing the children, meeting the needs of the children placed with them, and helping children build self-esteem; and PR-TFC addresses this information in their unit about child development. The results suggest that having training units dedicated specifically to children's needs provides treatment foster parent with information that significantly changes their empathy toward children. For the alternatives to corporal punishment and children's power and independence constructs, both training groups experienced changes in their attitudes towards these concepts although not significantly.

Results from this study are different than results found in previous studies examining parenting attitudes of foster parents, and may be due to the use of change scores that were examined between two groups of prospective treatment foster parents in this study. For example, Lee and Holland (1991) found no statistically significant difference between foster parents who were trained in MAPP and those in the control group who were untrained using the original version of the AAPI which has 32 questions instead of 40 questions. In addition, Nilsen (2007) found no significant differences between the two groups of foster parents who were trained versus untrained using the original version of the AAPI. Therefore, these results from the AAPI-2 should be considered preliminary as this is the first study to examine the changes that occurred between two groups of treatment foster parents after pre-service training. In addition, regression to the mean may have occurred where the extreme scores on the AAPI-2 in the

beginning of the pre-service may have changed to be closer to the average scores after pre-service training, and the change could be due to this phenomenon and not the pre-service training (Babbie, 2010). Also, the lack of difference found with the original version of the AAPI, and the significant changes found in the AAPI-2 may be explained by the revised version having higher reliabilities and lower standard errors, as well as newly added items on the constructs and an additional fifth construct as compared to the original version (Bavolek & Keene, 2010). However, it appears that the PR-TFC curriculum may prepare treatment foster parents for increasing their appropriate expectations of children and clear roles as treatment foster parents compared to MAPP, but further research is needed to make a confirmative statement about the cause of these changes. A similar conclusion can be drawn from the significant change in empathy toward children that occurred in the MAPP group compared to the PR-TFC group. The training components that directly influenced this change can only be speculated at this point.

Despite these uncertainties, these results are useful to know that parenting attitudes can change after pre-service training, and that pre-service trainings should address these areas to ensure prospective treatment foster parents have healthy attitudes about parenting. The results suggest that pre-service trainings that provide more information around child development, parent-child roles, and empathy toward children have a significant impact on treatment foster parents' attitudes toward these areas. Practical implications of knowing treatment foster parents' parenting attitudes can help with tailoring developmental plans and homework to increase their attitudes throughout

pre-service training, as well as identifying peer mentors who exhibit healthy parenting attitudes in the areas they seem to be lacking (Orme et al., 2004).

Changes in readiness to provide treatment foster care. Although treatment foster parents are a critical resource for the treatment foster care model, there is unfortunately little known about their characteristics in regards to their readiness to provide treatment foster care. There is an emphasis on the willingness and dedication to provide foster care to children with emotional and behavioral problems due to connections between these attitudes and increased placement success and stability (Cox et al., 2011). In addition, a greater willingness to foster children with emotional and behavioral problems is related to a greater personal dedication to fostering, more satisfaction with fostering, a greater potential to foster, and a smaller number of placement disruptions (Orme et al., 2006). Having a greater personal dedication to foster has been shown to lead to a greater potential to promote foster child development, and the intent to provide foster care in the long range (Orme et al., 2006). Therefore, understanding a foster parent's dedication and willingness to provide foster care may help with recruiting, training, and supporting them throughout the application process (Orme et al., 2004), and is a reason for including assessments of their dedication and willingness as competencies to measure in the Casey Home Assessment Protocol (CHAP) for prospective applicants.

Change in personal dedication to provide fostering. There are several motivators that have been identified for becoming foster parents, and the intrinsic motivator of altruism aligns closely with a foster parent's dedication to provide foster care. Studies have found that foster parents cite altruism as their motivating factor, because they want

to help children and to provide a stable environment for children in need (Rodger et al., 2006). However, little is known about whether dedication to provide foster care changes over time as the research done with the assessment was conducted on already licensed foster parents.

The results of this study showed that both training groups reported an increase in their personal dedication to provide fostering after the training although there was not a significant change. In comparison to results from already licensed foster parents (Orme et al., 2006), the treatment foster parents in this study were comparable as far as having an average score that translated into having medium potential to provide foster care for both groups before and after the training. These results might suggest that these treatment foster parents were already highly committed to providing foster care as research has shown that most potential foster parents consider the job of fostering for approximately one year before they contact a foster parent agency (Baum, Crase, & Crase, 2001), and so those who completed the training may have already made the decision to provide foster care before attending the pre-service training.

The reasons treatment foster parents did not experience a significant change in their dedication are unknown, and cannot be attributed to the pre-service training received at this point. This lack of significant change may be due to the Personal Dedication to Fostering Scale (PDFS) never being used as a pre/post measurement so it is unknown whether the assessment is sensitive to change, if treatment foster parents can truly experience change in this area based on the training they received, or if this was a regression to the mean phenomenon. However, practical implications of knowledge that treatment foster parents presented on average with medium potential, and also

experienced incremental change is important in designing trainings that engage treatment foster parents in discussions around their motivations and dedications for providing foster care. There is merit to assessing and identifying those parents who report a low dedication to provide foster care so that additional training and support can be provided throughout their licensing process.

Change in willingness to provide foster care. Treatment foster parents are responsible for implementation of behavioral management plans for children in their care; and a willingness to provide treatment for children who have emotional and behavioral issues is a key factor for successful implementation of behaviorism techniques (Bryant & Snodgrass, 1990; Chamberlain, 2003; Dore & Mullin, 2006). Especially considering this theory provides the basis for training treatment foster parents in ways to reinforce positive behaviors in children to promote increases in their appropriate behavior, and to reduce the instances of negative behaviors (Dore & Mullin, 2006). In addition, youth in foster care exhibit a range of emotional and behavioral issues due to their experiences of loss and separation from their caregivers (Bruskas, 2008; Oosterman, et al., 2007), and a willingness to provide foster care to a range of emotional and behavioral issues is necessary for promoting positive outcomes for youth in care.

The results of this study did not support the hypothesis that additional training in behaviorally based techniques would increase their willingness to provide foster care to children with these types of issues, because there were no significant changes between the groups. In addition, the MAPP group experienced a decrease in their scores suggesting that their willingness to provide foster care to youth with emotional and behavioral issues decreased after pre-service training. Although the average scores for

the PR-TFC group showed a slight increase, it was not significant, and when adjusted for the covariates it interestingly revealed a negative change score suggesting that their willingness slightly decreased after pre-service training. As a point of comparison, the already licensed foster parents who completed this scale reported a medium potential to provide foster care to children with emotional and behavioral issues (Orme et al., 2006), and both training groups had average scores in the medium potential range both before and after the pre-service training.

These results may suggest that these treatment foster parents were naïve to the types of children who were in foster care, and knowledge they learned from the training may have provided them with a more realistic viewpoint about the type of support and training they would need to help these children. It is important to note the options on the Willingness to Foster Scale range from 1 = *would not being willing to foster under any circumstances*, 2 = *might be willing to foster with a lot of help and support*, 3 = *probably be willing to foster with a little extra help and support*, and 4 = *would be willing to foster without any extra help or support*. Therefore, the wording of responses may have impacted the results, because through training they may have realized that they do need extra help and support to provide foster care to the complexities of issues of youth they will be responsible for providing treatment. This could be viewed as a positive characteristic of the treatment foster parent to be able to identify the need for help, and the pre-service training might help them make this discovery before a child is placed in the home so that extra supports can be put in place. Also, this is the first time the Willingness to Foster Scale-Emotional/Behavioral (WFS-EB) was used as pre/post measurement, and there also may be a regression to the mean phenomenon occurring

with the scores. Also, there is the possibility that the scale should be examined by items that pertain to behavioral issues and items that pertain to emotional issues as these may vary by participant and training group. Additional psychometric research on this scale should be conducted to see if there are differences in the loadings of these items.

The practical implication of these results show there is utility in measuring the amount of support and help treatment fosters need in order to understand if treatment foster parents feel they are able to manage the types of children in their care. In addition, the information gleaned from this assessment might help with making placement decisions, as those parents who report a high willingness to provide foster care to children with emotional and behavioral issues after receiving pre-service training could be matched with children who have very complex issues and vice versa (Cox et al., 2011). In addition, those who report a low willingness to provide foster care to youth with emotional and behavioral issues could receive additional training and support, or could be used for less intensive foster care services such as providing respite care or a shelter placement to determine if they feel they are able to provide more intensive care after gaining experience with children in the foster care system.

Licensing rates. There is a great deal of resources required to recruit, train, and license treatment foster parents, because unfortunately a small percentage of foster parents ultimately become licensed (Rhodes et al., 2003). There are several drop-off points that occur during the application process: during the first few contacts with the agency, self-selecting out during pre-service training, the agency decides the foster parent is not appropriate for providing foster care, the foster family completes the training but then decides not to have a child placed until the right circumstances are met (Rhodes et

al., 2003). There are speculations that effective pre-service trainings may have an impact on licensing rates (Piescher et al., 2008); however, there has not been an examination of licensing rates for treatment foster parents based on the type of pre-service training they received. Typically this information is only collected internally, and agency staff have an anecdotal knowledge of treatment foster parent licensing rates.

Results of this study showed the PR-TFC group had significantly more treatment foster parents who became licensed at the end of the pre-service training as compared to the MAPP group. Licensing rates for the PR-TFC group (51%) were comparable to another study that reported licensing rates of 46% who completed MAPP pre-service training; however, licensing rates for the MAPP group (20%) are lower than the research study examining MAPP training (Rhodes et al., 2003). There is the possibility that the MAPP curriculum guides treatment foster parents in their decision-making process to become foster parents based on the previous research that listed their curriculum as focusing more on this concept than parenting skills and knowledge (Puddy & Jackson, 2003). Especially considering 94% of treatment foster parents in the MAPP group compared to 62% from the PR-TFC group made the family decision to not become licensed instead of the agency making the decision not to license them. There might be components of the PR-TFC training, whether it is the trainer or the knowledge and skills they learn, that are more engaging for prospective treatment foster parents that leads to higher licensing rates. Therefore, the results of licensing rates is an important finding, but conclusions based on the effectiveness of training programs and licensing rates still needs to be explored.

The practical implication of these results show there is a need for constant recruiting and training of treatment foster parents in order to maintain enough foster parents to respond to the number of children in out-of-home placements. Having knowledge that only half of treatment foster parents who complete PR-TFC pre-service training actually become licensed means staff need to recruit double the number of treatment foster parents than the number of children in need of placements, and recruitment is an ongoing process that most likely will never stop (Baum et al., 2001). Because research on recruitment strategies has found that treatment foster parents are most often recruited by other treatment foster parents, it is important to keep a large pool of licensed treatment foster parents so that they can help with the recruitment process (Baum et al., 2001). In addition, the most common model of foster parent recruitment uses foster parents as trainers of other potential foster parents so that they can answer questions and provide realistic messages about providing foster care (Baum et al., 2001). Therefore, having licensed treatment foster parents is a crucial component to being able to provide foster care to children in out-of-home placements, to train other prospective treatment foster parents, and can be used as an indicator for a treatment foster parent's readiness to provide foster care.

Changes in readiness to provide treatment foster care after child placement.

Conducting follow-up after an intervention is important in order to determine if treatment gains are sustained over time, and provides more solid evidence for the effectiveness of the intervention as well as the ability to receive a stronger scientific rating on evidence-based clearinghouses such as California's Evidence-based Clearinghouse. Also, there is a large gap in knowledge about whether treatment foster parents' readiness to provide

treatment foster care changes over time, as most of the evaluations of pre-service trainings do not include a follow-up component (Dorsey et al., 2008). The follow-up results from this study are considered preliminary due to lack of a comparison group, but provide some information about the way their personal dedication and willingness to provide foster care increases over time. In addition, this is the first study to examine changes in treatment foster parents' readiness over time and especially after a child is placed in the home.

Changes in personal dedication to provide fostering at follow-up. Conclusions that can be drawn from significant changes the PR-TFC group experienced over time are limited, but suggest that personal dedication scores have the ability to change over time. The fact that the PDFS scores did not significantly change from pre to post aligns with previous results for the entire sample. The significant changes at follow-up could have been caused by a number of factors due to length of time it took to complete the follow-up; such as, amount of training, support, supervision the treatment foster parent received, or simply regression to the mean. In addition, the types of children placed in the home and their complexities of issues were not collected and could have influenced whether or not the treatment foster parent felt dedicated to providing treatment foster care. More research is needed in this area in order to determine the effects of pre-service training on dedication to provide foster care after controlling for these other factors. However, practical implications of tracking dedication over time might lend to understanding critical times to intervene and provide additional training and support to treatment foster parents. For example, if there is specific time point that treatment foster parents might

waver in their dedication and decision to remain foster parents, interventions could be implemented in order to prevent placement disruptions.

Changes in willingness to provide foster care at follow-up. There were interesting findings with the follow-up sample as their scores decreased from pre to post but then returned to a similar level as the pretest at time of follow-up. This movement may suggest that the PR-TFC group's willingness scores decreased at the end of pre-service training, but increased at the time of follow-up to return to how they felt when they started pre-service training. As there was no comparison group available, these scores provide preliminary information about the movement of scores across time for the PR-TFC group. There could have been a number of factors that influenced the movement of these scores such as the length of time to complete follow-up may have given the participants the training and support they needed to feel they were willing to provide treatment foster care to youth with emotional and behavioral issues, or the extreme scores could have changed due to the regression to the mean. In addition, their experience as treatment foster parents in implementing behavior management plans and honing their skills in changing difficult behaviors may have increased their willingness scores. Controlling for these factors would add information about the amount of change that occurs over time for treatment foster parents on their willingness to provide treatment to youth with emotional and behavioral issues that could be more directly attributed to the pre-service training they received. The practical implications of using this assessment could help with identifying training opportunities and the types of children to place with the treatment foster parents as child placements are temporary, and

if their willingness changes over time they might be able to take youth with more complex issues once they gain experience.

Attitudes about providing treatment foster care. Retaining quality foster parents is paramount to mental health organizations, because of the costs to constantly recruit new foster parents, and the assurance that children will experience more positive outcomes when experienced foster parents remain in their role (Festinger & Baker, 2013). Assessing foster parent satisfaction is one of the ways to monitor whether foster parents may decide to quit as higher scores predict their intent to stay in their foster parenting roles (Rodger et al., 2006). There is speculation around the use of effective training programs in TFC programs leading to increased treatment foster parent satisfaction and retention (Piescher et al., 2008), and retention information is important as nearly 50% of foster parents decide to quit within a year of fostering the first child (Gibbs, 2007). In addition, one of the factors that exerted influence on the intent to continue to foster was the foster parent's overall satisfaction (Denby et al., 1999), and foster parents who do not consider withdrawing their services report more positive relationships with the professional staff within their local child welfare agencies. (Rodger et al, 2006).

Unfortunately the options for data analysis were limited due to the small sample size in the comparison group and the uncertainty around the psychometric properties of the revised version of the survey. However, the results suggest the PR-TFC group was more satisfied in reviewing their average scores and 55% responded *very satisfied* to their overall satisfaction in comparison to 17% from the MAPP group. Conclusions based on these results are very limited and cannot be inferred from the pre-service training they received as there could be interactions with staff that may have positively influenced their

satisfaction ratings among other factors such as training and support they received.

While there is evidence that shows foster parent satisfaction is associated with retention, the relationship between these factors needs to be explored with treatment foster parents.

These results can be used for quality improvement activities in order to enhance programming that meets the needs of treatment foster parents, and can be reported to funders to provide evidence of the collaboration that exists between treatment foster parents and staff which is an important component of the treatment foster care model.

Study Limitations

This study had several strengths due to the inclusion of a comparison group, the use of standardized assessments, completion of the study in a naturalistic setting, and inclusion of a small follow-up component. However there were also several limitations that should be addressed in future research studies in order to be able to generalize the findings to the treatment foster care population. The main limitation of the study was that all of the data were archival data so there are several independent variables that were not collected and therefore could not be included in the data analysis. For example, a measurement of the therapeutic alliance between the youth and treatment foster parent, if collected, may have provided an explanation of treatment foster parent ratings of their dedication and willingness to provide foster care services or their retention as a provider. The other limitations of the study affect the internal and external validity of the results. For example, internal validity, or the ability to draw conclusions based on the fact that no other confounding variables could cause the effect on the dependent variables (Garson, 2013) was threatened due to the non-randomization of research participants into training

groups. This threat was minimized by the use of a comparison group and the use of covariates to systematically equalize the training groups.

The self-report nature of the instruments also may pose some response bias as the sample included prospective treatment foster parents who might be looking to provide a more favorable view of themselves in order to be certified as a foster parent with the agency, even though they were informed the instruments would not be used to determine their eligibility for providing foster care. External validity, the ability to generalize the findings across individuals, settings, and times (Garson, 2013) seems strong due to the purposive sample of prospective treatment foster parents, but may be limited due to the sample size, and one geographic location of North Carolina.

There also was a lack of fidelity measurements to the training curriculum, the length of time it took to complete the evaluation, and the small number of participants who were eligible for follow-up that limited data analysis that could be conducted on the assessments completed at follow-up. Fidelity to an intervention is an important measure to determine whether participants received the intervention as it was intended to be delivered (Bellg et al., 2004). By assessing fidelity, there can be greater confidence in the results because treatment outcomes can be reliably tied to the intervention instead of other unknown factors (Bellg et al., 2004). There are several strategies for enhancing treatment fidelity such as, the use of training manuals to ensure trainers are providing the same material to the participants, and testing acquisition of knowledge and observation of skills gained from the trainings. There is a fidelity assessment available for PR-TFC's pre-service training that aims to address whether participants received the intended components as well as knowledge questionnaires for each unit and an observation

assessment to determine if the treatment foster parents use the skills with children placed in their home; however, the fidelity assessment, knowledge questionnaires, and behavioral observation forms were not completed consistently for this study. In addition, all three of these forms need to be validated to ensure adherence to the core training components, knowledge gained, and skills used actually has an effect on desired training outcomes. For this study there could have been elements of either training that participants did not receive as intended, such as the frequency between training sessions could have been longer than recommended, or homework was not assigned between training sessions.

The original evaluation project was designed to be completed within a year; however due to changes in program leadership and staffing issues discussed earlier the evaluation took approximately three years longer to complete. In addition, there was an entire year that trainings may have occurred but no assessment packets were sent to Pressley Ridge. In any evaluation project or research study, there are factors that will sometimes impede progress especially when research is conducted directly in the field on top of the day-to-day requirements to run a foster care program. Therefore, there could have been a cohort effect on the training outcomes due to other confounding factors based on the longer passage of time to gather all the data.

The other limitation is around the small number of participants eligible to participate in the follow-up component of the study. Due to the importance of measuring changes from an intervention over time, especially when a child is placed in the home, there needs to be more studies that attempt to track changes after children are placed in the home. Unfortunately due to the small numbers in each training group at follow-up,

statistical analyses were limited to make any conclusions, and the length of time that had passed was far greater than planned thus reducing the ability to tie results directly to the pre-service training. The reality that the majority of training participants do not get licensed or have a child placed means that there needs to be larger numbers recruited for studies that evaluate pre-service trainings in order to have enough participants who are even eligible for a follow-up.

This limitation had an impact on the inability to fully address the third and fourth research questions due to the limited number of MAPP group participants who were contacted at time of follow-up. In addition, there were uncertainties about the version of the Foster Parent Satisfaction Survey (FPSS) as it was a revised version that had not been validated, and its use to perform any statistical analyses and draw conclusions based on the survey would have been questionable. The lack of numbers in each training group could have been due to the length of time that had passed since the participants had finished training, and it is possible that these participants were no longer foster parents with the agency and were reluctant to complete surveys about their experiences. Therefore, the conclusions about the PR-TFC's changes on scores at follow-up are not as strong as they could have been if there was a comparison group available, and if psychometrics of the FPSS could have been addressed.

Recommendations for Future Research

Despite limitations of this current study, there are several areas that can be identified for future research based on the knowledge that was gained from conducting this study. In order to address limitations of this current study, recommendations for

future research focus on enhancing the study design, and discussing additional options for data analysis.

Study designs. Although randomization is often difficult to achieve in naturalistic settings, results from a randomized control trial (RCT) would help to draw stronger conclusions about pre-service trainings as subjects would be randomly assigned to the intervention or comparison group thus reducing confounding variables. RCTs are considered the gold standard for research designs and are one of the criteria evidence-based clearinghouses uses to assign scientific ratings to interventions. Having more evidence-based pre-service trainings would allow for organizations to choose training programs that fit with their mission, values, and resources; and would better ensure positive outcomes for both training participants and the youth placed in their home. Also, research designs that incorporate a follow-up component would be ideal in order to see if the pre-service training effected participant outcomes over time especially when a child is placed in the home. As mentioned previously, the follow-up component for pre-service trainings requires an increase in subjects for each group due to the requirements for being eligible for follow-up.

Research designs that include expanded instrumentation would help to capture some of the variables that were not assessed in this study, such as fidelity assessments, knowledge questionnaires, use of skills with children placed in the home, therapeutic alliance, and child outcomes. For example, Nilsen (2007) discussed that data from self-reports of parenting attitudes may not actually correlate with their parenting skills. Therefore, program staff should observe skills in the home between treatment foster parents and children in order to determine if treatment foster parents are using the

therapeutic skills they learned in the pre-service training. Role-plays during the pre-service training could serve as a baseline to determine whether treatment foster parents are developing the skills throughout the training, and then at time of follow-up whether skills improved when a child was placed in the home.

A strong therapeutic alliance has been shown to have a positive influence on treatment outcomes, and a measure could be included to determine the therapeutic alliance between treatment foster parents and children placed in their home in order to determine if the relationship moderates their personal dedication, willingness, and satisfaction with providing foster care. In addition, as other researchers identified (Dorsey et al., 2008; Festinger & Baker, 2013), assessing children's behavior and functioning outcomes is an area in need of further research due to the limited amount of studies that collect and examine this type of information. Outcomes for children placed in the home could be collected at time of placement and approximately three months after placement to determine if treatment foster parents' skills have an influence on their outcomes. Another area of research would include treatment foster parents' voice through the use of qualitative research designs. A phenomenological study describing the common meaning of treatment foster parents' experiences with attending pre-service training and subsequently having children placed in their home would provide a rich description of their experiences along their journey, and would help to validate the limited quantitative research results currently available for treatment foster parents.

Data analysis. There are several data analysis options that were not addressed in this study due to the intent of this study focusing mainly on change between the two groups after pre-service training. However, the AAPI-2 provides information about

whether scores are considered high, moderate, or low risk for abuse, and moderation analyses could be conducted to see if their risk level significantly influences the direction and amount of change after pre-service training. In addition, the PDFS and WFS-EB offer whether participants' scores translate to high, medium, or low potential to provide foster care, and these groups could be examined to determine if their level of potential influences the amount of change after pre-service training using moderation analyses. The results from these analyses would provide information about even though treatment foster parents report low potential for providing foster care or are considered high risk for abuse, the pre-service training they receive may move them into the medium/high potential range or moderate/low risk for abuse. In addition, licensing and child placement rates could be examined by whether training participants' scores are in the low, medium, or high potential range in order to provide more information about the relationship between their scores and these important training outcome variables.

Summary

There were several salient trends in the field of treatment foster care that served as an impetus to identify effective training programs specifically for treatment foster parents that are offered as pre-service courses. For example, multiple funding entities are focusing on the use of treatment practices proven to be evidence-based in order to effectively serve the increasing numbers of children with behavioral and emotional needs that are in out-of-home care. Therefore, using treatment foster care programs that employ trained treatment foster parents is a viable option to serve children with emotional and behavioral problems. However, there is a gap in knowledge about training characteristics and outcomes that will prepare treatment foster parents in their role as

implementers of the TFC model and therapeutic change agents. Therefore, this study offered insight into the effectiveness of a pre-service training program that was designed specifically for treatment foster parents.

Results of this study provide preliminary results that suggest pre-service trainings designed specifically for treatment foster parents (PR-TFC) may influence their parenting attitudes, readiness to provide treatment foster care, and attitudes about providing foster care compared to trainings designed for foster parents. For example, contrary to previous findings about foster parents' parenting attitude scores after attending pre-service training, there were significant changes experienced by both training groups after attending pre-service training with the PR-TFC group experiencing change in two parenting constructs and the MAPP training group experience change in one parenting construct. Although treatment foster parents' personal dedication to provide foster care and willingness to provide foster care did not significantly change after pre-service, there are results to suggest that they increase after a child is placed in the home.

In addition, significantly more participants in the PR-TFC group became licensed compared to the MAPP group suggesting that the PR-TFC pre-service training may have better prepared them to be ready for their role as treatment foster parents relative to the MAPP training. By filling this gap in knowledge about pre-service trainings for treatment foster parents, mental health organizations can be in a better position to implement treatment practices shown to be effective, thus eliminating the use of ineffective practices and potentially improving outcomes for children with emotional and behavioral problems.

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