



Thinking about Foster Care:
Professionalised Foster Care and Treatment Foster Care
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FOREWORD

MacKillop Family Services established its Practice and Policy Unit in 2002 as a way of promoting a learning and practice culture in the organisation. The Unit provides space and resources for MacKillop practitioners to take up secondments for a period of time away from their usual work, in order to research and reflect on particular issues of concern.

Each year, through consultation across the organisation, the Unit identifies priority areas for drawing on practice expertise and for research and advocacy. One priority area identified had to do with the future development of foster care.

Katie Hooper was coordinator in the Specialised Home Based Care service in the MacKillop Child & Youth Services (Western) program. In the first half of 2004 she took up a secondment in the Practice and Policy Unit to look at better ways of assessing carers and to research therapeutic foster care and the professionalisation of foster care. Her research also included visits to foster care providers while on leave in the U.K.

This report reflects Katie's research into the professionalisation of foster care. It represents not only a review of research literature and policy documents, but also the fruit of interviews with providers in the U.K., and with practitioners in MacKillop and other agencies.

The report provides much background information on treatment foster care and professionalised foster care, and will be useful in future developments in foster care. Given the complex needs of children and young people in out of home care today, and the quality of outcomes that can be achieved from stable home based care, her report is valuable and timely. The information and options gathered here will be of great benefit to practitioners, service designers and policy makers alike.

John Honner
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Chapter 1

Introduction

MacKillop Family Services was established in 1997 as a refounding of seven long established Catholic services. MacKillop is a specialised provider of child, youth and family services to some of the most marginalised families in Melbourne and Geelong. Key areas of support include family preservation, specialist education, residential services, disability services, youth services and foster care. This work is coordinated through over 90 services and the efforts of some 360 staff and a further 350 volunteers. Much of MacKillop's work is with children and young people who have been placed in out of home care, either in home based care or residential services.

MacKillop Family Services provides a number of home based care service types in the Department of Human Services North-western and Barwon regions. These include respite care, foster care, Specialised Home Based Care (also known within MacKillop as innovative home-based care and flexipac arrangements).

The Australian and Victorian contexts for home based care have been recently well documented. There are increasing numbers of children being placed in out of home care,¹ the number of available care givers is decreasing rather than increasing, carers are not adequately rewarded for the work they do,² children and young people are presenting with increasingly complex needs, and there are concerns about the impact of the high number of placements on a child's ability to develop attachment and identity.³

The report was initially undertaken to explore alternative models of care, such as professional foster care, therapeutic foster care or treatment foster care. It soon become obvious that professional foster care is not a model or type of care, but rather an over all system of recognising the work foster carers do for the out of home care sector. In the U.K. the term professional foster care was not widely recognised and there was a much greater understanding of the concept of professionalisation of foster care.

The aim of this report is firstly to explore the professionalisation of foster care in other countries, particularly in the United Kingdom, and how foster care can be developed in the Victorian context; and, secondly, to consider other models of foster care that would suit the needs of children and young people who are currently being cared for by the residential care system.

The research into the professionalisation of foster care, therapeutic foster care and treatment foster care has been undertaken through exploration of literature, as well as

¹ *Child Protection Australia 2001-2002* (Canberra: AIHW,2003), p. 39.

² Marilyn McHugh, *The Costs of Caring* (Sydney: SPRC, 2003).

³ Allen Consulting, *Protecting Children: The Child Protection Outcomes Project* (2003). This report had been commissioned by DHS and followed two prior DHS reports: *An Integrated Strategy for Child Protection and Placement Services* (September 2002) and *Public Parenting* (June 2003).

through interviews with service providers and advocacy agencies in the United Kingdom.

The report has four parts:

1. a report on the literature review;
2. a chapter on contacts made in the U.K. and information about the services interviewed;
3. three chapters covering discussions about the professionalisation of foster care, therapeutic foster care and treatment foster care;
4. and a final set of recommendations.

1.1 Definitions

For the purposes of this report the terms ‘foster care’, ‘professionalisation of foster care’, ‘specialised home-based care’, ‘therapeutic foster care’ and ‘treatment foster care’ will be used with the following particular meanings.

Foster care

Foster care is broadly defined as referring to a situation in which children live in other people’s families. This may have been because their parents had not the means to look after them, but more usually today to protect them from abuse or neglect, and sometimes because their parents feel unable to control them and their behaviour is socially disruptive or dangerous.

In Victoria general foster care is defined as “placements for children and young people up to the age of 18 years of age who are unable to live with their families of origin on either a short term or long term basis. Caregivers look after children and young people in their own homes.” (DHS, *Public Parenting*, 2003)

For the purpose of this report the term “foster care” will be used with these meanings in mind, although there are a number of variations between the systems and countries within which foster care is operating (these differences are further highlighted in discussions in the following chapters.

Professionalised foster care

For the purposes of this report the professionalisation of foster care means a well resourced service system that incorporates recognition of foster carers’ skills. (National Foster Care Association, London 1999). This service system would not only have clear quality standards for delivery of the service and codes of practice on the recruitment, assessment, approval, training, management and support of carers, but it would mean that the foster carers would be playing their role as full partners in fostering teams. There would be clear career paths for foster carers linked to training, competencies and payment for skills. This is further discussed in Chapter 4 below.

Specialised home-based care (SHBC)

SHBC is a model of care used in Victoria. SHBC is a more intensive foster care model that caters for children and young people in the care of the State (who have suffered some form of abuse or neglect). It offers placement options for children and young people for whom less intensive placements have been inappropriate or unsuccessful because of the child or young person's challenging behaviour or additional needs. The aim of these models is to give the child, young person or sibling group some stability and security while reunification with their families or permanency planning can occur.

Due to the complex needs, challenging behaviour or disability that these carers manage, the tax free reimbursement that they receive is higher than that of foster care.

Not only is the reimbursement that the specialised home-based care foster family receives higher than that for foster care, but the model is also designed to offer increased support to the family. This is done by having lower ratios of fostering social workers to children or young people that they work with. MacKillop Family Services work at a one to six ratio of staff to children or young people.

Innovative home-based care and flexipac care are similar to SHBC, other than that these types of care are often set up as individualised placements for very high needs young people.

Therapeutic foster care

Therapeutic foster care is a term used at Kent Country council in the U.K.. This model of care is for children and young people aged between 4 and 13 years of who are displaying emotional problems. The children and young people referred to this service have behavioural issues that may be related to a background of loss, separation, family violence and financial hardship. The aim of the service is for the foster family to provide a stable and secure home environment so that the child psychologists can work with the children and young people and their carers and families to address these emotional difficulties. The goal is for the children and young people to return home, but if this is not possible stability is sought through adoption or another long term foster placement.

In the U.K. this service is seen as a specialist service and therefore the therapeutic foster family receives increased carer reimbursements as well as additional training in behavior management and attachment issues. See Chapter 5 below.

Treatment foster care

Treatment foster care (TFC) is a home based placement which provides a normalising environment in which to treat children whose needs are better suited in a home based placement than more intrusive residential setting but for whom a traditional foster care setting cannot manage their needs (Redding et al 2000).

There are many terms used for treatment foster care program, including specialised foster care, intensive foster care, therapeutic foster care and treatment family care (Redding et al 2000), as well as foster family-based treatment,

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treatment foster care, family-based residential treatment and foster family care (Reddy and Pfeiffer 1997).

The American Foster Family-Based Treatment Association (FFTA) defines treatment foster care as a unique model of care that provides children with a combination of the best elements of traditional foster care and residential treatment centres.⁴ This means a combination of a nurturing and therapeutic family environment with an active and structured treatment that is carried out by the carer.

The FFTA describe the difference between treatment foster care and traditional foster care in terms of where the treatment occurs. Treatment foster care addresses the emotional, behavioral and medical problems in the foster home. Traditional foster care, on the other hand, provides a nurturing, safe environment while therapeutic treatment occurs outside the foster home. Reddy and Pfeiffer also stress the importance of the place where the treatment occurs in their descriptions, dividing treatment foster care into two general approaches: specialised foster care, where the foster carer provides a nurturing therapeutic environment while mental health professionals treat the young person; and treatment foster care, where the foster carer is viewed as the primary change agent (Reddy and Pfeiffer 1997).

Key features of Multidimensional Treatment Foster Care (a proactive approach taken to reduce problem behavior) are:

- Close attention to behaviour by the foster carer, who reports it back to the care team
- Case managers carrying smaller case loads
- Careful recruitment and training of foster carers
- Parents are involved in developing the treatment plan
- On call support
- Daily sheets and weekly supervision (Fisher and Chamberlain 2000).

See Chapter 6 below for further comments on Treatment Foster Care.

⁴ www.fftta.org

Chapter 2

Report on Literature Review

This chapter provides a summary of findings from the review of literature on various forms of foster care and their effectiveness. See the bibliography at the conclusion of this report for further references.

2.1 Foster care

Societies have always needed to manage orphaned children. Western societies have also needed to contend with caring for children whose parents could not care for them. When Australia was settled by white people there was also a need to care for abandoned and neglected children (Tomison 2002). Tomison notes that children were “initially boarded out with approved families or later resided in orphanages”. While many Churches became involved in running orphanages during the difficult social situations in Australia in the nineteenth century (such as during the gold rushes or depressions), with many children abandoned and neglected, there was also a concern about the conditions experienced by children in care (Tomison 2002).

As early as 1909 American politicians were debating the best approach to managing children in ways other than orphanages (Rosenfield et al 1997). Placing children with “carefully selected local families rather than orphanages or railroad trains taking orphans west” (Rosenfield et al 1997, p 448) was suggested. Rosenfield et al go on to highlight a number of social policies that impacted on planning for children and families in the early twentieth century. Some of these included government support during the Great Depression and the 1935 Social Security Act (Rosenfield et al 1997).

A number of authors who write about the development of foster care highlight Kempe et al’s article, ‘The battered child syndrome’ in the *Journal of the American Medical Association* (1962), as the impetus for a wave of public concern about children, which in turn led to review and development of services (Tomison 2002, Rosenfield et al 1997).

The National Foster Care Association (London 1999) highlights a number of legal influences on foster care. One of the major influences on the United Kingdom Law was the United Nations Convention on the Rights of the Child (CROC), adopted by the UN General Assembly in 1989. The CROC impacted on a number of Acts relating to children across the United Kingdom between 1989 and 1995.

The National Foster Care Association also commented on “the Changes in family and social structures, social work practice and the economy of social care provision” (London 1999, p 4) and how this has impacted on the changes to foster care in recent years.

The U.K. Joint working party on foster care acknowledged that the task of fostering in the U.K. today is far more complex and demanding than in previous times (National Foster Care Association, London 1999). The heightened complexities include: the need to care for more vulnerable children and young people; information recording; family contact; involvement with more services in relation to the children's needs; as well as meetings and skills development. The foster family's ability to maintain their own privacy is also challenged.

Another issue highlighted by the U.K. Joint Working Party on Foster Care is the demographic changes and how "the fewer people fit the traditional profile of foster carers – a two-parent family with only one wage-earner" (National Foster Care Association 1999, p. 5).

2.2 Professional foster care

The Children's Act (1989) in England and Wales incorporate foster carers as one of many professionals involved in the care system. This immediately gives foster carers a clear mandate for being involved in children's lives and a vital part of the system. While work has been undertaken for many years in the U.K. to highlight the integral part foster carers play in the care system, the battle to truly professionalise foster care continues. The argument for professional foster care has been taken up by the British Association for Adoption and Fostering (BAAF) over a number of years. They are continually trying to define a service system that would cater for all children and young people in the U.K..

In 1999 a U.K. joint working party (National Foster Care Association 1999, p. 5), highlighted the following influences on foster care in the U.K.:

- Growth of the independent non government sector of foster care (both not for profit and even more recently for profit organisations)
- The offer of considerable financial incentives, improved levels of support and increased training opportunities for foster carers
- Over all under resourced and under researched nature of foster care services.

Hutchinson et al 2003 state that there have been improvements in some foster care services, as well as a number of specialist services developed in the U.K. that incorporate increased support and payment schemes to foster carers. While such changes are welcome, the authors argue that many more improvements are needed to ensure that children and young people in the U.K. are cared for appropriately. The changes agencies and governments need to make to ensure an appropriate system include:

- Put in place a structure which requires and enables foster carers to develop and demonstrate the necessary knowledge and skills
- Regularly assess the capacities of carers at different points in their fostering career
- Match the needs of individual looked after children with the appropriately skilled carer
- Base the financial reward to the carer on the acknowledged level of skill of the carer rather than on the characteristic of the individual foster children

- Create a professionalised fostering service which offers a career structure to carers, with all that involves in terms of training, support, remuneration and working conditions, and in return requires of them a professional commitment to the service (Hutchinson et al 2003, p. 8.).

2.3 Treatment foster care

Treatment foster care has been a service model, aiming to meet the needs of children who require intense care, since the 1950s (Reddy and Pfeiffer 1997). Reddy and Pfeiffer cite Waskowitz (1954) as believing that TFC was initially developed to move children back from residential care to their families, but TFC soon became seen as an alternative to residential care (Reddy and Pfeiffer 1997).

Steib identifies the era of deinstitutionalisation (from residential care) of children and young people who cannot live with their families and who have challenging behavior in the 1970s as the time that treatment foster care really developed (Steib 2002). It appears that the mental health services also played a large role in the development of this service type, thus leading to the notion of ‘treatment’ in the title description. Treatment foster care (also known as therapeutic foster care, foster family-based treatment and specialised foster care) programs were developed in the 1970s as a response to the “limitations of the current child welfare service system, the crisis in traditional foster care services, and the lack of family-based mental health interventions for children who are not able to live with their own families” (Meadowcroft et al 1994, p. 565).

It is consistently noted in the literature that TFC is an economically appealing alternative to residential care for support of children and young people with emotional and behavioral difficulties (Farmer et al 2002, Chamberlain 2000).

The 1980s saw a number of factors impacting on the development of treatment foster care. These included an increased public awareness of the needs of “troublesome children” (Meadowcroft et al 1994, p. 566), the burden of the increasing costs of children’s services for states and governments, the increased number of treatment foster care services that were developing, the establishment of a North America association of treatment foster care providers, and studies on evaluations of treatment foster care services (Meadowcroft et al 1994).

The late 1980s saw the development of standards in the joining together of the TFC programs in North America (Farmer et al 2002). The Foster Family-Based Treatment Association (FFTA) Board approved the current version of the Program Standards for treatment Foster Care in 1995.

Some outcomes of treatment foster care have been tested. Chamberlain (2000) comments on a study that compared six to twelve year olds who were seriously emotionally disturbed and were placed in TFC with a similar group of children who remained at home and whose families received intensive case management. The children that remained at home did as well as those placed in care (TFC). One variation was that the children in TFC did not receive family therapy as part of their treatment plan.

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The Oregon Social Learning Centre has a program called Multidimensional Treatment Foster Care (MTFC). This is a treatment foster care program for young people involved in the juvenile justice system. A major objective of the Oregon Social Learning Centre is to undertake evaluations and document outcomes of the programs that they run. There have been a number of studies undertaken since 1983. Chamberlain and Fisher (2000) report on an evaluation of outcomes undertaken for MTFC for Juvenile Offenders. The target group that was researched between 1991 to 1996, included 79 boys whom the juvenile court mandated to out-of-home care (randomly to MTFC or Group Care). In Group Care programs, the boys lived with six to 15 other boys in family style group homes or cottages on the grounds of larger institutions and participated in daily group therapy.

Data on official arrest rates at one year post discharge showed that the boys in MTFC had fewer arrests than boys in the Group Care. Self reports of delinquent activity were fewer for boys from the MTFC group than for boys from Group Care. Similarly, the number of days incarcerated were fewer for boys in MTFC than Group Care, and absconding behaviour occurred less in MTFC boys than in the Group Care group. Two years post discharge data was available for 76% of their sample and the results continued to favour boys in the MTFC group.

Redding et al (2000), conclude that further research is required to understand the characteristics that mark successful treatment foster care placements. They also noted that placement stability is important for children in care and that there are a number of factors that are associated with long term placements. These factors include an authoritative sensitive parenting style, high levels of social, emotional and informational support, and a well defined treatment and service delivery model.

Overall, treatment foster care works well when all parties involved feel supported and have a voice, there is a clear plan (as well as available resources) for a stable placement and conditions for return to the biological family, there is a good fit between foster children and foster families, and there is sufficient training and preparation for foster parents. (Redding et al 2000, p. 443).

As a therapeutic service for children with emotional and behavioural disturbance, treatment foster care produces large positive effects on increasing placement permanency and children's social skills, and medium positive effects on reducing behaviour problems, improving psychological adjustment and reducing restrictiveness of post discharge placement (Reddy and Pfeiffer, 1997). This result was gained via a review of published outcome studies between 1974 and 1996.

Chapter 3

Visit to the United Kingdom

This chapter reports on interviews with the managers and workers of various out of home care services providers and advocacy organisations in April 2004, along with basic contact details and backgrounds of the agencies contacted. Subsequent chapters will report on findings and discussions resulting from the interviews.

The organisations contacted were Kent County Council, British Association for Adoption and Fostering, The Fostering Network and Foster Care Associates.

3.1 Kent County Council (KCC)

70 Stour St, Canterbury CT1 2NW
www.kent.gov.U.K.

Kent is the largest local authority in the U.K.. There are 980 children in foster care managed by this local authority. There are currently 694 foster carers across the programs. The region is divided into four patches and therefore four teams. Key contacts at KCC were Teresa Vickery (Manager), Annie Bousfield (Program Manager Treatment Foster Care), and Helen Perkins (Fostering Social Worker on the Therapeutic foster care team).

Kent (<http://www.kent.gov.U.K./ss/fostering03/foster/type.html>) offers six foster care services. These are short term foster care, long term foster care, respite foster care, day care foster care, respite for children with disabilities, and parent and child foster care.

Kent also offers a range of specialist services: concurrency placements, emergency and assessment foster care, therapeutic foster care, remand foster care and treatment foster care. Carer reimbursement rates for Kent County Council vary between foster care and specialist services and depending of the age of the child or young person.

Type of Foster Care	Age of Young Person	Total amount paid per week	Maintenance per week	Professional fee per week
Mainstream Foster Care	0-8	£179.34	£93.17	£86.17
Mainstream Foster Care	9-18	£294.14	£124.04	£170.10
Specialist services	0-8	£450	£363.83	£86.17
Specialist services	9-18	£450	£279.90	£170.10

Carers in the Specialist Schemes receive the total amount when children are in care, and the professional fee only, as a retainer, when children are not in their care. All carers are entitled to two weeks holiday pay, i.e. two weeks professional fee. Respite Carers are paid pro rata the fee of whichever programme they are providing respite for.

3.2 British Association for Adoption and Fostering (BAAF)

Skyline House, 200 Union St, London SE1 0LX
www.baaf.org.U.K.

BAAF is the leading U.K. membership organisation. It promotes the highest standards of child-centered policies and services for children separated from their families or origin. It has position statements on planning for babies, fostering skills and private fostering.

Contacts at BAAF included Jane Asquith (BAAF's Consultant in the North West); Barbara Hutchinson (BAAF's Deputy Chief Executive), and Katrina Wilson (Coordinator of publications at BAAF).

BAAF runs courses, seminars, consultancies and conferences around the U.K. for people involved in the care of children, to share skills and good practice. They have a publications department which produces books, guides and leaflets on fostering and adoption.

3.3 The Fostering Network

87 Blackfriars Rd, London SE1 8HA
www.thefostering.net

The Fostering Network is a charity for any persons involved in fostering, and exists to ensure that fostered children receive the highest standards of care. They offer consultancy, publication and training services. The contact at the Fostering Network is Cheri Talbot, (Training Manager).

The Fostering Network believes that carers should be reimbursed the expenses of caring for a child/ young person. They term this amount "the allowance". This amount does not include reward or payment for the carer themselves. Weekly reimbursements (allowances) proposed are:

	0-4 years old	5-10 years old	11-15 years old	16+ years old
Outside London	£108.49	£123.58	£153.84	£191.37
Inside London	£127.32	£145.15	£180.75	£224.50

The Fostering Network undertook a survey on allowance and pay in April 2004. This survey covered carers in the whole of the United Kingdom. 1,129 foster carers responded to the survey. The survey indicated that 97% of carers receive an allowance for caring for children. Only 34% of foster carers said that this allowance adequately covered expenses. The survey showed that nearly half of the fostercarers do not receive any professional fee for their foster carer skills, time and experience.

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The Fostering Network argues that foster carers should be regarded as part of the social care work force, not as volunteers, and that they should receive a payment to recognise their skills and experience.

3.4 Foster Care Associates (FCA)

150-156 Borough High St, London SE1 1LB
www.thefca.co.U.K.

Foster Care Associates (FCA) is a U.K. wide organisation that offers high quality home based placements to children/ young people who are “looked after” by local authorities. It specialises in placing children/ young people who have complex and complicated histories. It does this by offering a number of specialist schemes such as; remand foster care and young mothers and babies foster placements. The contact at FCA is Marcus Mikely (Director FCA London).

FCA, an independent fostering agency, is a private company and is currently undergoing accreditation by the U.K. government. The London region of FCA cares for approximately 100 children/ young people. There are currently 62 foster carers. Weekly reimbursements for specialist services to young people of all ages are \$350.

Chapter 4

Professionalisation of Foster Care

This chapter reports on various discussions about the professionalisation of foster care held in the U.K.

4.1 BAAF

Jane Asquith, BAAF's Consultant in the North West, talked about the development of a more professionalised care system and what still needed to be put in place to secure a safe system for English children and competent carers.

Not only did the Children's Act (1989) in England incorporate foster carers in its discussion of professionals involved in the care system, but it also corresponded with the time when the government was closing residential facilities and needed an alternative setting for the care of challenging children and young people.

Many of the developments of a professional career structure for foster carers arose out of historical difficulties within the foster care system, notably the development of specialist foster care services and then the development of independent providers. Carers in specialist services were seen as superior to other carers due to the increased level of reimbursement they received compared to mainstream foster care. It was not clear however, what the additional skills were that the increased payment coincided with. It was also not clear as to how a care family would move between specialist schemes or from a specialist scheme to a mainstream foster care scheme.

Independent providers caused frustration because they were in a position to offer increased reimbursements by having their foster carers become self employed and therefore receiving an increased payment. This payment was made up of two parts. Firstly there was a maintenance component, which covered reimbursement for the costs in relation to the child or young person, and secondly there was a professional fee which was for skills and services.

As a result of these tensions, a more professionalised system developed in the U.K. that offered carers a career structure. This career structure is competency based and required evidence to show these set competencies were being met. For example, a foster carer could start as a voluntary foster carer and then with defined training and experience could travel along a career path. For example, a kinship carer will get the maintenance allowance but not the professional fee. To get the professional fee, the kinship carer would have to meet some of the competencies and show the required evidence. In this case the kinship carer would possibly get the professional fee for extra children they take (other than the kinship placement).

In the U.K. each local authority or independent agency is able to set its own payment scheme, depending on what funds they had available. This often depended on how wealthy a borough was or what services an agency is offering. Foster carers could move from Voluntary Carer to a Level One Carer, Level 2 carer and then Level 3 Carer. The relevant competencies and payments are set by the agency and at this time there was no standard set of competencies. Level 3 carers are normally full time

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carers with no other source of income. They are expected to be available twenty four hours a day to meet the needs of the children they care for.

When a child with no challenging behaviours was placed with a Level 3 competent carer, the carer reimbursement was not linked to the child or the child's behaviour but rather to the carer skill level. In this case the carer would still get a Level 3 pay rate as this carer still has skills appropriate for this level of payment. It would, however, seem like a misuse of placement and skills, as this carer could manage a child with more challenging behaviours.

Similarly, a child with very challenging behaviour could be placed with a voluntary or Level 1 carer, but this carer would not receive any higher professional fee. Again the fee is not linked to the child but rather to the carer's skills. The concern in this case would be that the carer could be over whelmed and leave the service with "burnout" or disillusioned about the work they were trying to undertake.

Changes to the tax system for foster families had taken much lobbying over a number of years. Foster carers are all now self-employed in the eyes of the tax system. The maintenance section of the carer payment does not incur tax because it is a reimbursement for expenses. The professional fee comes to approximately £250 per week, which normally falls below a taxable income. One of the developments in the professionalisation of foster care over the coming months will be lobbying for a 52 week payment scheme, including paid leave, for foster carers.

A comprehensive document is used to do all OH&S checks prior to accreditation.

The writer the professionalisation of fostering has met with mixed reaction from carers: some carers like it, but others don't believe that foster care should be professionalised. In the U.K. there is still room for both voluntary carers and carers who are paid for their skills in a comprehensive system.

4.2 The Fostering Network

The Fostering Network has produced material to be used in assessing, training and accrediting carers. The resource is called "the skills to foster" and it is a course pack that contains everything needed to run an in house preparation to be a foster carer program. It covers training sessions in:

- what do foster carers do?
- who are the children and young people?
- working together
- safer caring
- understanding behaviour
- moving on
- sons and daughters – what's fostering going to mean for me?

Each Local Authority or agency then sets their own competencies and levels of skills payment. Training potential foster carers is a vital part of the system and that there is no clearer way of passing information on than by those who undertake the task.

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Competency around training other carers, speaking at forums or sitting on accreditation panels is often what makes up Level 3. Level 2 is often a competency around working with natural families, access visits and managing difficult family situations.

One limitation of the payment for skills scheme and competency based assessment is the appropriateness of these models for non English speaking carers, as well as their limited access to the training modules.

There is a National Vocational Qualification (NVQ) in the U.K. for foster carers and residential care workers. The qualification involves 17 work books and provides a range of activity based tasks and case studies. www.nec.ac.U.K./resources lists the following workbooks:

- Promoting equality, diversity and rights
- Receiving, giving and storing information
- Playing your part in planning care
- Developing working relationships with children and young people
- Helping to protect children and young people from abuse
- Developing knowledge and practice
- Supporting children and young people through change
- Preparing your family and friends for foster care
- Promoting educational opportunities
- Promoting health and social well-being
- Preventing and managing challenging behaviour
- Promoting a positive sense of self and identity
- Supporting children and young people when they are distressed
- Helping young people towards independence
- Helping children and young people keep in touch
- Supporting children and young people whose care is changing
- Helping your team practice effectively.

The NVQ can be used as evidence for agency set competencies. Many Level 2 carers have undertaken this training as part of their development. This training is paid for by the foster care provider.

There are a number of places where foster carers can access professional development. Once they are clear about their career path and individual development plans, they can access training to achieve agency set competencies via the agencies training calendar, external training such as through the Fostering Networks Open Training Courses, or conferences, and the NVQ.

4.3 Foster Care Associates

The Foster Care Associates pays all carers a flat fee regardless of the age of the child or young person in their care. As all the services were specialist services, this policy operated across the board. The only exception to this rule was if there was a one off

placement request by the local authority for a highly special needs placement. In this case there were two options:

1. get double carer payments for the carer and double agency costs. The carer would receive the double carer payment for expenses incurred and the agency would employ extra staff or support with their additional allocation. (i.e. an educational worker if the child was not attending school).
2. get double carer payments and no extra agency cost. In this case there carer would get the additional payment for costs incurred or skills required.

All carers go through nationally approved training and accreditation consistent with nationally accredited competencies. Once they are approved carers have access to a core agency training and are required to do six modules in the first 12 months as a carer. These include U.K. Law, Child Protection and diversity training.

The agency either provides the appropriate course or pays for required course costs. NVQ is also offered and paid for by the agency, and is encouraged for professional development. Because many carers only care for children in their home for a defined period of time, such a qualification opens the foster carers' options post caring for children or young people. Once they have stopped being an active foster carer they can undertake further study and work in the field in a different capacity.

One of the major competencies that needs to be addressed to be a specialist carer is availability. If there is a school meeting, is that carer able to get to it? What does it mean if the child is excluded from school? Who then cares for the child on that day?

4.4 Summary Discussion

From these interviews it is clear that there are a number of different organisations in the U.K. providing professional foster care services. These organisations vary from local authorities to non government organisations and privately run organisations. None of the organisations interviewed ran programs or models known as professional foster care but all talked about the importance of professionalising foster care so that carers were able to continue to develop if they so desired and children were cared for by a skilled set of caregivers.

It also appears that the resources available to foster care services are different to those allocated in Australia. The model most often used in the U.K. is for a foster family to have what is termed a fostering social worker who supports the carer while another worker is allocated to the case work with the child in care. The fostering social worker's role is to recruit new carers, as well as to undertake support and supervision of the agency's foster family. The fostering social worker would also discuss (career) development plans and training priorities for the foster carer.

It appears that the pre-accreditation training and accreditation process is similar across most of the organisations. This is due to the national standards and the resources that have been developed to introduce fostering to potential carers. The resources include

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information on training sessions that can be run by the organisation, as well as information for applicants about skills and abilities required to meet the key competencies.

There does not appear to be a consistent approach within the U.K. to the career path options across all organisations. While the ambiguity would seem unfair to many carers, it has the benefit of organisations being able to set appropriate competencies based on the needs of their programs and the children they are targeting. In the Victorian system, it would be useful to ensure that carers were being offered relevant training to meet the demands of the children they are caring for. For this to occur further work is required on the competencies that follow accreditation where these competencies are program specific.

Another issue that needs to be discussed when looking at the professionalisation of foster care is the issue of support versus supervision. In the British system, a fostering social worker's role is to assess, support and provide ongoing development for the foster carer. In the Victorian system the fostering social worker works with both the foster child and the carer. This means that further role clarity or resources may be needed. Due to the 24 hour nature of the work a clear pastoral care or support resource needs to be factored into the service, separate from formal supervision or professional development.

The amounts that foster carers receive for providing their service vary across organisations. It appears that nearly all foster carers in the U.K. receive an allowance (a reimbursement to cover the costs of caring for a child), but the amount of this allowance varies. Only half of foster carers in the U.K. receive any form of payment for skills, time and experience.

In Victoria, the subject that needs further discussion and clarification is the impact of Victorian work place laws on a payment scheme for foster carers. Legislation that would need to be looked at includes OH&S and awards (including leave entitlements). Other major issues that need to be discussed include the carer position description and the rights a family would have to say no to a requested placement if there was a vacancy.

Chapter 5

Therapeutic Foster Care

5.1 Kent Therapeutic Foster Care

Kent's Therapeutic Foster Care Service is for children aged 0-11 years old. Most of the children in the program have emotional problems and relationships and social interactions are difficult for these children. Children are referred to this program due to behavioural difficulties, meaning that the children cannot be placed in more main stream foster services. Most of these children have suffered previous placement disruption.

Children referred to the Therapeutic Foster Care Service have a history of family disruption and display behaviours associated with poor attachments to primary care givers. This may be due to family separation, violence or financial hardships.

On placement a psychological assessment is undertaken and the developmental needs of the child are identified. These needs are often around attachment issues and lead to the development of a plan that will assist with the child's behaviour.

The characteristics of carers in this program are that they have extensive experience with children and children in care (one has years of residential care experience and the other two have years of foster care experience); they have undertaken the pre accreditation training, participate in on going service training and are encouraged to do NVQ3 (which is paid for by the fostering agency); they have competencies additional to foster carers (i.e. working with birth families); there are no other children in placement, and if there are other children they are much older than the cared for child; that at least one of the carers is available at all times (i.e. doesn't work).

The Lead Fostering Social Worker has daily telephone contact with the carer and monitors each child's behaviour and development. She also has regular fortnightly face to face supervision sessions with the carer.

The Lead Fostering Social Worker, who is the case manager, convenes a consultation team to meet every two months. Invited to this meeting are the consulting psychologist, consulting psychiatrist, and the current carer. This meeting is to support the carer and further develop skills and strategies for behaviour management and attachment building. It is hoped that this team can provide a settled and stable home environment so that the therapeutic work that is being done by others can be successful.

Separate to this meeting is a networking meeting. In attendance at this meeting are the child's social worker, current carers, educational and health services, the consulting psychologist and the child's mental health (CAMHS) worker. It is at this meeting that the network tries to get behind the behaviour and make therapeutic changes.

5.2 Summary Discussion – comparison with Specialised Home Based Care

Kent County Council's Therapeutic Foster Care has many similarities to MacKillop Family Services' Specialised Home Based Care. Both use experienced, highly skilled carers to provide a stable environment for children and young people who are displaying difficult behaviour.

The hope of both programs is that the stability and security of the placement will provide a context for mental health services to work with the child or young person to address issues that have been caused by earlier abuse neglect or disruption.

It appears that the British mental health services, however, are more linked closely with children in the care system and that they play a pivotal role in the management of these children and addressing their behavioural issues. In Victoria the links do not appear to be as close and many children with disruptive behaviour are not being seen by mental health services.

Because of their experience and skill levels, foster carers on the Specialised Home Based Care team are expected (other than in exceptional circumstances of safety risk) to attend case plans and work with families. Further training is required in Child Protection and working with families to ensure that these carers are competent with these skills.

Chapter 6

Treatment Foster Care

6.1 Kent Treatment Foster Care

A Kent County Council Social Services have also developed a Treatment Foster Care Service. They have adapted this service from the Oregon Social Learning Centre Community Programs. The Kent Treatment Foster Care Service is not a Juvenile Justice Service – as is the original in Oregon – and does not therefore have the weight of the law and remand motivating the young person to participate. Instead it is a “voluntary” service where young people have to want to participate in the program. It is based on a premise that a young person will be motivated to work with the treatment foster care team to recognise and change those aspects of their behaviour, which are impacting on them progressing in their lives.

There is currently a target of five young people, and the age range is 11-16 years old. The target young person will be experiencing issues with the criminal system, have depression or self harming behaviour, will have been traumatised and will be unable to benefit from mainstream fostering services. Placements will be for up to 18 months with a view to moving the young person back to their family or into supported accommodation until they can live independently.

The goal of the program is to “decrease the antisocial behaviour and increase the appropriate behaviour”. The four objectives are to

1. provide the young person with close supervision
2. provide the young person with fair and consistent limits and consequences
3. provide a supportive relationship for the young person
4. minimise associations with peers who may be a bad influence.

6.2 Treatment Foster Carer and Team

No treatment foster carers had been recruited at the time of the interview. In potential care families, the Treatment Foster Carers needed to have a working knowledge of the care system and be experienced in behaviour management strategies. They would also need to have a demonstrated ability to work as part of a team and follow directions from the rest of the team about the behaviour modification strategies. The carer would need to be available 24 hours a day for the program and it would be therefore very unlikely that the carer would be able to have other employment.

The Treatment Foster Care team is made up of a dedicated specialist foster carer and a number of other professionals from the health, wellbeing and educational fields.

The team at Kent will include the following:

- *Treatment foster carer.* The primary role of this person is to implement the young person’s program and to encourage and support the young person to

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achieve the goal of behaviour modification. The treatment foster carer is critical to the program as they are “on the spot with all the behaviour” and are able to communicate the information back to the program manager as to what the target behaviours are.

- *Foster care program manager.* This is a slightly different model to those that are used in other treatment Foster Care models. The plan is for this person to manage the program, manage the recruitment of the carers and facilitate the meetings. It is still the program supervisor’s role to do the clinical treatment work, accept the referral and formulate the individual plan.
- *Program supervisor,* a psychologist who will coordinate, supervise and individualise the young persons treatment plan. This person will have contact with all members of the treatment team to gather information into the young persons treatment plan and will be on 24 hour “on call” for all clinical decisions.
- *Fostering social worker.* This person will recruit and assess potential carers in the local government area of Kent. This will be done to government standards. This person would support the foster family on a day to day basis. This would include making daily (week days only) phone calls to the treatment foster carer to go over the check list of behaviours (part of the individualised plan called the Daily Report).
- *Social worker.* This person will be the young person’s social worker. The role of this worker is to meet government standards in relation to child protection and “Looking After Children” standards.
- *Therapists.* Depending on the situation, the young person may have a therapist and the family may have a family therapist. It would be expected by the program that the young person’s therapist would support the young person to practice the behaviour modifications and support them through the changes that are occurring. This therapist, along with the young person’s social worker would act as the young person’s advocate.
- *Family therapist.* If the family had a family therapist, this person would work with the family to get them ready for the young person’s home return. This person would work closely with the program supervisor to structure access or home visits.
- *Skills worker.* This person would work part time and do some one to one activities with the young person. This youth or skills worker would get the young person linked into community activities and be with them while they practiced the skills that the young person is developing.
- *Education Support.* This support worker would be an Educational Psychologist and would undertake educational assessments and support.

This model has challenges for all involved, primarily due to its very prescriptive format. In the care team there are a number of highly experienced professionals, as

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well as a foster carer who is central to the program and a highly respected part of the team. There will need to be great clarity about lines of communication and roles.

The differences between the Treatment Foster Care (TFC) program and mainstream foster care can be summarised as follows:

- TFC places one young person with a carer family at a time
- TFC uses a team approach to treatment, with the Treatment Foster Carer as part of a team.
- The treatment foster carer implements an individualised, structured program for each young person under the guidance of the program supervisor
- The treatment foster carer receives an enhanced level of support from the program staff with crisis intervention available 24 hours a day.

6.3 Summary Discussion

The model of treatment foster care that is being adapted to be used in Kent is based on a service that has been used to manage young people in the juvenile justice system in America. The model is very much a behaviour adjustment/ management model and the young people agreeing to participate in it are motivated by the fact that if they do not participate they will be remanded into a detention facility. It will be interesting to see if the young people of Kent engage as well as they have in the USA.

The target population in the USA and U.K. does appear to be similar to many young people in residential care at MacKillop Family Services. An appropriately managed and supported home based care option may meet their needs. Treatment foster care may be an appropriate model. Cost analysis would need to occur comparing treatment foster care to residential care and specialised home based care.

Treatment foster care is not based on forming long-term stable relationship to facilitate change but rather working to a behaviour management plan to increase appropriate behaviour. Residential staff at MacKillop use both attachment theory and behaviour management techniques in terms of their theoretical approach to working with young people needing care. Home based carers at MacKillop use a nurturing philosophy and attachment theory to stabilise the children in care enough to allow counselling to address some of their emotional issues. Due to the underlying philosophy of the Treatment Foster Care being different to that of other home based care types, it would be important to utilise the skills of residential care programs in the development of such a program.

Conclusion

Recommendations

The following recommendations arise from this research:

1. That MacKillop Family Services formulate a strategic plan to develop professionalisation of its foster care service. This plan would need to incorporate carers who want to consider a “career” in fostering as well as those that are happy to play a more informal role in the support of children and young people in the community.
2. That training be a component of this plan and that foster carers be offered training that not only meets their learning needs but also is offered in a way that acknowledges their other commitments.
3. That carers be involved in more aspects of the foster care service and that consideration be given to reimbursement for this service. This could include accreditation panels, delivery of training, formal support to other carers (i.e. during allegations of abuse by carers). That carers undertaking such roles be formally trained to participate in this way.
4. That foster carers have clear policy and practice documentation.
5. For formal links to be explored between MacKillop’s home based carers and consulting psychologists. That this be done to ensure that carers have access to a child psychologist for secondary consultation about management of children in their care. This would also mean that additional support would be available to the foster carers.
6. That stronger links be made between MacKillop’s home based care teams and mental health services. A number of children and young people have come into specialised home based care who are not currently referred to mental health services.
7. That participation in a treatment foster care service be explored. As Oregon Social Learning Centre (OSLC) has established not only a comprehensive model of treatment foster care and thorough supporting documentation for such a program, but also a number of services in a number of countries, their support should be sought in setting up such a program.

In the end, the question is not, ‘What model should we use?’ Or ‘What rates of pay do we give our foster carers?’, but rather, ‘How do we provide the best service to children and young people in out of home care and their families?’ A higher level of specific training and an acknowledgement of the professional role of carers will certainly contribute to this end.

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