A New Chance is the report of a study commissioned by Cooperation and Working Together (CAWT). CAWT is an umbrella body composed of the statutory health and social care agencies adjacent to the border in both Irish jurisdictions. With funding obtained under the European Union, EU INTERREG IIIA Programme for Ireland and Northern Ireland 2000-2006, the study examines the possibility of developing high-support treatment foster care in the CAWT region.

Drawing from the literature and research on foster care, it identifies important areas that a high-support foster care scheme should address in order to produce positive outcomes for young people in adversity. Four typical schemes are described. One of these, Multi-Dimensional Treatment Foster Care devised by the Oregon Social Learning Centre, makes use of foster carers as members of a highly-supported team implementing a dedicated programme based on the needs of the young person placed with them. This programme is focused on important social domains in the young person’s life.

Multi-Dimensional Treatment Foster Care has achieved positive outcomes stretching up to two years following treatment. The implications of introducing it into the CAWT area are reviewed while taking account of issues raised through consultation with interested stakeholders. An outline model is proposed which may meet the demographic, cultural and legal requirements of the area. Also considered are the possible costs, the savings and the benefits for agencies, young people and their families that may arise from its introduction.

Eric Plunkett is a Principal Social Worker, Health Service Executive, North-West, Republic of Ireland. As Project Manager of A New Chance: Cross-Border Foster Care Project, he coordinated the research and consultation processes upon which this report is based. He has worked as a social worker for over 30 years in both childcare and criminal justice settings in Northern Ireland, Scotland and the Republic of Ireland.

Robbie Gilligan is Professor of Social Work and Social Policy at Trinity College Dublin. He is also Head of the School of Social Work and Social Policy, and Associate Director (and co-founder) of the Children’s Research Centre at TCD. His research interests include children in state care, family support, and programmes to combat social disadvantage among young people. He has particular interest in strength-based perspectives and has experience in evaluation and action-research.
A New Chance -

An evidence-based approach to the state care of young people with challenging behaviour

Eric Plunkett, Robbie Gilligan.
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Abstract

This report examines the possibility of developing a high support treatment foster care programme for young people who present with challenging behaviour in the CAWT region. This is the area spanning the border between Northern Ireland and the Republic of Ireland. The proposal it makes, to introduce Multi-Dimensional Treatment Foster Care, takes account of the separate historical development and differing social service infrastructure in both jurisdictions represented in the area.

Drawing from the literature and research on foster care, it identifies important areas that a high support foster care scheme should address in order to produce positive outcomes for young people in adversity. The report describes four typical schemes. One of these, Multi-Dimensional Treatment Foster Care devised by the Oregon Social Learning Centre demonstrates a sound evidence base. It makes use of foster carers as members of a highly supported team implementing a dedicated programme based on the needs of the young person placed with them. This programme is focused on important social domains in the young person’s life.

Multi-Dimensional Treatment Foster Care has achieved positive outcomes stretching up to two years following treatment. The report describes this programme and how it has been applied in other countries. It reviews the implications of introducing it into the CAWT area that takes account of the issues raised during the consultation processes undertaken during the project. It proposes an outline model which may meet the demographic, cultural and legal requirements of the area. This also considers the possible costs, the savings and the benefits for agencies, young people and their families that may arise from its introduction.
Foreword

This report has been produced as the result of a research piece commissioned by the CAWT Family and Child Care Subgroup. The Subgroup was interested in the strategic direction and practice issues in foster care but were specifically concerned about children in care with complex needs who experienced a range of personal and social difficulties. The Subgroup felt it would be important to put a picture together of how children and young people who challenged mainstream foster care services were being cared for across the then four border Health Boards. It was also felt that it would be a worthwhile and useful exercise to identify a model of foster care that could deliver positive outcomes for this group of children.

As a partnership project the success in presenting this final document has rested not only on the tireless work of the author Eric Plunkett but also in the cooperation of Health Service personnel and service users on the north and south of the border in Ireland. In particular the gathering of information to satisfy the field research piece is set against a variety of delivery systems for foster care services.

The project set out in April 2004 to undertake the agreed work and has completed within the planned timeframe. The completion of this report was linked into a number of stages through which the findings and recommendations were reached. This involved the completion of a literature review, a survey, and a consultation process with dissemination of information through a conference in November 2005.

This report brings together the work of those stages providing information on a number of projects that exist internationally that provide high support foster care, set against information about the needs of children locally who present with challenging behaviour. This led to the identification of a high support foster care model, which has reported a proven track record in the U.S. and U.K., one that could accommodate the needs of the children and young people we often struggle with.

The findings and recommendations of this report come at a stage when commissioning bodies for foster care services north and south are considering the current design of existing foster care schemes in an attempt to address a shortfall of available and suitable placements for children. The project team hopes that this report will provide food for thought for those who are involved in drawing up specifications for enhancing current models of delivery or designing new ones.

On behalf of the Project Board

Eugene Bigley
Regional Services Manager, Alternative Care
Health Service Executive, North West.
Preface
Preface

Cooperation and Working Together (CAWT)

Cooperation and Working Together (CAWT) is an umbrella organisation established in 1992 by agreement between the four Health Boards and Health and Social Service Trusts on each side of the Irish border. In the Republic of Ireland these were the North Western Health Board, the North Eastern Health Board (now the Health Service Executive, West/North West area and Health Service Executive, Dublin/North East respectively) and their five Community Care Areas. In Northern Ireland these are the Western Health and Social Services Board, and the Southern Health Social Services Board and their associated Trusts. They constitute the CAWT partners.

The CAWT area encompasses the region indicated in the map below.

Figure 1. Map of the CAWT area

From the City of Derry in the northwest to the town of Drogheda, barely 30 miles from Dublin, in the south, CAWT encompasses a population over one million people. It is composed of the 10 counties straddling the Irish border. These are Donegal, Sligo, Leitrim, Cavan, Monaghan, Meath, Louth - all in the Republic of Ireland and Tyrone, Fermanagh, Armagh, together with parts of Down and Londonderry - all in Northern Ireland.
CAWT's objective is to promote cooperation between its partners for the benefit of the health and social wellbeing of the population in border areas. A small administrative centre based in Derry supports 13 subgroups each of which is focused on a particular health and social service provision. These subgroups are composed of experts in the specialist areas drawn from the member partner agencies. Each develops proposals for projects that are incorporated into the CAWT business plan. Once a subgroup has been successful in drawing down funding for a project, it appoints a Project Board to oversee its implementation.

The CAWT Family and Childcare Subgroup identified the provision of care for children with challenging behaviour as an issue common in both jurisdictions on the island of Ireland.

Members representing the partner agencies were aware of the difficulties in finding appropriate placements for such children. Often, the solutions created a mismatch between the needs of the children themselves and service provision. Developing a more effective and wider range of services to address the issue was thus a priority.

**A New Chance - Cross-Border Foster Care Project**

A proposal to seek funding from the European Union's INTERREG IIIA Programme for Ireland and Northern Ireland 2000-2006 was accepted. A project board was appointed with the aim of:

- designing a scheme for the development of high support foster care for young people with challenging behaviours and complex needs in the CAWT area.

The project A New Chance - Cross-Border Foster Care Project was established with that brief in April 2004, with Eric Plunkett, Principal Social Worker, Health Service Executive - Northwest, as manager. Shortly thereafter, Professor Robbie Gilligan, Head of Dept. of Social Studies, Trinity College, Dublin, was appointed as consultant.

The study is the final report of the project. Together with earlier discussion papers, and the complete Research Survey Report, it can be downloaded from the CAWT website, [www.cawt.com](http://www.cawt.com).

The study concerns the state care of young people who present with challenging behaviour. Its observations, conclusions and recommendations apply equally to young men and young women. To emphasise this point, young people referred to are described alternately in the feminine or masculine genders.
Acknowledgements

A New Chance - Cross-Border Foster Care Project was assisted both in the undertaking of its work and in the preparation of this report by a number of people to whom grateful appreciation is owed. These include:

- The members of the CAWT Family and Childcare Subgroup and its Project Board as follows: Ms. Nuala Doherty, Mr. Eugene Bigley, Dr. Aisling Gillen, Mr. Christy O’Kane, Mr. Martin Quinn, Ms. Liz Shaw, Mr. Godfrey Young, Ms. Mary Browne, Ms. Margy Dyas, and Ms. Katherine McElroy.
- Ms. Claire Grant, Ms. Siobhan Kelly and Mr. Sean O’Connor, social workers from Sligo who collected the research study data.
- Ms. Kathy Byrne, Sligo and Dr. Philip Curry, Trinity College Dublin, who respectively analysed and proofed the data from the research survey.
- Ms. Bridie Colreavy, and Ms. Aisling McGowan, Sligo who organised, and Mr. Mark McChrystal, Derry, who facilitated, the consultative seminar.
- Ms. Frances McLaughlin, Ms. Sadie Bergin and the staff in the CAWT office in Derry, who were readily available with advice and support.
- Ms. Mary Payne, Lisdeel Family Placement Service, Dublin and Mr. John Sheldon, Belfast Community Placement Service, who willingly and patiently sacrificed time in outlining their work.
- Dr. Phil Fisher, Oregon Social Learning Centre, Ms. Rosemarie Roberts, National Treatment Foster Care Project - England, both of whom gave so willingly of their time both for consultation and to present at the consultative seminar in Armagh.
- Professor Kjell Hansson, Mr. Per Schuller, and Ms. Nicolina Fransson, Familjeforum, Lund, Sweden; Ms. Mona Duckert, Ms. Tone Fiane Christiansen, Bufetat, State Child-Care Service, Tonsberg, Norway - who also gave willingly of their time for consultation in relation to the implementation of the projects in their respective countries.
- Social workers, managers, foster carers, young people, and representatives of voluntary agencies who participated in consultation meetings and attended the seminar in Armagh.

There is no question but that the willing cooperation of all was an essential ingredient in informing the project. This report is the fruit of their assistance. The adoption of the report and the future implementation of the proposals would be a fitting tribute to their efforts.

Eric Plunkett,

Robbie Gilligan.

February 2006
Recommendations arising from the report
Recommendations arising from the report

All the recommendations which follow are important. However, they are listed in the order of their priority rather than the order in which they may be found in the body of the report.

Recommendation 1
The CAWT partners should actively consider promoting the development of Multi-Dimensional Treatment Foster Care.

Recommendation 2
The CAWT partners should seek funding for the implementation of Multi-Dimensional Treatment Foster Care in its region, on the basis that:
• there is an established need for a high support foster care scheme in the CAWT region
• such a scheme would be consistent with statutory direction that young people should be provided for in the community
• it is consistent with public policy that interventions should be evidence based
• implementation of Multi-Dimensional Treatment Foster Care would reduce and in some cases eliminate significant costs currently incurred in the management of young people with challenging behaviour

Recommendation 3
In implementing the Multi-Dimensional Treatment Foster Care programme developed by the Oregon Social Learning Centre, faithful application to the programme as it was designed is essential to guarantee the desired outcomes. Consequently, the Oregon Social Learning Centre should be closely involved in all aspects of the design and implementation of a scheme in the CAWT area.

Recommendation 4
To implement Multi-Dimensional Treatment Foster Care with fidelity to its design, it would be necessary for the CAWT partners to:
• enter into a contract with the Oregon Social Learning Centre to oversee and support the implementation of Multi-Dimensional Treatment Foster Care
• commission from the Oregon Social Learning Centre a package of training, supervision and support for the introduction of Multi-dimensional Treatment Foster Care
• plan for the certification by the Oregon Social Learning Centre of local staff to undertake training and support for Multi-Dimensional Treatment Foster Care programmes in the future

Recommendation 5
In implementing a Multi-dimensional Treatment Foster Care scheme in the region, a lead NGO agency should be appointed to work in partnership with the CAWT associate agencies:
• The lead NGO agency should have authority to appoint an Implementation Group and Site Teams.
• The Implementation Group should draft clear and concise policies and procedures relating to the operation of the scheme, which give due emphasis to the requirements of the research evaluation study.
• Site Teams should undertake the recruitment of foster carers in consultation with the regular foster care system and be responsible for the day-to-day implementation of Multi-Dimensional Treatment Foster Care.
• Training of foster carers should be undertaken by the Oregon Social Learning Centre in conjunction with the Implementation Group.
• Consultation forums should be established with young people, foster carers, referral agencies and other stakeholders.

Recommendation 6
Some Health and Social Service Trusts and Health Service Executive, Community Care Areas, report low numbers of children who present with challenging behaviour. In these areas consideration should be given to the introduction of the Early Intervention or KEEP projects. These would benefit younger age children including those who are in regular foster care.

Recommendation 7
A recognised research institution should be commissioned to undertake a comprehensive evaluation of implementation and outcomes resulting from a proposed scheme.

Recommendation 8
Following a decision by the CAWT partners to implement Multidimensional Treatment Foster Care, consultation should take place with schools regarding the programme. Consideration should also be given to the inclusion of educational representation on the CAWT Family and Child Care Subgroup.

Recommendation 9
The possibility of post-treatment care being provided by foster carers and the fees to be paid to them should be clearly outlined in any proposed scheme.

Recommendation 10
Following implementation of a Multi-Dimensional Treatment Foster Care scheme, acceptance of referrals during the Early Operation Period should be staggered in order to allow staff and site teams to develop their confidence and abilities.
Executive summary of report
Executive summary of report

Introduction

With a population of over one million people, the demographic characteristics of the CAWT region are varied.

- Statutory services in both Northern Ireland and the Republic of Ireland are generally provided by statutory agencies through dedicated professional teams based in large towns.
- The CAWT partners commissioned A New Chance - Cross-Border Foster Care Project in order to seek a new direction in addressing the problem of managing young people in care who present with challenging behaviour.
- The project had three phases: research, consultation and outline design.
- The research and consultation phases were influenced by discussions and interviews with statutory and voluntary social service agencies who provide for the care of children in Northern Ireland, the Republic of Ireland, Britain, Europe and the United States.
- The three phases of the project were undertaken concurrently. Consequently, the report is structured by:
  ➢ outlining a description of the context in which the project developed
  ➢ the extent of the problem reported in the CAWT area
  ➢ high support foster care as a possible way forward
  ➢ how high support foster care is provided elsewhere
  ➢ a provisional proposal for an MTFC scheme

The social and historical context

- Historically, foster care has been an important feature in the provision of alternative care in both the Republic of Ireland and Northern Ireland.
- There have been significant differences in the development and use of services for the care of vulnerable children in each area. These were removed with the introduction of similar legislation in both jurisdictions during the last 15 years.
- The focus of this legislation placed the duty on each state to be proactive in identifying and providing for the needs of children whose care was inadequate.
- The challenge which this creates has placed a serious strain on resources. It has resulted in mixed outcomes, particularly for children who are in care and especially in respect of those who present with challenging behaviour.

The extent of difficulties reported in the CAWT area

- Of the 1,343 young people in care in the CAWT region, 182 (10.7%) are reported to present serious management difficulties and 39 (2.7%) to be intensely difficult to manage.
- Most children present with challenging behaviour that has multiple features.
• There are differences in the severity of behaviour reported by girls as opposed to boys.
• While older age groups constitute the largest number of children reported to present with challenging behaviour, younger children also similarly present.
• Consideration of the survey results suggests that:
  ➢ the high level of support that may be needed to assist children with challenging behaviour is not always available within the alternative care framework
  ➢ the definition of challenging behaviour should focus on the effects that behaviour will have for a child’s prospect of positive life experiences in the future
  ➢ any system designed to support children should address their social interactions, education, behaviour, and close relationships
  ➢ consideration of gender differences in the presentation of difficult behaviour should be given particular attention in the implementation of a high support foster care scheme
  ➢ early identification of appropriate responses to children’s needs should be addressed to forestall more serious consequences later
  ➢ frequent change of placement is a predictor of placement breakdown. Early identification of behaviour which contributes to placement disruption can reduce poor outcomes for children later on

High-support foster care as the Way Forward

• The CAWT partners initiative in commissioning A New Chance was founded on the premise that existing arrangements for the care of young people with challenging behaviour do not deliver sufficiently satisfactory outcomes for them.
• The goal of high support foster care is to provide a stable foundation upon which a young person may develop the continuity of relationships necessary to combat the adversity of his early life experiences and to support him in the transition to a stable adult life.
• Implementing a high support foster care programme, to achieve the positive outcomes proposed, will require a dedicated plan to address a child’s needs across many social dimensions and interactions of his daily life.
• Desired outcomes from high support foster care can be achieved with comprehensive planning. This is dependent on a scheme being organised and supported by the skill and expertise of professionals and others working alongside the carers.

How-high support foster care is provided in other countries

• Many high support, specialist, or treatment foster care schemes have been developed in response to local situations.
• Often, the cost of providing for the care of children with challenging behaviour is a critical factor in prompting the setup of schemes.
• Most schemes concentrate on giving intense support and enhanced reward to foster carers in assisting them to help a child to develop positive social skills and appropriate behaviour.
• Many schemes aim for stability of foster care as an outcome, which may in turn lead to further stability in adult life.
• A lesser number of schemes apply a team approach. Foster carers, as members of a team, participate in the implementation of a rigorous programme focused on multiple social dimensions of a child’s life.
• Such schemes generally operate in the context of a throughcare plan targeted toward an identified adult life pathway for the child.
• A review of four typical schemes suggested variable outcomes depending upon:
  ➢ the nature of their organisation
  ➢ their capacity to adhere to the implementation of the model as designed
  ➢ the degree of independence accorded to foster carers
  ➢ the intensity of support available to them
  ➢ the existence of a realistic and practical throughcare plan

The case for Multi-Dimensional Treatment Foster Care

• Multi-Dimensional Treatment Foster Care is an intervention targeted at young people who present behaviour difficulties arising from traumatic early life experiences.
• The programme operates in the context of a rigorous design which, when implemented faithfully, has an evidence base for positive outcomes in respect of young people placed in it.
• To provide it, a dedicated team of professionals implement a structured behaviour management programme, alongside trained foster carers, across multiple social domains of a child’s life.
• Very good outcomes have been validated from implementation of the programme in the United States.
• MTFC related programmes progress from prevention to treatment across stages of a child’s development from preschool, through latency, to adolescence.
• Apart from the United States, MTFC programs are being implemented in Canada, Sweden and England.
• The examination of the Swedish and English pilot schemes, together with a Norwegian adaptation of MTFC, was undertaken in the course of A New Chance-Cross-border Foster Care Project.
• This identified a number of important issues to be considered in implementing the programme relating to:
  ➢ funding
  ➢ organisation structure
  ➢ planning
Introducing Multi-Dimensional Treatment Foster Care in the CAWT area

- The CAWT area is very suitable for the introduction of Multi-Dimensional Treatment Foster Care.
- The nature of the CAWT partnership and constitution is such that it could have a major role in relation to the introduction, development and implementation of MTFC programmes.
- Partnership between an NGO and statutory agencies in the CAWT area would provide a secure foundation for the establishment of an MTFC scheme.
- The survey of children in care in the CAWT area has identified possible savings that could result from the introduction of an MTFC scheme in the region.
- Procedures should be devised to account for costs incurred in the implementation of the programme balanced against the cost of alternative interventions not used in respect of each child.

The cost of implementing a Multi-Dimensional Treatment Foster Care scheme

- For the development of Multi-Dimensional Treatment Foster Care in the CAWT area there are three identifiable funding phases:
  - commissioning
  - start-up
  - early operation
- If implemented, the costs for the commissioning phase would be the responsibility of the CAWT Family and Child Care Subgroup. These would be met from the funds allocated to the project.
- Once funding has been obtained for a proposed scheme, the CAWT partners should agree a contract with the Oregon Social Learning Centre to advise and provide training for the implementation of MTFC.
- Following their recruitment, the development and implementation of the scheme would be the responsibility of the Implementation Group and Site Teams.
- Estimates for the funding required should recognise that the amounts will vary during each of the three funding phases.
- Funding required for the development phases should be secure and should not depend on fees paid for cases referred.
- As the scheme moves to full operation, a means of protecting it against funding problems arising from referral variations should be considered.
- Depending upon the number of sites in operation, the cost for a child to participate in a program will vary between €147,000/£99,000 and €126,000/£81,000 per year.
Conclusion

• Of many high support foster care schemes that operate, Multi-Dimensional Treatment Foster Care stands out in terms of validated outcomes it has achieved in respect of the care of young people with challenging behaviour.
• These outcomes are dependent upon MTFC being implemented with fidelity to its design.
• Uniquely, a dedicated team as the primary agent of change that includes foster carers, delivers as a unit, a predetermined programme addressed to meeting the child’s needs.
• The significant cost associated with investing in MTFC should be set against the benefits that will accrue to young people, foster carers, social workers and statutory agencies.
• Once the programme is implemented as designed the promised benefits to them will be achieved.
Chapter 1 -

Introduction
1. INTRODUCTION

The CAWT region is composed of areas that come under the jurisdiction of two separate governments. Nevertheless, difficulties experienced in relation to young people with challenging behaviour are similar. Their problems present an opportunity to study shared experiences, across the area, with the object of developing practical solutions.

The demographic characteristics of the CAWT region are varied. The largest centre of population is the City of Derry. Other medium-sized and large towns are Letterkenny, Strabane, Sligo, Enniskillen, Carrick-on-Shannon, Cavan, Monaghan, Omagh, Armagh, Dungannon, Craigavon, Newry, Dundalk and Drogheda. Although Derry is located in the West, the largest population concentrations are in the east roughly along the Belfast to Dublin corridor. To the West there is a considerable length of coastline and a small number of offshore island communities. Inland, mountains and lakes contribute to the natural splendour and beauty of the region. However, their remote and marginal rural location often mean hardship and isolation to their populations. Throughout the region both urban and rural communities each with their own individual characteristics present a major challenge in delivering accessible social services to all.

<table>
<thead>
<tr>
<th>Table 1.1: Population of the CAWT area</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Southern Health and Social Services Board</strong></td>
</tr>
<tr>
<td>321,000</td>
</tr>
<tr>
<td>Newry/ Mourne</td>
</tr>
<tr>
<td>64,500</td>
</tr>
</tbody>
</table>

Figures for population obtained from Department of Health Trust/HSE Internet web sites.
Table 1.1 on the previous page illustrates the population distribution of the Boards and Health Service Executive regions together with that of their Trusts and Community Care Areas. The Health Service Executive West/North West Area has the lowest population in the region. Conversely it has the largest geographical area and the highest unemployment level and index of poverty in the Republic of Ireland.

The delivery of services is very similar in each jurisdiction. These are generally provided by statutory agencies based in large towns in each Trust/Community Care Area. Children’s services are delivered by different professionals often grouped together, although not exclusively so, in dedicated teams. In respect of children who may be in need of care and protection social work is the key profession, also organised in dedicated teams. Those teams may have access to other professional support services. Typically they may be divided on the following basis:

- **Child protection**: Usually this is the first referral point for a child in respect of whom there are concerns. Normally, this will result in an assessment of the child’s needs. Decisions on further intervention may then follow including the possibility of the child being admitted to care.
- **Family support** is provided in circumstances where a child is not believed to require protection. Generally, the family circumstances are such that if supported, its functioning and long-term stability would improve.
- **Family placement** involves the assessment, recruitment and ongoing support of foster carers. It is utilised to identify, recruit and support carers with whom children are placed, whose circumstances require their admission to care.

**A New Chance - Cross-Border High-Support Foster Care Project**

The title of this project, “A New Chance,” is optimistic. It addresses a particular problem for children in adversity that has been difficult to solve. The project brief, as outlined in its application for EU funding, has a narrow focus. It specifically targets only the development of high support foster care for children with challenging behaviours. That focus is further restricted by the proposition that the project should undertake this task “by exploring the design of a service to meet their needs, while simultaneously reducing pressure on existing residential facilities”. Three concurrent phases in which the project was to engage were identified as follows:

- Research
- Consultation
- Outline Service Design

Because of the wide variation in social, demographic and geographic features in the CAWT area, this report proposes an outline design for a high support scheme only. A more comprehensive and detailed design can only follow a decision to implement the recommended programme. Such a design would then be tailored to the individual needs and profile of the areas in which it is to be implemented.
It is important that in implementing the proposals in this report, the CAWT partners should:

- adopt a distinct programme, which commands the support and commitment of all key stakeholders
- implement such a programme faithfully, on the basis that there is clear evidence of positive outcomes for young people who avail of it
- target the identified needs of young people presenting with challenging behaviour
- be informed by the existing experience of those most closely involved in alternative care services

In relation to outcomes, on one extreme, the project brief may be said to imply a desired outcome which simply reduces the use, and hence the cost of high support residential facilities. On the other, however, the project may seek as a more ambitious outcome the design of an evidence-based scheme that assists young people in their transition to a stable adulthood.

In achieving the above objectives, the methodology adopted is illustrated in Figure 1.1 on the next page.
Figure 1.1: A New Chance – Cross-Border Foster Care Project – methodology

**RESEARCH**
- Literature review
- Identification and comparison of existing high support schemes
- Review operation of multidimensional treatment foster care
- Survey of children in care population in CAWT region

**CONSULTATION**
- Meetings with stakeholders
- Discussion documents circulated
- Information exchange with international high support agencies
- Consultative seminar

**OUTLINE OF SCHEME**
- Evidence base for positive outcomes
- Positive impact on existing foster care services
- Balance of medium-term cost savings against outcomes for young people
- Cross-border cooperation to minimise cost and maximise efficiency

**RESEARCH CONTACTS**
- Belfast Community Placement Service
- Bufetat (statutory childcare organisation), Tonsberg, Norway
- Community Alternative Placement Scheme, Scotland
- English Midlands Regional Specialist Schemes Group
- Familjeforum, Lund, Sweden
- Lisdeel Family Placement Service, Dublin
- Multi-Dimensional Treatment Foster Care, Oregon
- National Treatment Foster Care Project, England
- Trust/HSE Frontline Staff

**CONSULTATION CONTACTS**
- Barnardo’s Trust/HSE Frontline Staff
- Children in Need Northern Ireland
- Foster Care Associates/Fostering First
- Fostering Network
- Irish Association of Young People in Care
- Irish Foster Care Association
- Trust/HSE Frontline Staff
- Trust/HSE Management Teams
- Oregon Social Learning Centre
- Voice of Young People in Care
• **Research**

The research phase had two key elements.

1. **A review of relevant existing schemes.**

   ➢ A literature review identified specialised foster care schemes in European and other jurisdictions. It focused on specific themes, which were identified as important in addressing the management of young people with challenging behaviour.

   ➢ Four representative schemes drawn from Ireland, Britain and United States were selected for further study. Fig. 1.2 below illustrates how they were selected.

   ➢ One of those schemes, Multi-Dimensional Treatment Foster Care, had an evidence base for very positive outcomes. Visits to sites in England, Sweden and Norway, where variations of that programme are implemented, were undertaken. Interviews with service providers identified the issues which implementation presented.

2. **A survey of the population of young people in the CAWT area sought to estimate the numbers of young people presenting with challenging behaviour and to profile the nature of that behaviour.**

• **Consultation**

   ➢ Contact was established with key stakeholders - agency managers, social workers, foster carers, young people (the latter two through their representative organisations). As the project progressed consultative meetings were organised throughout the CAWT area to inform and consult with stakeholders.

   ➢ Two discussion documents and the survey report were circulated to those consulted\textsuperscript{2,3}, the object was to inform and obtain feedback on the progress of the project.

   ➢ Information was exchanged through meetings and contacts with organisations providing high support foster care services in Ireland, Europe and the United States.

   ➢ A consultative seminar was organised in December 2005. Attendance consisted of an invited audience of up to 100 stakeholders and decision makers from both sides of the Irish border. They considered issues that Multi-Dimensional Treatment Foster Care would present if implemented in one, or both, Irish jurisdictions.
Proposal for an outline scheme

Drawing together the information gained through the research and consultation phases, an outline model of a high support foster care scheme is proposed. It is proposed on the basis that:

➢ there is a firm evidence base validating positive outcomes when it is applied in a manner faithful to its design
➢ its design is likely to have a positive impact on existing mainstream foster care services
➢ the costs of its introduction are set against the following benefits indicated by experience elsewhere:
  ❖ immediate current cost savings in respect of enhanced payments paid to support young children with challenging behaviour
  ❖ medium-term current and capital cost savings in respect of special arrangements and resources engaged to provide for the care of a minority of young people who are very difficult to manage
  ❖ long-term savings gained from the transition to stable adulthood of young people who may otherwise be a drain on resources of the health, social service or criminal justice systems
➢ within the limits set by the separate legal jurisdictions, sharing resources, in terms of support, information and training on a cross-border basis would maximise the efficiency of a high support foster care system

Finally, the design of the proposed model takes account of the social, cultural and legal context of both jurisdictions on the island of Ireland.
Summary

• With a population of over one million people, the demographic characteristics of the CAWT region are varied.
• Statutory services in both Northern Ireland and the Republic of Ireland are generally provided by statutory agencies through dedicated professional teams based in large towns.
• The CAWT partners commissioned A New Chance - Cross-Border Foster Care Project in order to seek a new direction in addressing the problem of managing young people in care who present with challenging behaviour.
• The project had three phases, research, consultation and outline design.
• The research and consultation phases were influenced by discussions and interviews with statutory and voluntary social service agencies who provide for the care of children in Northern Ireland, the Republic of Ireland, Britain, Europe and the United States.
• The three phases of the project were undertaken concurrently. Consequently, the report is structured by
  ➢ outlining a description of the context in which the project developed
  ➢ the extent of the problem reported in the CAWT area
  ➢ high support foster care as a possible way forward
  ➢ how high support foster care is provided elsewhere
  ➢ a provisional proposal for an MTFC scheme

Chapter 2 -

The social and historical context
2. THE SOCIAL AND HISTORICAL CONTEXT

The use of foster care has been well-established as a means of caring for parentless children in both jurisdictions for many generations. However, poverty, combined with social changes and political tensions, resulted in a fluctuating balance between the demand for foster care as opposed to the demand for residential care places.

There were significant differences. The numbers of children in care in the Republic of Ireland increased during the period 1950 to 1980, but by much smaller numbers than those experienced in Northern Ireland. This is partly explained by the absence of an organised child welfare system in the Irish State. Similarly, an increase in the numbers of children in residential care was caused by the State taking over the responsibility for children previously being cared for in the voluntary sector. In the Republic, the legislative framework was largely undeveloped and the numbers of children in care as percentage of the population was comparatively low. In Northern Ireland on the other hand, the legislative framework and the organisation of social services mirrored the more advanced developments in Britain.

In common with other countries, the 1980s saw the profile of children coming into care changing in both parts of the island. Whereas previously children tended to be admitted as a result of family tragedy or circumstance, greater numbers had now experienced various forms of abuse or neglect. In turn, this created increasing pressure on the system to adapt more appropriately to the needs of children.

The last 15 years saw significant legislative developments. These included the introduction of the Child Care Act, 1991 and the Children Act, 2001 in the Republic and the Children (N. I.) Order, 1995 in Northern Ireland. Taken together, this legislation departed from a practice which had applied for over 100 years. Previously, the State had a duty to react only when a child’s circumstances or behaviour suggested that they may need protection: now governments had the duty to be proactive. They were under obligation to seek out children whose needs were not being met and to provide for them. In doing so, there was a new emphasis that:

- children should be supported in their own families and communities and
- they should be admitted to care only if every attempt to achieve that had been tried first

This in turn led to the development of the concept of partnership between children, their natural family, their carers and agencies. If taken into care, available options were:

- care by relatives
- foster care
- residential care

Almost overnight the major legislative differences between the Republic and Northern Ireland were eliminated. Equally, the challenges and difficulties were replicated in each place.
Predictably, these developments required a significant investment in the child care system for their implementation. However, the needs focused approach underpinning them created its own difficulties. It was not easy to match needs to resources and plan for future developments at the same time. The new legislation increased the responsibilities of statutory social service agencies to address the needs of children, but governments did not always provide sufficient resources enabling them to meet these. For children whose difficulties were significantly greater than had been experienced previously, their management could pose major challenges. Foster care, the preferred option, was often poorly resourced and carers were perceived to be unable to manage the behaviour presented by the children placed with them\textsuperscript{2,3}. In addition, children’s experiences of the care system and the outcomes for them have been, at best, mixed. Frequently, inadequate care planning, difficulty in maintaining contact with birth families, shortage of resources, frequent changes of placement and poor educational support have combined. Many children face lonely and unstable lives; may be found sleeping rough on the street; suffer chronic mental ill-health and are disproportionately represented in the prison population\textsuperscript{4}.

The challenge this presents to the design of systems to produce better outcomes is exemplified by the findings of an inspection into fostering in Northern Ireland conducted in 1998 as follows:

- the demand for foster care places exceeded supply
- the level of recruitment in areas was failing to meet the annual turnover of foster carers
- levels of placement disruption for children in Northern Ireland was high and for young children of significant concern
- the remuneration and support of foster carers needed to be reviewed in light of the changing nature of the fostering task
- the deployment of staff in fostering teams was insufficient to ensure that adequate resources were available for the recruitment, support, training and retention of foster carers\textsuperscript{5}

Where placements were available, often they were not appropriate to the needs of the children in question. A review of childcare services suggested that in Northern Ireland investment in foster care had led to an imbalance in the supply of residential placements that should be rectified. In particular, pressures were created due to the problems associated with retention and recruitment of foster carers, the provision of educational arrangements for looked-after children and the difficulties posed by the management of challenging and/or offending behaviour\textsuperscript{6}. In both jurisdictions, but particularly in the Republic, public criticism has been fuelled by judicial decisions which have criticised as inadequate the State’s provision of care for needy children.

These developments have consequences in terms of the outcomes for all young people in care. Of particular concern are those who have had adverse life experiences. They may present with behaviour that is challenging, sometimes in the extreme. They create new demands for scarce resources to provide for their care. A number of responses have been developed to respond to their needs:

- In the Republic of Ireland, the Children Act (2001) established the Special Residential Services Board with a function of coordinating, monitoring, and supporting the delivery of residential accommodation for children detained in child detention schools and special care units.
• In the North and the Republic, several high support and additional, separate secure accommodation facilities have been established. These operate in different parts of the country to provide specifically for children whose behaviour is extremely difficult to control.

• In both jurisdictions, resources are frequently diverted on a case-by-case basis to provide special arrangements for such young people.

• In both jurisdictions, private fostering agencies are sometimes utilised to provide highly supported placements. Similar placements are not available in mainstream statutory care.

These arrangements are very costly and draw upon existing budgets, further limiting the resources available to other needy children. Furthermore, the experience of front-line staff is that options are frequently chosen as a crisis response to contain immediate situations. There is likely to be little consideration whether the intervention would meet the needs of the children involved, or that it would produce successful outcomes for them.
Summary

- Historically, foster care has been an important feature in the provision of alternative care in both the Republic of Ireland and Northern Ireland.
- There have been significant differences in the development and use of services for the care of vulnerable children in each area. These were removed with the introduction of similar legislation in both jurisdictions during the last 15 years.
- The focus of this legislation placed the duty on each state to be proactive in identifying and providing for the needs of children whose care was inadequate.
- The challenge which this creates has placed a serious strain on resources. It has resulted in mixed outcomes, particularly for children who are in care, and especially in respect of those who present with challenging behaviour.

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Chapter 3 -

The extent of difficulties reported among young people in care in the CAWT area
3. THE EXTENT OF DIFFICULTIES REPORTED AMONG YOUNG PEOPLE IN CARE IN THE CAWT AREA

On both sides of the border it is family and child care services which assess, coordinate and provide care arrangements for children who cannot be looked after by their families. These services are organised and provided through locally-based statutory agencies referred to as Health and Social Service Trusts (in the North) and Health Service Executive, Community Care Areas (in the Republic).

It is these services which can document the nature and extent of the challenging behaviour presented by young people in care. In the context of this study it is important to quantify these features. In doing so, consideration should be given to:

- differences across and within the separate jurisdictions of the CAWT area
- variations in the types of difficulties presented and their intensity

A survey was undertaken as part of the study with the co-operation of all the relevant statutory agencies in the CAWT area to quantify this information.

How many young people in care present with challenging behaviour?

In estimating the number of looked-after young people who may present with challenging behaviour, the criterion was that those difficulties should be of such a serious or persistent nature that a child’s existing care placement was in danger of being undermined. It is important to emphasise that the results are an estimate and provide “ballpark figures” only. Nevertheless, the results do provide a useful and informative indicator of the numbers and profile of young people who may benefit from a high-support foster care scheme.

Of note in Figure 3.1 on the next page, is that a majority of young people in care are reported not to meet that criterion for challenging behaviour. Nevertheless, 143 (11%) do present with serious difficulties and an additional 39 (3%) with intense difficulties. These are the children whose behaviour demands a concentration of resources. Although a minority, the significance of their number justifies consideration of a different approach in providing for their care.
Table 3.1 overleaf, illustrates the distribution of young people reported to present with challenging behaviour in each Trust/Community Care Area in the CAWT region as a factor of the total population of children in care in that area. There are surprising variations in the number of children presenting across the region. These seem to bear no obvious relationship to the numbers of children in care or the intensity of difficulties that may reasonably be expected to present in those areas. For example, of the 10 Trust/Community Care Areas, Foyle Trust, which has the largest number of children in care, has the second lowest percentage and the third lowest number of children presenting with serious management difficulties. The reasons for this bear further study. Until then, it is worth pointing out that the explanation could equally be that different areas may provide more, or less, support to young people and their carers, that they may be better or worse at identifying vulnerable children who require care or that there are greater or lesser tolerances for difficult behaviour across care areas.
<table>
<thead>
<tr>
<th>TABLE 3.1: Intensity of reported management difficulties by Trust /HSE care area</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>No management difficulties</td>
</tr>
<tr>
<td>Serious management difficulties</td>
</tr>
<tr>
<td>Intense management difficulties</td>
</tr>
<tr>
<td>TOTAL:</td>
</tr>
</tbody>
</table>
Figure 3.2 above illustrates the spread of young people in care reported to present with challenging behaviour across the CAWT region. The variation revealed is less significant than the numbers so reported to present. Foyle, Sligo/Leitrim and Cavan/Monaghan are the areas with apparently the least number of young people presenting difficulties. Yet in each area there are a significant minority of children whose behaviour has the potential to cause considerable challenges. Indeed, front-line social workers and carers report that just one child who has been severely damaged by her/her life experiences may require the diversion of substantial numbers of staff and material resources to support her care. This may occur unpredictably. Resources may be required for an uncertain period; there may be little opportunity to consider their reallocation or make plans in her interests, or those of other children and families.

What constitutes challenging behaviour?

The information collected in the survey and illustrated above was obtained from front-line social work managers. They were asked to identify those children in care in their area whose behaviour was sufficiently challenging to pose a serious risk to the stability of their existing care placement. This was a fairly crude measure in that it assumed as a positive outcome for young people in care only that their behaviour did not disrupt the management of their care. It was chosen because it reflected the definition of children to be targeted outlined in this project's application for EU funding as “children requiring high support facilities”. This is not untypical. For example, the Children (N.I.) Order 1995, in setting out the criteria for placement in secure accommodation, balances the concept of the likelihood of a young person “injuring himself or others” with the likelihood of his suffering “significant harm if he absconds”. A survey of characteristics regarded as important by referrers to high support services in Ireland extends the criteria to focus on extreme behaviour and multiple needs.
However, other views consider challenging behaviour from the perspective of its effect on a young person’s social functioning⁴. One definition which takes that perspective is as follows:

…Behaviour which does, or is likely to, interfere with a young person’s optimum learning or engagement in positive social interactions with peers or adults⁵.

Clearly, this moves the emphasis away from the severity of a young person’s behaviour. It may be said to be more in line with the proactive needs-based direction of current legislation in that it focuses on children themselves. It implies that consideration of arrangements to provide for their care should address the needs which lie behind their behaviour. However, it is the priority given to that young person’s learning and interaction with peers and adults that is important. The definition goes beyond a child’s immediate presentation and instead looks to an outcome that will give her the prospect of stable relationships and positive life experiences in the future.

The issue of learning is increasingly being recognised as fundamental if a child in care is to avail of opportunities which may open doors to a more stable lifestyle. Research indicates that outcomes for such children are often poor⁶. An English study of children in foster care found that care professionals’ predictions of school failure were consistently accurate. However, it is not necessarily bleak. Over half the children subsequently settled happily in other schools or education units: clearly, they were not intrinsically incompatible with school. Indeed, it could be argued that the accuracy of those predictions provides an opportunity for interventions designed to produce a different outcome⁷. The importance therefore, of giving priority to the educational needs of children in care cannot be over emphasised.

What difficulties is it considered that young people whose behaviour is challenging are likely to present?

It would be unreasonable to expect that such children would neatly present with just one aspect of difficult behaviour. Not surprisingly, many will have multiple difficulties that account for their challenging behaviour. The CAWT region survey suggests that most children who display serious management difficulties are likely to present with from three to nine difficulties (see Table 3.2 on the next page) — although it is important to re-emphasise this does not necessarily reflect the degree of those difficulties. A further illustration of this is represented by the breakdown of difficulties presented, illustrated on the basis of types of behaviour (Figure 3.3) and different experiences thought to be at the root of those difficulties (Figure 3.4).
Severe Inappropriate Behaviour describes situations where a young person displays serious, unprovoked behaviour inappropriate to the context in which it occurs.

Predatory Sexual Behaviour describes a young person who because of a history of perpetrating abuse is thought to present a risk to other children.

### TABLE 3.2: Number of reported serious management difficulties per child in care

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1161</td>
</tr>
<tr>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>2</td>
<td>15</td>
</tr>
<tr>
<td>3</td>
<td>17</td>
</tr>
<tr>
<td>4</td>
<td>25</td>
</tr>
<tr>
<td>5</td>
<td>21</td>
</tr>
<tr>
<td>6</td>
<td>19</td>
</tr>
<tr>
<td>7</td>
<td>21</td>
</tr>
<tr>
<td>8</td>
<td>17</td>
</tr>
<tr>
<td>9</td>
<td>11</td>
</tr>
<tr>
<td>10</td>
<td>7</td>
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<td>6</td>
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<td>12</td>
<td>13</td>
</tr>
<tr>
<td>13</td>
<td>1</td>
</tr>
<tr>
<td>14</td>
<td>2</td>
</tr>
<tr>
<td>TOTAL:</td>
<td>1343</td>
</tr>
</tbody>
</table>

### Figure 3.3: Types of reported behaviour presenting management difficulty for children in care

*Severe Inappropriate Behaviour* describes situations where a young person displays serious, unprovoked behaviour inappropriate to the context in which it occurs.

**Predatory Sexual Behaviour** describes a young person who because of a history of perpetrating abuse is thought to present a risk to other children.
Examination of Figure 3.3 and Figure 3.4 reveals the critical issues for young people that any system designed to help them should address. Tables 3.2, 3.3 and 3.3a illustrate both the numbers of children likely to be represented and how they are divided between boys and girls.

Not surprisingly experience of emotional trauma and attachment issues is the problem most frequently presented. It is not unreasonable to infer a connection between that and the next most frequent problem the presentation of severe inappropriate behaviour. The inability to establish and maintain close relationships with others may provoke unexplained outbursts of difficult behaviour. There is a growing awareness that addressing the problems of attachment and behaviour concurrently can produce positive outcomes for young people.

Similarly, the problems associated with social functioning that may in turn provoke a child’s isolation or withdrawal figure prominently. School difficulties, too, are a major issue. All of these are well documented to have consequences which if not separately addressed are likely to negatively affect a child’s future life.

The frequency of difficulties presented divides fairly evenly on a gender basis. There are predictable differences when individual types of difficulty reported are examined: more boys than girls are violent; more girls are sexually abused. However, where differences are more pronounced it is the behaviour of girls that is reported more frequently.
For instance, a considerably greater number of girls are reported as persistent runaways, as substance abusers or to self-harm. Surprisingly, more girls than boys are reported to present a risk of sexually abusing other children. That outcome may be explained by reference to other research evidence suggesting that girls' experience of state care differs from that of boys. The profile of their life experiences indicates a lower tolerance level at which their behaviour initiates intervention by state agencies. This is likely to be driven by a perception that girls' vulnerability necessitates greater protection. While these differences bear further study, they do point to issues on which a high-support foster care system should focus.
What is the context in which challenging behaviour may occur?

Children with challenging behaviour are likely to have had very difficult life experiences. For many, the nature of those experiences will only have become apparent as their behaviour deteriorates. By then, it is likely that high-level support will be required to help them. The reality is that such support may not be available, at least immediately. In those circumstances, poor planning, multiple placements and inadequate professional assistance for the children and their carers may follow.

It is to be expected that the majority of children presenting with difficulties are in the older age groups. Tables 3.4 and 3.5 suggest confirmation of this in the CAWT area. The highest number of children, (between 30 - 40%), are in the 16 to 18 age range. Understandably, they often get priority in the allocation of resources. Nevertheless, it is important to note that somewhere in the region of 25% of children aged under 12 are reported with difficulties in the areas which are likely to have great effect on their future stability. This includes Severe Inappropriate Behaviour, Social Inadequacy/Isolation, School/Leisure Disruption and Emotional Trauma/Attachment. This is consistent with studies indicating greater likelihood of poor outcomes for those aged 11 and 15 years, but which also confirmed evidence that many younger children present difficulties. 

![Table 3.4: Type of reported behaviour difficulty by age group](image)
Difficult behaviour will place pressure on carers and increase the possibility for a child of both placement breakdown and disruption. Multiple placements are a predictor of breakdown. However, difficult behaviour may itself contribute to breakdown and then a change of placements. The evidence is that negative effects of changes in placement do not arise where movement is for reasons other than that to do with the child’s behaviour. Consequently, the identification and appropriate response to such behaviour early on may protect children from that cycle developing.

That evidence underlines the importance of considering the needs of younger children in the care system when designing interventions to address the problem of challenging behaviour. This point is further emphasised when the percentage of children in the CAWT region reported to have experienced multiple placements are identified. These are illustrated in Figure 3.5. The numbers involved are indicated in Table 3.6. Again, although these figures bear further study, they are consistent with the relationship referred to above between multiple care placement, difficult behaviour and poor outcomes.

Of the children in the total population who have experienced multiple placements, 65% are reported to present serious management difficulties and a further 25% intense management difficulties. The difference compared to those who have experienced a single placement is stark.
### TABLE 3.6: Intensity of reported management issues for children in care who have experienced multiple placements

<table>
<thead>
<tr>
<th></th>
<th>Multiple placements</th>
<th>Single placement</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>No management difficulties</td>
<td>12 (10.4%)</td>
<td>1149 (93.6%)</td>
<td>1161 (86.4%)</td>
</tr>
<tr>
<td>Serious management difficulties</td>
<td>74 (64.3%)</td>
<td>69 (5.6%)</td>
<td>143 (10.6%)</td>
</tr>
<tr>
<td>Intense management difficulties</td>
<td>29 (25.2%)</td>
<td>10 (0.8%)</td>
<td>39 (2.9%)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>115 (100%)</td>
<td>1228 (100%)</td>
<td>1343 (100%)</td>
</tr>
</tbody>
</table>

### Figure 3.5: Intensity of management difficulties reported for children in care who have experienced multiple placements

[Bar chart showing the intensity of management difficulties for children in care who have experienced multiple placements. The chart includes three categories: No management difficulties, Serious management difficulties, and Intense management difficulties. Each category is divided into two segments: No multiple placements and Multiple placements.]
Summary

• Of the 1,343 young people in care in the CAWT region, 182 (10.7%) are reported to present serious management difficulties and 39 (2.7%) to be intensely difficult to manage.
• Most children present with challenging behaviour that has multiple features.
• There are differences in the severity of behaviour reported by girls as opposed to boys.
• While older age groups constitute the largest number of children reported to present with challenging behaviour, younger children also similarly present.
• Among critical issues for children in care who present with challenging behaviour are:
  ➢ Their need for a more intensive level of intervention than may be available within the existing alternative care framework.
  ➢ A definition of challenging behaviour focused on the adverse effects that such behaviour will have for a child’s prospect of positive life experiences in the future.
  ➢ A system designed to address those children’s social interactions, education, behaviour, and close relationships.
  ➢ Giving particular attention to gender differences as a factor in the nature and presentation of difficult behaviour.
  ➢ Prioritising early identification of appropriate responses to the needs of children in care in order to forestall more serious consequences later.
  ➢ Prioritising early intervention to address behaviour which contributes to placement disruption in order to reduce poor outcomes for children later on.

Chapter 4 -

High-support foster care as the way forward
4. HIGH-SUPPORT FOSTER CARE AS THE WAY FORWARD

The management of young people with challenging behaviour presents particular difficulties. Generally, the focus of interventions is to ensure that a child is cared for:

- in her family, or
- by regular foster carers with additional support, or
- by specialist foster carers, or
- in mainstream residential care, or
- in high support/secure residential care

In the CAWT region, the care for such a child will generally have presented difficulty in regular foster care or a residential placement. If such placements are no longer feasible, each Trust/Community Care Area has access to a small number of places in high support, or secure residential homes. These may only be accessed in respect of children meeting the relevant criteria. Most commonly, high support and secure placements are located a considerable distance from a young person’s home.

CAWT’s initiative in commissioning the study was founded on the premise that existing arrangements for the care of this population of young people do not deliver sufficiently satisfactory outcomes for them. It is in that context that the brief for the study proposed high-support foster care as an alternative that would yield greater benefits.

In contrast to mainstream foster care, high-support foster care is typically short-term. It cannot then hope to deal with and resolve for a child all the varied needs he presents. Instead, the goal is to provide him with a firm platform on which he can start to address his difficulties. Ideally, this platform will encompass all the important relationships and dimensions of his life. Their co-operation and incorporation into a high-support foster care programme will ensure that the platform it has created will be a firm foundation for his continuing progress and stability into the future.

This may be achieved by specific features to which high-support foster care can give priority:

- **Stable and Secure Care.**
  ➢ Dedicated and trained carers providing a supportive environment.

- **Comprehensive Support to:**
  ➢ the child in respect of:
    ✤ emotional issues
    ✤ behavioural issues
    ✤ social issues
  ➢ the foster carers in respect of their relationship:
    ✤ with the foster child
    ✤ with his parents
    ✤ with social workers and the Social Service Agency
with their own children, including the impact of the fostering experience on them

- Throughcare Plan
  ➢ Framed so that important dimensions of a child’s future life beyond the high support period are involved and considered in the provision of high support care.

There is a need for a balanced and holistic approach in throughcare planning for children. This should give attention to developing a young person’s interpersonal relationship skills and nurturing self-efficacy through raising self-esteem and confidence alongside the more traditional areas of practical living skills. Helping a child develop her abilities in these areas will increase her resilience to withstand many of the negative effects of her adverse life experiences. This would be a significant boost to her prospects of a stable adult life.

The attraction of high support foster care is it can provide a concentrated focus on a child’s needs and the means to address them. Targeting in a throughcare plan social dimensions in which a child functions throughout childhood and into adulthood can provide a framework in which progress achieved may continue to be built upon.

The focus of high-support foster care

Ideally, a high-support foster care operates within the framework of a detailed throughcare plan. That plan is based on a comprehensive assessment of the young person:

- her needs
- her abilities
- her health status
- her family, social and other supports
- her ambitions

In addition, it identifies objectives to be targeted for the young person as she develops into adulthood. These include:

- long-term parenting options for her
- educational opportunities open to her
- appropriate social activities and relationships available to her

The throughcare plan is the map which charts the young person’s pathway through high-support and beyond. The high-support period, which is typically 8 to 12 months, will be guided by that plan in providing intensive day-to-day care to a child or young person that addresses key issues in the child’s life such as:

- trust in relationships
- behaviour
- self esteem
- social skills
• relations with birth family
• motivation
• behaviour and learning in school
• relations with peers
• engagement in leisure pursuits

The precise set of issues will differ slightly for each child, and issues may need to be prioritised and dealt with in a certain order. Since it is comparatively short term (6-12 months) in duration, high-support foster care cannot hope to tackle and resolve all the critical issues in any young person’s profile. But high-support foster care can make a major contribution. It can clearly identify the issues and highlight risk and protective factors. These can give focus to work with the child not just in the high-support foster care period, but in the long-term placement that will follow.

High-support foster care will help to clarify the nature of the child’s relationship with her birth family and the level and scope of contact that may be helpful at this point. It will help to identify any conflicts, anxieties and misunderstandings in the child - family relationship that may be fuelling anger and errant behaviour. It will help to specify the educational needs of the young person and the tailored programme of educational support that may be required. It will help to illuminate the quality of the peer relations the young person has and any help that may be needed in addressing issues such as social withdrawal or over-aggressive behaviour with peers.

High-support foster care is about intensive support and care to the young person. It focuses not just on the relationship between the child and the foster carers day to day, but also on the child’s relationship with key other people in their lives, for example, family members, teachers and friends. These relationships are potential sources of risk and resilience in the young person’s progress towards adulthood.
Summary

• The CAWT partners initiative to commission *A New Chance* was founded on the premise that existing arrangements for the care of young people with challenging behaviour are not delivering sufficiently satisfactory outcomes for them.

• The goal of high-support foster care is to provide a stable foundation upon which such a young person may develop the continuity of relationships necessary to combat the adversity of his early life experiences and to support him in the transition to a stable adult life.

• In building a platform to achieve that outcome, high-support foster care should operate in the context of a throughcare plan designed to address a child’s needs across multiple social dimensions, relationships and networks in his life pathway to adulthood.

• Desired outcomes from the application of a high-support foster care throughcare plan is dependent on a scheme being organised and supported by the skill and expertise of professionals and others working alongside the carers.

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Chapter 5 -
Examples of how high-support foster care is provided in different places
5. EXAMPLES OF HOW HIGH-SUPPORT FOSTER CARE IS PROVIDED IN DIFFERENT PLACES

An overview

The management of young people with challenging behaviour within the care system is an issue which can drain resources in already overstretched child welfare systems. At the commencement of A New Chance, a preliminary survey of a majority of the English local authority websites was undertaken. Its object was to identify and profile the range of special foster care arrangements for children with challenging behaviour. This revealed that many schemes had evolved in response to crisis situations and had provided placements in circumstances where mainstream alternatives were unavailable. They had consequently reduced their reliance on costly placements in other local authorities or private agencies. The schemes operated on the basis of providing highly supported foster care placements to children with challenging behaviours. These involved enhanced payment to foster carers of £300 - £500 per week per child, in addition to maintenance allowances. They were supported by foster care teams with reduced caseloads and which frequently had access to multidisciplinary professional support.

A number of such schemes had developed an informal support network centred in the English Midlands. They met from three to four times a year with the object of sharing knowledge and experience. In a meeting of that group, the view was put forward that the lack of support available to carers and children in mainstream foster care contributed to the numbers of children presenting with challenging behaviour. This view suggested that the service being provided by specialist schemes if available to all children in care would significantly reduce the behaviour difficulties being experienced.

It is the case however, that there are a multitude of different schemes operating in Britain and elsewhere, the object of which is to support the care of looked-after young people. A review of innovative schemes and good practice in Britain1 describes many of these. Only some are stand-alone specialist schemes for young people with challenging behaviour. Of those, few have been evaluated independently. The schemes described and the supports outlined in the review reflect the issues which research has identified as important for children in care, particularly those whose behaviour is difficult to manage. These include:

- access to individual therapy
- focus on a child’s educational needs
- support to carers in relation to attachment issues
- supporting contact with the child’s family
- the availability of mental health professionals
- special provision for children who are:
  - aggressive, or
  - who display sexually abusive, or
  - sexualised behaviour, or
  - who may have mental health, or
  - learning disabilities
The review did reveal many examples of exciting and innovative developments. However, it was also the case that there were significant variations throughout the country particularly relating to the involvement of carers, children and relatives in policy development and the evaluation processes of fostering agencies. A review of research literature in foster care indicates variable outcomes from specialist schemes that were subjected to rigorous methods of evaluation. For instance:

- “To date, there is no evidence that schemes which train carers in listening or managing behaviour, and do more than this, have a significant impact on outcomes.”
- One American scheme has been positively evaluated in comparison to residential care and in relation to both delinquents and disturbed young people. It gives close attention to schooling. It provides intensive support for carers, training of both carers, social workers and where appropriate birth parents in the same social learning approach.

An American review of outcome studies on the effectiveness of treatment foster care for children and adolescents identified a multiplicity of models which it divided into roughly two types as follows:

- On the one hand, foster parents are the primary change agents who are given training and provided with support services to design and implement interventions for the children in their home. As needed, mental health and medical professionals are accessed as consultants rather than provided directly by the programme.
- On the other, also within their own home, foster parents carry out individualised interventions that are based on a programme model. They are supported and supervised by mental health professionals who work alongside them and who play a key role in the development and implementation of interventions and are typically employed by the programme.

The review did not distinguish between these two types in analysing outcomes. The authors were surprised that outcomes were neither uniformly positive nor persuasively strong. Nevertheless they did report positive social-psychological changes in children and adolescents. The largest of these related to improvements in children’s social skills and placement permanency. There were also lesser improvements in reducing behaviour problems, decreasing levels of restrictiveness at post-discharge placement and increasing psychological adjustment. However, a similar study found that the implementation of model programmes were not prevalent. Furthermore, the positive results that they demonstrated were not available in interventions that relied on the foster carers as the key change agents.

This distinction replicates the experience in Britain and Ireland, although somewhat less evenly. Mainstream foster care operates on the basis of carers being recruited, trained and matched with children who are then placed with them. The ideal is the design of a care plan based on the needs of children - together with their cooperation, that of their parents, foster carers and other disciplines. The foster carers then implement the plan, albeit supported by social workers and others as required. Unfortunately, the reality may fall short of this.
Most treatment foster care schemes rectify this by offering increased support in terms of training, access to professional services and financial reward. In principle they rely on the foster carers to get on with it once a child has been placed. Sometimes, because the carers are felt to have quasi-professional status, they are expected to undertake more complex tasks such as arranging and managing contact with families, report writing etc. Very few schemes use a treatment team in which the members, including the foster carers, devise and implement the treatment programme together. Nevertheless, the British government has funded a pilot programme in England which will evaluate the effectiveness of that approach there. This is one of the schemes to be examined in more detail below.

What are the practical issues raised by the implementation of treatment/high-support foster care?

In illustrating how high-support foster care programmes operate a number were chosen for further examination. The basis on which they were chosen was that:

- they reflected examples of programmes implemented in Britain or Ireland
- they had been evaluated
- they were operating according to protocols

A detailed examination of the schemes and outline of their operation and implementation is outlined in a position paper compiled earlier in this project. What follows below is a summary of the schemes and the issues that their implementation raises.
Case Study 1

Lisdeel Family Placement Initiative

Location:
Lisdeel Family Placement Initiative is located on the northern side of the city of Dublin in the Republic of Ireland. Its client base is drawn from that area as are the foster carers with whom the children are placed.

Target group:
Lisdeel provides a service to young people (aged 6 - 12 years) whose circumstances require that they be in long-term care. The severity or otherwise of a child’s behaviour is not a criterion. Experience has been that behaviour difficulties can be quite varied. Children are accepted on a case-by-case basis. Exclusions are only contemplated in cases of severe mental health problems or excessive violence.

Function and organisation:
Lisdeel operates in a partnership between a religious order, the Daughters of Charity, and the statutory authority, the Health Service Executive (HSE), Northern Area who jointly fund the service.

There are two arms to the intervention provided by Lisdeel:

• Lisdeel House, a small residential unit, prepares children for long-term foster care.
• Lisdeel Family Placement Service recruits and trains foster carers. It then matches and places children with them.

Carers are regarded as integral members of the Lisdeel Family Placement Initiative team. Support to them as the primary care agents is provided by the placement service which can access limited counselling support if required for the child.

Planning:
Ideally the child when admitted is accompanied by a comprehensive care plan devised by the local community care social worker in conjunction with Lisdeel. This does not always happen. Lisdeel itself undertakes a comprehensive assessment of the child which guides its support to the child and carers. Responsibility for plans on discharge from care are the responsibility of the local community care social worker. Similarly, throughout the child’s placement in care, the local statutory agency retains responsibility for the review and monitoring of the foster placements.

Programme of care:
When accepted on the programme, a child is placed for six months in Lisdeel House. She is introduced to “Friendship Families”. These are approved short-term foster carers. They help
prepare a child for long-term foster care; they will also be available as permanent respite carers for that child. Concurrently, long-term carers are recruited. Following matching and placement, staff in Lisdeel House continue support to the child and the carers for a six months transition period. From that point social workers from Lisdeel Family Placement Service provide the support to the carers.

Support for the child is the responsibility of the social worker allocated from the local office of the HSE. This involves implementation and monitoring of his care plan, contact and work with his family and accessing other professional services for her.

Addressing key social domains:
Home. Family participation is sought from the outset in relation to all important matters relating to the child. Arrangements for ongoing contact are primarily the task of the foster carers, supported by the Family Placement Service social worker. Issues concerning the natural families own lives which may impact on a child’s future life are the responsibility of the local community care social worker.

Leisure. A child’s interests and abilities are identified during his placement in Lisdeel House. These are encouraged, facilitated and coordinated by a resource worker attached to the placement service.

School. From a child’s placement in Lisdeel House, efforts are made to establish relationships with teachers. Other supports may be sought and obtained as they are identified.

Outcomes

The evaluation of long-term outcomes is necessarily limited by the fact that only five children had been through Lisdeel in its three years of operation. However, the following findings were reported:

- The five children placed experienced smooth transitions from Lisdeel house to their foster families
- Up to May 2002, none of the young people placed had a need for crisis intervention or emergency respite care
- The recruitment processes for foster carers had both a higher rate of applications, and a higher number of applicants recommended for approval, than those reported in other schemes
- The thoroughness and attention to detail resulted in the recruitment and appointment of foster carers being slow
- The preparatory period for residence in Lisdeel house was more than twice that stated at the outset
- The unavailability of area HSE social workers created difficulties for the placement and support to young people which added to the burden of the workload for Lisdeel staff
Case Study 2

South and East Belfast Community Placement Service
(Belfast CPS)

Location:
Belfast CPS is based in the southeast of the city of Belfast in Northern Ireland. It draws its client base from that area. Foster carers recruited by the scheme and with whom the children are placed may be within a radius of 30 miles.

Target group:
It provides an alternative to residential care for young people aged 14 to 17 years, who present with challenging behaviour, most, but not all of whom come from residential care. There are no restrictions on referrals, and nor are there exclusions based on severity of behaviour, although if arson, severe violence or cruelty is indicated, specific consideration would be given on a case-by-case basis.

Function and organisation:
Belfast CPS operates as a partnership between the local statutory Trust and Barnardos, a well-known NGO. Funding and staffing are provided by the Trust, but the dispersal of those funds is administered by Barnardos. The structure separates the care of adolescents with difficulties from the mainstream care system. There, they may not be given priority, particularly in the allocation of fostering placements. Consequently, Belfast CPS recruits its own foster carers with whom children are placed.

Planning:
The development of care plans is the responsibility of the local Trust. The scheme makes a point of establishing relationships with local social workers at the outset. This helps to ensure that plans are completed, implemented and reviewed. Throughcare issues are not addressed because a young person does not remain in foster care after 18 years. At that point responsibility passes to a different social work team in the Trust. Statutory responsibility for the monitoring and review of placements remains with the local Trust.

Programme of care:
The matching of young people is assisted by a detailed referral form and the close links between the scheme and the Trust mainstream care system. The process takes about six months. This facilitates introductions and informed decision-making by the child and carers following which placement commences.

Routines and boundaries are clearly agreed and outlined to both child and carer at the outset. It is emphasised to the young person that she has responsibility to accept the commitments undertaken. There is no formal plan agreed at the outset to address issues connected with the young person’s behaviour or social skills. Agreement by both young
person and carer to the placement and its conditions is fundamental. However, for the young person, his choice is limited by the requirement that he cooperates. While great efforts are made to persuade a young person to accept the placement in his own interests, it is an assumed condition of his participation that he will cooperate with other supports and arrangements. If not the placement ends and less attractive options come into play.

Foster carers are the primary change agents and support to them is available on demand from social workers attached to the scheme. Support to the children is the responsibility of the local Trust social work team. However, staff shortages there, result in the scheme social workers sharing that function. Access to professional services is available on request although on a patchy basis.

**Addressing key social domains:**

**Home**  
The ethos, emphasised during the induction, assessment process and post placement training, is to stress the importance of family. This was achieved through the scheme and foster carers working in partnership. Contact arrangements did not address the context of family problems that may have contributed to a young person coming into care.

**Leisure**  
Involvement in outside activities/sports is encouraged but the philosophy is to encourage young people to develop interests naturally, facilitated by the foster carers and supported by the scheme.

**School**  
Carers are encouraged to establish relationships with schools on an ongoing basis.

**Outcomes**

Belfast CPS has not been subjected to an evaluation. However the following outcomes have been indicated:

- There have been significantly fewer residential beds in the South and East Belfast Trust (a total of 22 including 4 secure beds) compared to other Trusts in Belfast.
- The number of responses to recruitment campaigns appears to have reduced over the years. However, an impression, not scientifically validated, suggests that the rate of approvals as a percentage of applicants at 50% is good.
- Improving the retention rate of foster carers from the national average of 7 years to 10 years has been a target of the scheme. That target seems likely to be met.
- Between 30 and 40 young people have been successfully placed with the scheme for a duration of six months or more over the last two years.
- Difficulties in accessing area team social workers have been a problem for the scheme.
Community Alternative Placement Scheme (CAPS)
(The description of CAPS which follows is described in the past tense, as it is based on a research evaluation conducted between 1997 and 2000).

Location:
CAPS was an initiative undertaken by NCH, - Action for Children, Scotland. Based in Central Scotland, its original intention was to draw clients and recruit foster carers from that area. Funding was to come from surrounding local authorities. However, they were unable to meet earlier commitments to reserve and pay for a sufficient number of placements. Consequently, its target base for referrals and the recruitment of carers was extended to the whole of Scotland.

Target group:
The primary focus was intended to be on children aged 12 to 16 who were close to secure care. The widening of the referral base resulted in those criteria not being strictly adhered to. Nonetheless, the project sought to keep its focus on young people with exceptional emotional and behavioural difficulties. There were no specific exclusion criteria. Each young person was considered on a case-by-case basis, taking into account also if carers with appropriate experience and skills could be identified.

Function and organisation: CAPS was designed to provide foster care to young people for a period of six months. This was subsequently revised upwards to 12 - 18 months. The object was to provide an intensive placement at a point of high risk. The young person would then move onto mainstream provision. The project was structured as a team in which foster carers were equal professional members who were properly rewarded, supported and recognised. They were paid a salary and one carer was expected to be full-time in the home. They were also obliged to undertake tasks such as report writing, normally the function of social workers. They were required to have a high tolerance level for difficult behaviour.

Planning:
A throughcare plan was devised at the point of placement in cooperation between the Team, local authorities, young people and natural families. It addressed issues designed to help the young person develop appropriate social and behavioural skills. In addition it identified follow-on placements. Weekly meetings were chaired by a senior practitioner. They were attended by the carer, social worker, young person, parent and others closely involved in the placement, reviewed progress and identified issues to be addressed.

Programme of care:
Once recruited by the scheme, carers were matched with young people. This was the senior practitioner’s decision. It operated as a shared process between the carers and young people. Placement was staggered over several weeks and followed introduction, familiarisation
meetings and overnights. In principle, a young person’s commitment to the project was required. However, it is recognised that when the option was secure care, the element of choice was limited.

**Addressing key social domains:**

**Home**  
Contact with the natural family was an important feature in which carers were expected to have a key role. This included assisting a young person and her family in planning for reintegration where appropriate. Local authority social workers continued to be the liaison between the young person and her home. Family interventions and organising future care arrangements continued to be their responsibility. Practical difficulties sometimes arose when children were placed a considerable distance from their homes. This had negative consequences for supporting family involvement.

**Leisure**  
The throughcare plan identified leisure activities in which the young person could be involved. The foster carers organised and facilitated these in the context of their role in helping the young person to develop appropriate social skills.

**School**  
The original intention of CAPS was to give priority to a child’s educational development. However, funding for the resources required were not forthcoming. This was a significant gap in the service it had been hoped to provide. Nevertheless the throughcare plan did identify education needs. The foster carer’s function was to address these and progress was reviewed at the weekly team meetings.
Outcomes

Movements on leaving care

1. CAPS placements
   • Only one young person who had left had moved to a living situation planned at the outset.
   • Only six young people were in an institutional setting at the second stage.
   • Only four young people were in an institutional setting at the third stage.

2. Secure Placements
   • 15 young people had moved to a living situation planned at the outset.
   • 15 were in an institutional setting at the second stage.
   • Seven were in an institutional setting at the third stage.

Developments in relation to important aspects in young people’s lives

1. Family relationships
   • CAPS
     ➢ Contact with their parents or families increased during placement for more young people who did not plan to return home than for those who did.
     ➢ 40% (8) had reduced contact during placement. For some, this was a result of being placed far from home.
   • SECURE CARE
     ➢ 45% (9) of young people reported improvement in family relationships. Over 50% (12) had more contact than they had at the start.

2. Preparation for independent living
   • Few from either sample who had left the school had obtained educational qualifications or were in employment or education.
   • Accommodation circumstances at the time the research ended for those moving towards independent living were more often poor than good.

Very similar outcomes were achieved in respect of young people in both samples.
Case Study 4\textsuperscript{12}

**Multi-Dimensional Treatment Foster Care, Oregon (MTFC)**

*Location:*
MTFC was devised by Dr Patricia Chamberlain from the Oregon Social Learning Centre, United States of America. Typically it is implemented by local non-governmental social service agencies who may be funded on a case-by-case basis to recruit and provide short-term foster care for individual children from the area in which the agency is based.

*Target group:*
The programme is designed as an alternative to institutional care for young people aged 12 to 17 years. The criterion for acceptance onto the programme is the likelihood of admission to institutional care. It is not the presentation of challenging behaviour per se.

*Function and organisation:*
The ethos underpinning MTFC is that positive outcomes result from the following assumptions:

- Providing a consistent reinforcing environment where the youth is mentored and encouraged.
- Providing a clear structure and limits with well-specified consequences through a behaviour management programme delivered in a teaching oriented way.
- Providing close supervision of the youth’s whereabouts.
- Preventing associations between the youth and peers with problems (especially conduct related problems), and helping the youth develop skills for having relationships with positive peers.

The behaviour management programme is implemented during a youth’s placement with specially trained foster carers for a period of approximately 12 months. The foster carers work as part of the team of up to seven people from a variety of disciplines. Decisions in relation to work with the young person are made within the team as a whole. At the outset, each member of the team is allocated specific tasks in relation to multiple social dimensions recognised as important for that child. Progress on these are regularly reviewed.

*Planning:*
A throughcare plan is devised once the child and carers are matched. The details of the behaviour management programme are also agreed at that point. Tasks are allocated to individual team members relating to a child’s education, leisure, development of social skills, natural family contact and support. Assistance to the family emphasises parent/child interaction in preparation for the child’s possible return home. Progress is reviewed on a daily and weekly basis and the plan adapted accordingly.
Programme of care:
The child is prepared for the programme and her agreement to participate obtained prior to her being matched with carers. Once the details of the throughcare plan and behaviour management programme are agreed by the team, the child is introduced to the carers and the placement begins immediately.

The carers implement the behaviour management programme routinely and consistently. Progress is recorded and considered on a daily basis by the programme manager who may then contact the carers, if appropriate. The team as a whole meet on a weekly basis when progress made or the need for further support or intervention is considered.

Foster carers are required to work as a team and are not expected to make independent decisions. They are paid a fee higher than that applying to regular foster carers. Other team members are available to them for consultation on a 24/7 basis. Direct work and contact with the natural family is the responsibility of other team members. Carers and parents meet only at periodic case reviews.

Addressing key social domains:
Home In most cases the expectation is that the child will return to live with her family. The team members’ function is to help the family deal with problems in their own lives. This reduces the likelihood of her returning an environment similar to that which contributed to her problems. Prioritising family contact is an essential part of this.

School Contact with the child’s school is established at an early stage of the programme by the team member allocated that task. The object is to:
• gain the school’s support
• obtain its cooperation in monitoring the child’s school behaviour, also reviewed on a daily basis by the programme
• facilitate and plan for additional educational support for the child as required

Leisure Another team member has responsibility for helping the child to develop her social skills. Leisure opportunities are actively sought out as opportunities for the child to develop positive relationships with peers and learn appropriate skills in the context of activity-based social interaction.
Outcomes

Outcomes were evaluated in three studies and identified during the first two years of post treatment follow-up as follows:

1. **Comparing the rate of admission to State penal institutions of those who had participated in MTFC to those who had received treatment in other community-based programmes.**
   - Young persons in MTFC spent significantly fewer days locked up.
   - Although young persons in each group spent the same amount of time in treatment, those in MTFC were more likely to have completed their treatment programme.

2. **Comparing the effectiveness of MTFC with ‘treatment as usual’ in the community for young people (aged 9 to 18 years) leaving the State Mental Hospital.**
   - Young persons in the MTFC group were placed out of hospital significantly more quickly than those in the control group.
   - MTFC youngsters were placed in family settings, whereas control youths tended to be placed in institutional settings.

3. **Comparing the disruption rate in regular foster care between carers participating in an adapted MTFC programme and those who were not.**
   - In the adapted MTFC model there was a significantly higher retention rate for foster carers.
   - Young people whose foster carers participated in the adapted MTFC model had significantly fewer disruptions in their placements.
   - Young people in the adapted MTFC model showed the largest drop in rate of problem behaviours at three months follow up.
Design issues to be addressed for the development of a high-support foster care scheme that arise from the case studies

The review of the schemes summarised above identifies critical issues that a high-support foster care scheme should address as follows:

• an organisation structure that has a clear brief, and that encompasses formal relationships with statutory referral agencies
• the design of a programme that is evidence based and implemented by a dedicated team including foster carers
• a target group of young people that is clearly defined in terms of their geography and severity of behaviour
• foster carer role, support and training that is structured and comprehensive
• young people’s participation in terms of their co-operation and continuing contact with their birth family
• referral agencies role in supporting the programme, undertaking statutory functions, and in following through on throughcare plans
• ethical and philosophical issues which, if not addressed, could have the capacity to undermine a child’s participation in a programme

Each of these issues raise complex considerations which bear further examination:

• Organisation structure
  There are advantages to an organisation structure being a partnership between an NGO and a statutory agency.
  ➢ Necessary close relationships with the statutory agency will be facilitated.
    ❖ In particular, these relate to statutory requirements for care planning, reviews and monitoring of placements.
  ➢ NGO involvement will require a contractual relationship.
  ➢ Contractual agreement will commit necessary resources at the outset.
  ➢ There will be protection against the diversion of resources by statutory agencies that can arise in emergencies.

• Programme design
  Comparisons between the schemes outlined suggest that positive outcomes result from a team approach. This is particularly the case when a structured programme is implemented.

• Target client group
  ➢ Clarity regarding the target client group in terms of their age and criteria for referral is important.
  ➢ If the focus is on those presenting serious behaviour difficulties, then very limited exclusion criteria should apply.
The CAPS scheme illustrated the difficulties that can arise if referrals are drawn from a very wide geographical area.

**Foster carers**

- Close and supportive relationships between a high-support and mainstream foster care scheme is necessary to:
  - avoid both competing in the same pool for potential carers
  - ensure joint involvement in planning for the child
  - ensure the availability of a post treatment placement

- All the schemes ascribed specific tasks and roles to carers. Those which emphasised the value of the role and the support it required had better outcomes. The Oregon model had the best outcomes. It did not expect carers to take responsibility for decisions relating to a child. These were undertaken in the context of the agreed throughcare plan, by a team that included them.

- The training of carers was a key component of all schemes. Alone in the Oregon model, training concentrated on implementation, by carers in conjunction with the team, of a structured behaviour management programme.

- All schemes recognise that the investment in training and support to carers assumes a high level of responsibility and commitment from them. With the exception of Lisdeel, this was reflected in the fee paid to carers. The long-term stability of any scheme would suggest as appropriate the fee paid in Britain to high-support carers. This amounts to between £300 and £500 per week plus maintenance allowances.

**Young people**

- Most schemes introduce young people to carers through a staggered placement process. The Oregon model emphasised the detailed information to the young person. Once her agreement to participate was given, she was introduced to carers and placement followed immediately. This was based on the principle that the child was choosing the programme, of which the carers are a part. Belfast CPS adapted this approach, albeit after the child had been introduced and placed in a traditional way. Then, if he wanted to opt out, he was reminded of his agreement to participate and of the less desirable alternatives on offer.

- Family contact is emphasised in all schemes. Oregon's emphasis is on helping the birth family develop new methods of parent/child interaction. The object was to create a changed environment in the event of the child returning home.

**Referral agencies**

- Although not part of the treatment team, they will have an important role:
  - their involvement in, and agreement with, the initial throughcare plan is essential
  - they will have a continuing statutory function in relation to review and monitoring of care placements for the duration of the programme
  - they will have an essential function relating to the identification of long-term care arrangements and the support to the young person following the end of the programme

- The operation of the functions outlined above must be clearly agreed prior to the placement. Failure to do this has the potential to undermine the programme.
Many high-support, specialist, or treatment foster care schemes have been developed in response to local situations. Often, the cost of providing for the care of children with challenging behaviour is a critical factor in prompting the setup of schemes. Most schemes concentrate on giving intense support and enhanced reward to foster carers in assisting them to help a child to develop positive social skills and appropriate behaviour. Many schemes aim for stability of foster care as an outcome, which may in turn lead to further stability in adult life. A lesser number of schemes apply a team approach. Foster carers, as members of a team, participate in the implementation of a rigorous programme focused on multiple social dimensions of a child’s life. Such schemes generally operate in the context of a throughcare plan targeted toward an identified adult life pathway for the child. A review of four typical schemes suggested variable outcomes depending upon:

- the nature of their organisation
- their capacity to adhere to the implementation of the model as designed
- the degree of independence accorded to foster carers
- the intensity of support available to them
- the existence of a realistic and practical throughcare plan

Ethical and philosophical issues

- The emotional needs of children are dealt with by all the programmes. Different emphases relate in part to the age groups catered for. The more structured models combine response to the child’s emotional needs with a focus on helping her develop skills in social domains.
- Again, all schemes promote and make provision for contact with the natural family. In most, foster carers have a key role in this. Oregon is the exception. There, all contact between the team and birth parents is through the programme manager, not the foster carers. This is to ensure that parents’ involvement in the programme is consistent with the throughcare plan and is not undermined by mixed messages.
- Referral agencies who refer children to the programme must be committed to what it involves. They are delegating the responsibility for the management of the child to the scheme. They must understand what their role is and the commitment it requires of them. This needs to be established at the outset firmly and in writing.
- It is the responsibility of referral agencies to ensure that statutory care standards are met in respect of children in their care. This is an issue that needs to be addressed before a child is placed.
- The right of children to be consulted and listened to have been laid down by the UN Convention on the Rights of the Child. Giving children a voice is recognised in all programmes and is required by national standards.

Summary

- Many high-support, specialist, or treatment foster care schemes have been developed in response to local situations.
- Often, the cost of providing for the care of children with challenging behaviour is a critical factor in prompting the setup of schemes.
- Most schemes concentrate on giving intense support and enhanced reward to foster carers in assisting them to help a child to develop positive social skills and appropriate behaviour.
- Many schemes aim for stability of foster care as an outcome, which may in turn lead to further stability in adult life.
- A lesser number of schemes apply a team approach. Foster carers, as members of a team, participate in the implementation of a rigorous programme focused on multiple social dimensions of a child’s life.
- Such schemes generally operate in the context of a throughcare plan targeted toward an identified adult life pathway for the child.
- A review of four typical schemes suggested variable outcomes depending upon:


Chapter 6 -

The case for Multi-Dimensional Treatment Foster Care
6. THE CASE FOR MULTI-DIMENSIONAL TREATMENT FOSTER CARE

The attraction of MTFC is that it addresses in one programme of intervention the principal factors that research indicates contribute to successful outcomes for children in care. These include:

- comprehensive assessment of the young person
- detailed and comprehensive planning
- continuing focus on the child’s needs and progress
- birth family involvement
- intensive support to, and recognition of, carer role
- regular and effective review

Multi-Dimensional Treatment Foster Care operates a dedicated team approach. All team members work together in applying a behaviour management programme across multiple domains of a child’s life. Foster carers are key members of the team in their direct day-to-day relationship with the child. This is a significant difference to the practice adopted in other high-support schemes. Importantly, the evaluation of schemes in the United States presents convincing evidence that the programme assists many children in their transition to a stable adult life.

MTFC arose from evidence-based research which indicates that interventions for children who were offenders and displaying difficult behaviour show the best outcomes when centred on supportive adults. This suggests that treatment for such young people based around peer groups is counterproductive, confirms behaviour and at best does little to advance good outcomes for a young person.1

The programme was devised in the Oregon Social Learning Centre. Its knowledge base is drawn from family therapy and systems theory. Initial designs focused on the natural parents of children. These involved helping parents develop systematic routines relating to the care of their children. The belief was that this would positively affect their behaviour. The goal was to support parents intensively: it involved them implementing a rigorous programme designed in line with those routines. Many parents were unable to easily assimilate new ways of relating to their children. It was difficult to do alongside what could amount to too chaotic lifestyles, often contributory factors to their children’s behaviour in the first instance. The development of a specialist fostering service was considered a possible solution to this problem. Hence, the Multi-Dimensional Treatment Foster Care model evolved.
How does it work?

Figure 6.1 below illustrates a child’s pathway through the programme. Referral will generally come from statutory social service agencies, guided by the criteria for acceptance onto the programme.

Such criteria will primarily consider the severity of behaviour presented by the young person. Very limited exclusion criteria will relate to a child’s:

- capacity to understand and cooperate with the programme requirements
- his home being outside the programme catchment area
- being outside the programme’s age range

Once admitted, he will be placed with treatment foster carers for a period of up to 12 months during which he participates in a rigorous behaviour management programme. This is implemented by a treatment team including the carers. His future long-term carers (possibly his parents) participate in this programme. At the end of the treatment period, placement with his long-term carers will be followed by three months treatment team aftercare. This will accompany transfer of responsibility for the management of the young person to the referral agency, which in turn will have been closely involved in the planning for, and review of, the child’s progress throughout his participation in the programme.
Figure 6.2 illustrates how the programme is structured

**Figure 6.2: MTFC programme structure**

![Diagram showing the MTFC programme structure]

Diagram courtesy Dr Phil Fisher OSLC

Figure 6.2 illustrates that MTFC is structured so that:

- It addresses the child’s behaviour through a team approach operating in multiple contexts of that child’s life.
- Foster carers are recruited and trained to deliver a treatment programme as part of a multidisciplinary team, addressing the child’s needs.
  - The treatment programme is focused on the young person’s interactions in the foster home, in school, in her relationship with her birth family and her community.

Figure 6.3 on the next page illustrates the makeup of the Multi-Dimensional Treatment Foster Care team together with the multidisciplinary and multi-dimensional focus it applies in addressing the child’s difficulties.
As can be seen above, the child is the centre-point on which the treatment team, including the foster carers, is focused. However, that focus is within the context of the social dimensions of the child’s life, namely her family, her school and her leisure pursuits in the community. The dedicated team members interact together and with the child, her family, her school and other social networks. All team members are involved in devising a behaviour management programme based on the child’s needs.
Treatment Team Roles

• Programme Supervisor: organises all aspects of MTFC treatment and interagency cooperation, is the primary advocate and support link for Foster Carers. She provides clinical support for the team members.

• Foster Carer Recruiter/Trainer: coordinates foster care recruitment campaigns, submits assessments to statutory agency fostering committees and works alongside the Programme Supervisor in support to carers.

• Foster Carers: provide the day-to-day care for the child; implement the behaviour management programme in their home; record and report the child’s progress at home and in school on a daily basis to the programme team. They are recruited locally and come from all walks of life. Contraindications of suitability are:
  ➢ unwillingness to work as a team member in undertaking an active treatment approach
  ➢ resistance to rewarding young people for doing what they would normally be expected to do

• Parents Daily Report Caller: a position that may be combined with the Foster Carer Recruiter/Trainer. He receives, in a daily telephone conversation, the Foster Carer’s report on the child’s progress. That information, together with any additional observations or requests made by the Foster Carers, is conveyed to the Programme Supervisor.

• Skills Trainer: teaches youths positive behaviour and problem-solving skills through intensive one-to-one interaction and skills practice in the community.

• Individual Therapist: serves as an advocate and support person as the youth adjusts to life in the foster home, particularly in relation to emotional issues that may also include relationships with his family.

• Family Therapist: develops a relationship with the family that allows new methods of parent management which will help to maintain the gains made by the child in his future relationships with the family, particularly if he returns home.

• Consultant Psychiatrist: assesses the child’s mental health diagnosis in the context of the programme and together with the programme team evaluates the impact of medication changes on the child’s functioning. He is likely to be employed on a sessional basis.

• Psychologist: assesses the child’s behavioural, emotional and educational functioning. If not already a member of the team, a psychologist will be employed on a sessional basis.

The team undertakes, in an integrated way, tasks that in other schemes may be spread across several agencies and professionals. Each one of up to eight members has a specific function over the whole lifetime of every case. The progress achieved in all the tasks is coordinated and reviewed by the team, including the foster carers. The stratification of team roles that this involves has the following advantages:

• it provides for efficient coordination of the team
it limits unnecessary contact with the child by team members (no more than four team members, including the carers, relate to the child on a regular basis)

• it creates a framework in which the Team as a whole can regularly consider progress in the child’s life and review the plan of intervention

• it eliminates the potential for role confusion which could undermine the objectives of the programme

Figures 6.4, 6.4a and 6.4b below illustrate how the stratification of team roles limits the interaction between the child, his birth family, his school and team members.

Figure 6.4: Interaction between young person and key team members

In the context of the programme, the child interacts regularly with no more than the four team members, illustrated in the green box in Figure 6.4. With those on the left, such contact will only be periodic. For instance, with the family therapist, contact will only occur if she and the child’s individual therapist undertake joint work with his parents. Generally this would be in preparation for the child to return home. Contact with the psychiatrist would be limited to initial assessment and review of medication if appropriate. A psychologist is likely to be a member of the team. He will have a direct role in respect of a psychological assessment initially, and then only in relation to his main team function.
No more than four members of the team interact regularly with the school. Of significance here is that the Programme Supervisor is the liaison person between the school and the team. This is a principle that is applied in relation to other linkages as will be seen in Figure 6.4b below.

For the birth family, only two team members have regular contact with them in the context of the concentrated work that is required in anticipation of their child’s reintegration back home. Of significance is that they have no contact with the foster carers. Again, the Programme Supervisor is the liaison person with whom the birth family relate in respect of all issues concerning the programme and their child, including contact arrangements.
In MTFC planning, implementation and standards of care are also provided for. In relation to standards of care, the legal responsibility for this is unmistakably the responsibility of the statutory referral agency. In order to ensure that roles and responsibilities are clearly understood and do not have the potential to undermine a programme of care for the child, a number of steps should be undertaken as follows:

- Consultation with the appropriate Social Services Inspectorate as the standards authority
- Programme agreement with statutory agencies regarding procedures to be adopted
- Programme supervisor agreement with the referral agency on a case-by-case basis relating to the application of the procedures

Figure 6.5 below illustrates how this might operate.

Figure 6.5: MTFC and adherence to statutory standards

A basic presumption underlining the agreements suggested above is the understanding by the MTFC programme and the statutory agency of their mutual roles and objectives. This will ensure commitment by both to the principles of the programme and the achievement of desired outcomes for the young people referred.

A similar presumption applies to the design of a throughcare plan and the implementation of a programme in respect of an individual child following referral. How this may operate is illustrated in Figure 6.6 on the next page.
In MTFC all of the work in relation to the child and her family across multiple social contexts is undertaken within the programme by a multi-professional team, including foster carers. Consequently, the work normally undertaken in regular foster care by the child’s social worker and the link worker respectively is largely delegated to the MTFC programme at the outset. Figure 6.3b above illustrates how this is agreed within the framework of a throughcare plan that adheres to statutory and standards directions. The statutory agency is represented by the Child’s Social Worker and the Link Worker. They will agree with the MTFC team coordinated by the Programme Supervisor the following:

- the throughcare plan to be implemented by the MTFC team
- arrangements for regular review of progress
- arrangements for statutory monitoring and review of the child
- arrangements for statutory monitoring and review of foster placement

It would be likely that such agreements will provide that the Programme Supervisor is the liaison for contact between the team, the foster carers, the child and the statutory agency. This ensures that the objectives of the throughcare, agreed by all at the outset, would not be unintentionally undermined. The throughcare plan is central. It specifies the plan that the MTFC team will implement for the child from her admission to the programme to the period of her discharge and beyond: it outlines how the monitoring and review functions of the statutory authority will be undertaken in a manner that does not endanger the objectives of the programme.
How does Multi-Dimensional Treatment Foster Care care differ from regular foster care?

The delivery of a team and behaviour management approach to address a child’s needs is a central feature of the Multi-Dimensional Treatment Foster Care. This is absent in regular foster care.

Figure 6.7 below illustrates how regular foster care is organised.

![Figure 6.7: Regular foster care](image)

Social workers have a key role both in planning and providing for the care of a child and also for ensuring that statutory standards of care are met.

- The carers and the child together are one unit, which is the focus of intervention
- The carers and the child are supported by:
  - the link worker who also monitors and reviews the placement
  - the child’s social worker who is the key worker in terms of work with the child, and who:
    - coordinates the care plan
    - links with the child and her family
    - monitors progress
    - reviews progress against the care plan
    - makes after care arrangements
• Other professionals may be called in at the request of the carers or the child’s social worker.
  ➢ They are unlikely to coordinate their work with the child as part of a team.
  ➢ They may only have limited contact with each other.
  ➢ Their intervention with the child may be biased in favour of their own professional focus.
  ➢ They may take little account of other issues or developments in the child’s life.
• Simultaneously, the natural family may have engaged either directly or through the child’s social worker professional services to assist it.
  ➢ Such professionals are generally additional to those treating their child.
• It is likely that there would be little if any contact between the multitude of professionals involved.

In Multi-Dimensional Treatment Foster Care roles and functions are clearly stratified:

• The day-to-day responsibility for the care of the child and his relationship with his family is delegated to the MTFC treatment team in the context of its delivery of the behaviour management programme, which is the centrepoint of the scheme.
• The referral agency continues to have the statutory responsibility for the maintenance of standards in respect of foster carers and the plans for the child’s care.
• The referral agency participates in regular programme reviews and continues to have responsibility for planning the child’s future care.

**Behaviour management programme**

This is the centrepoint of the scheme. It is delivered by the foster carers alongside the team. Carers are trained in implementing an individualised daily behaviour management programme for youths. Training emphasis is placed on methods and techniques for reinforcing and encouraging positive achievements. Where criticism is necessary, it is undertaken in a matter-of-fact and even slightly sympathetic manner. Carers provide daily feedback on progress to a young person: he may earn or lose points for performing prescribed routine activities and adhering to rules. The programme is structured on a three-level system through which, ideally, a youth progresses in from 8 to 12 months. Progress through the levels results in less structure and greater independence. This is illustrated in Table 6.1.

**Table 6.1: MTFC behaviour management programme levels system**

<table>
<thead>
<tr>
<th>Typical Duration</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Expected Behaviour</strong></td>
<td>Three weeks</td>
<td>Four months</td>
<td>Three months</td>
</tr>
<tr>
<td>Undertaking prescribed routine activities</td>
<td>Higher compliance with rules</td>
<td>No association with undesirable peers</td>
<td></td>
</tr>
<tr>
<td><strong>Privileges</strong></td>
<td>Access to enjoyable activities</td>
<td>Limited free time in the community and expanded list of activities</td>
<td>Greater independence, less structured activities and frequent home visits</td>
</tr>
<tr>
<td><strong>Points for Progress Through Levels</strong></td>
<td>2100</td>
<td>Assessment of progress</td>
<td>Assessment of progress</td>
</tr>
</tbody>
</table>
• Level 1 is highly supervised and structured. The child is awarded points for routine daily activities such as:
  ➢ getting up on time
  ➢ getting ready for school
  ➢ doing chores
  ➢ having a cooperative manner etc
  ➢ other behaviour designated by the carers and the team

The child earns points for achieving the expected behaviour and also smaller awards such as participation in “fun” activities. Once he earns 2100 points, he progresses to Level 2.

• Level 2 involves greater contact with her natural family and social networks. These are highly structured and monitored. Expectations of behaviour are similarly greater. Privileges may be “fun” activities or small amounts of money. Advance to Level 3 follows assessment of progress.

• Level 3 allows freedom to engage in social activities which are unsupervised. More frequent and much longer home visits are encouraged. Pro-social behaviour is expected and rewarded as at the lower levels. Satisfactory progress will expedite moving home or to the agreed long-term carers.

How the points system works

The points system is organised on the basis of a young person earning a maximum of 100 points per day over a three-week period. The details of the system are agreed with young person prior to his entry onto the programme. By agreement, points will be awarded for routine tasks, particularly those with which the child may have had difficulty. They are expected to earn a minimum number of points every day, but the emphasis of the programme is on the positive rather than the negative. Consequently more points are awarded for good behaviour than are taken away for bad. Similarly, when points are removed they are done so in the context of a goal which can be targeted for the next day. The points system is tied in with rewards which act as a stimulus to progress. These may be enjoyable activities, treats, or money. An important component of the programme is recognition of the necessity to reward children for behaviour which might normally be expected in others of a similar age. The following example from the MTFC-England programme illustrates this.
Case Example: Carrie

“Carrie earned over the minimum points requirement each day in the first two weeks of her placement. Her foster carers, Terri and Alan, reported she was cooperative, compliant and helpful and initially struggled with their reluctance to take away points, feeling that her minor behaviours should be ignored as they were understandable in the circumstances.

At the point when Carrie was due to transfer from Level 1 to Level 2 she ran away in the early hours of the morning, taking £20 in cash and some food. She had been doing well in the education unit and a place had been found for her at the local school to start after the half term holiday. Her first meeting with her aunt (who it was hoped would care for Carrie in the long-term) was about to take place. She had previously received a letter via her social worker from an ex-boyfriend in the residential unit. The clinical team surmised that she had become overwhelmed and that this was a flight response. She was picked up by the police on her way to the residential unit and was returned to Terri and Alan the following day.

Carrie’s concerns about rejection and shame regarding the theft, and the foster carers’ feelings of being let down and “taken in” by Carrie, were all dealt with sensitively by the programme supervisor. The foster carers learnt that Carrie’s behaviour was a reflection of her past experience and not to take it personally. The incident reinforced for them the need to use the programme staff and points system rigorously. The programme supervisor agreed that Carrie could move up to Level 2, but devised a significant work chore in the community as a consequence of the stealing. She is now gaining points for every day that she remains in the placement and she doesn’t run, and these points are being saved to buy some new jeans.”
Foster carers record daily the progress and the points awarded on a prescribed chart illustrated in Figure 6.8 below. This, along with a similar report obtained by the foster carer from the school, is conveyed to the programme supervisor.

**Figure 6.8: Parent daily record report form**
The Parents Daily Report (PDR) provides the programme supervisor with an overview of the young person’s progress. This will enable her and the other team members to consider if team interventions should be adjusted. It also informs the programme supervisor whether the carer may need assistance or encouragement to deal with the young person’s behaviour and interactions in the foster home. Information in the report can alert her to spirals of negative interaction. Early identification of these can avoid a young person’s progress being undermined and it can promote the development of a positive carer/child relationship. This is a feature which, if undetected, research has identified as a contributor to placement disruption.3

The individual therapist and the skills trainer who work with the youth also utilise the PDR. Their role is twofold. On the one hand they support the youngster’s adjustment in the MTFC home where the main treatment effect is expected to occur. Secondly, they support the youth in helping him acquire and practice the skills needed to relate successfully to adults and peers. All of this has the objective of the child returning to his family. The birth family therapist works with them and as the child progresses to Level 3 this may involve joint work with the individual therapist. The work with the child and his family will involve:

- **School:** The skills trainer establishes contact with the school at an early stage. She addresses issues raised in the daily school reports with the school and young person. Through learning techniques and roleplaying, she assists the young person to develop the skills to interact positively with others in formal and informal settings.

- **Natural Family:** Where a young person is expected to return home, the involvement of the natural parents in the programme is essential. The family therapist has the main role in helping them. The roles are to:
  - increase their effectiveness in supervising, encouraging and supporting their child
  - to follow this with consequences for the youngster, as appropriate

In addition, the family therapist and the parents cooperate in developing their problem-solving, communication, conflict avoidance and advocacy skills.

As the child moves through the levels, he spends more time at home. These periods are used to support the parents in implementing the behavioural techniques applied on the programme. Often the skills trainer may assist this process in helping the child and his parents become accustomed to a changed environment

**Aftercare**

The work of the treatment programme is targeted at the young person’s successful integration into an identified post-treatment care arrangement. Ideally this is with her natural family. Where this is not possible, alternative arrangements are identified, at most three months into the programme. In the absence of her parents, suitable relatives may be available, or failing that alternative long-term carers. Those future carers are included in the programme in the same way as would the natural parents.
At the end of the treatment programme, which may be 12 months, the child either moves back home or to the carers who have participated in the programme. Aftercare support continues. This includes weekly parent/group meetings; PDR calls continue, first on a daily basis, graduating to weekly at six-months post placement.

Other MTFC Related Programmes.

The Oregon Social Learning Centre has designed other programmes based on the original concept of the Multi-Dimensional Treatment Foster Care model. Their development recognises the needs of young people at different stages of their development. In addition, they target the support to young people with the object of avoiding unnecessary changes in their care arrangements. These programmes may be attractive from a CAWT perspective. Particularly for younger children, they would offer support to existing foster carers in the management of young people in their care. The need for this was an issue raised during the consultation process.

Figure 6.9 illustrates how MTFC programmes progress from prevention to treatment across different stages of a child’s development.

![Figure 6.9: MTFC family of programmes](Diagram courtesy Dr Phil Fisher, OSLC)

A brief description of these programmes follows:
This programme, previously called Early Intervention Foster Care (EIFC), is targeted at preschool age children. Typically, they may be in care because of parental maltreatment and display challenging, aggressive and oppositional behaviour. This is likely to provoke multiple disruption to a child in regular foster care.

The programme is an adaptation of MTFC described earlier. It targets behaviour, emotional regulation and developmental delay, using age appropriate techniques over a period of 24 months. It concentrates on the development of parenting practices that entail engagement with, and monitoring of, the child in relation to discipline and positive reinforcement. The rationale for this is that parental figures are the child’s primary agents of socialisation prior to school entry. Depending on the child circumstances, her natural parents, or long-term foster carers are the focus of intervention.

MTFC-P attempts to break or prevent the cycle of multiple placements that can be caused by foster care break down or disruption. Children come into the programme either on their admission to care, or coinciding with current placement failure. It is easier for a child to begin when he is entering a new placement. Also, the new foster carers trained in the approach are then in a good position to start afresh with the child. At the end of the treatment, following an approximate three-month aftercare period, the programme ends. If children are not to return home, the treatment carers will continue providing long-term care.

Consequently, progress on the programme is designed to reverse the negative effects for the child of placement disruption. Similarly to the MTFC adolescent programme, it uses a team approach. The child’s progress is reviewed and plans adopted as needed in the context of daily contact with the foster carer and weekly meetings. A significant addition to the programme is a therapeutic playgroup. This occurs once a week. This provides a location in which interventions that take place in the treatment foster home are practised in a social setting.

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**Outcomes**

- Permanent placement success rate following treatment showed a 50% improvement compared to a control group in regular foster care.
- The likelihood of failure of placement in each group was similar for the first eight months of placement. Thereafter, failure in regular foster care increased substantially, whereas in the treatment group it did so marginally.
- For those children involved in the programme, the probability of failed permanent placements remained stable as the number of prior placements increased. In the control group, the likelihood of failed permanent placement increased as related to an increase in the number of prior placements.
This programme is designed to provide regular foster carers with general support and specific parent management training (PMT). It is targeted at the children in their care aged between 4 and 11 years. A study to evaluate the programme with an older age group is just commencing. The programme arose in recognition of the difficulties foster carers face. Despite their best efforts and intentions, they often do not have the benefit of meaningful or relevant consultation on developmental or mental health issues. Through parent training, rather than directly addressing her behaviour, the parents are empowered to bring about positive change in their child.

Implementation of KEEP involves training a group of facilitators and co-facilitators to conduct the intervention. They are then supervised by a consultant for a one-year period. The facilitators' weekly meetings with groups of foster carers are videotaped. Concurrently, carers keep PDR records, which are reviewed by the facilitators and consultant. They discuss these and the videotaped meetings during weekly telephone consultations. Support and intervention is adapted accordingly.

Outcomes

Evaluation of the scheme is currently being analysed. Outcomes assessed include levels of:

- child functioning
- child psychopathology
- parenting practices
- parent-child interactions
- service system outcomes such as:
  ➢ number of out-of-home placements
  ➢ mental health service usage
  ➢ foster parent retention

Preliminary results indicate that KEEP children:

- have fewer behavioral problems than those in the control group over time
- go home to parents or to live with relatives more often
- are removed from their foster homes less often on request from their foster carers
Where are Multi-Dimensional Treatment Foster Care or related programmes applied?

Where an MTFC programme is implemented, successful outcomes are predicted when there is:

- eager buy-in to the model at the system, agency, and clinician levels
- capacity to fund the model
- ongoing staff training, supervision, and support
- recruitment and support to foster parents
- fidelity to MTFC mechanisms:
  - parent daily reporting
  - quarterly programme reviews
  - monitoring outcomes

MTFC is being implemented widely in the United States and has recently been introduced into Canada. In Europe, sites are operating in Sweden and a large pilot programme is being undertaken in 20 English local authorities. In both of these countries, agencies entered into a contract with the Oregon Social Learning Centre (OSLC) for the introduction of the programme. OSLC provided training to staff and carers. This included on-site and remote supervision as the programme was implemented. Somewhat differently, in Norway the government have introduced a nationwide programme for parent management training (PMT). This programme was also developed in the Oregon Social Learning Centre. Within the framework of that programme, a small pilot treatment foster care project adapting MTFC methods was designed. It was introduced in Tonsberg, approximately 40 km from Oslo.

The operation of these projects was examined in the course of “A New Chance - Cross-Border Foster Care Project” and are outlined on the next page:
England: National Treatment Foster Care Project (MTFC-E)

- **Structure:** This project has been set up on a pilot basis by the Department for Education and Skills (DfES) within state agencies.
  - Each scheme is located within one of 20 local authorities in England.
  - Sites have a dedicated staffing structure headed by a programme manager.
  - In addition to the skills trainer there may be an education worker on the team.
  - A foster care/recruiter may give support to the foster carers jointly with the programme supervisor.
  - Each team can accommodate from 8 - 10 cases at a time.
  - The professional background of the teams is typically social work, psychology, education and family therapy.
  - Reporting arrangements are through the relevant local authority, which has executive responsibility for the implementation of the project in its area.
  - A National Project Team with offices in London and Manchester has the function of:
    - overseeing the development of the pilot schemes in each site
    - providing a national framework and network for training and support
    - ensuring that there is model fidelity
    - providing 24/7 advice and support to sites

- **System and agency commitment to the model:** The initiative for the model came from a senior civil servant within the DfES. This placed the commitment for its development on a sound foundation. Other issues are as follows:
  - The National Project Team emphasises the need for rigour to the model as designed. This is necessary to achieve the outcomes promised and to ensure that comparisons with other sites are valid.
  - Since the National Team does not have executive responsibility there have been occasions when project sites have been directed by their local authority managers to set aside procedures in order to address crisis problems.
  - Referrals do not automatically follow the introduction of the programme. Continual work must be undertaken informing agencies and communities about it.
  - Gaining the support and confidence of schools in cooperating with the programme is a major problem. Having a teacher on the team is very useful in addressing this.

- **Funding:** A consortium of local authority and state partnership agencies (e.g. Education and Mental Health) bid as a multiagency team for £400,000 setup costs to deliver MTFC with fidelity for a period of four years in each site.
This funding comes from the DfES. It is designed as a pump priming grant for 6-9 months to get the programme up and running. The objective is that continued funding should be provided from savings accruing to these agencies from its introduction.

Identifying such savings can be a difficulty since agencies often do not have accounting procedures that detail costs incurred as current expenditure.

Costs to be funded from savings are between £110 - £120,000 per child (based on four placements and one respite carer) reducing to around £90,000, based on seven placements and one respite.

- **Training, supervision and support:** The National Team collaborates with the Oregon Social Learning Centre to provide initial and ongoing joint training of teams and carers.

The objective of site teams training carers themselves has been slower to develop than hoped.

- **Foster care recruitment and support:** Recruitment is undertaken directly by each site team. The practice is to recruit five carers for four children, one being to provide respite. Issues are as follows:

  - The recruitment of carers is difficult and needs to be a continuous task, which is the responsibility of the foster care recruiter.
  - The problem is not just the availability of high-support foster carers for the treatment programme, but also the availability of mainstream foster carers in the aftercare period.
  - There has been experience of inappropriate foster carers being recruited principally out of desperation: the need to find a placement for a particular child.
  - In some sites the lack of post MTFC-E placements has resulted in the foster care recruiter advertising directly for carers to provide such placements.

- **Conditions for carers:**
  - one of the foster carers must be available full-time for the task

- **Fidelity to the programme:** An addition to the programme implemented in England is that admission assessment measures include comprehensive mental health, physical, educational skills and cognitive assessments on each child admitted.

A major function of the National Treatment Team is to ensure that fidelity to the programme is maintained. This is a challenging task for two reasons:

  - the dispersal of 20 sites throughout England
  - day-to-day executive authority being the responsibility of the local authority rather than the National Team
• Progress and evaluation:

➢ 19 teams now funded.
➢ 8 teams now have young people in placements.
➢ First child was admitted in April 2004.
➢ 29 children currently in the programme.
➢ 48 children admitted over last 18 months.
➢ 4 children “graduated” - 3 to long term single foster placements, one home to family.
➢ 15 children left earlier than planned.
➢ Independent evaluation team at Universities of York (Prof Ian Sinclair, Dr Nina Biehal) and Manchester (Dr Jonathan Green) conducting a randomised controlled trial to evaluate outcomes.

Outline based on interview with Ms. Rosemarie Roberts, National Treatment Foster Care Project, England, July 2005.
Sweden: Familjeforum Multi-Dimensional Treatment Foster Care Project

- **Structure**: Familjeforum is a private, self-financing, nonprofitmaking family support agency that operates in Lund (southern Sweden) and in Stockholm. It obtained training and certification from OSLC to implement MTFC. It has been implementing the programme since November 2000. Two teams, who work half-time, manage three to four cases each.
  - The professional background of the team is social work and family therapy
  - There is no teacher or psychologist member of the team.
  - Where it is necessary, consultants are employed to undertake assessments.

- **System and agency commitment to the model**: Commitment to delivery of the programme is important on a number of levels as follows:
  - Familjeforum insists on rigorous application of the model as it is designed. Social service agencies’ commitment is necessary to ensure cooperation on a day-to-day basis and in respect of throughcare arrangements relating to cases in which they have an involvement. Some difficulties have been experienced as follows:
    - Social workers do not always agree that their and the birth parents contact with the foster carers should be through the programme manager.
    - Social workers feel that they should be able to provide the same sort of support offered in the programme to all children they deal with.
    - MTFC foster carers higher rates of payment may cause tension among mainstream carers who manage difficult children also.
  - Schools can be sceptical about the project in the first instance. The initial work is undertaken by the case manager with the school principal. This is followed by the foster carers and the skills trainer taking on the lead role, possibly together with the case manager.

- **Funding**: There is no direct state funding other than for the evaluation of the project. Funding for individual cases comes from statutory agencies on a charge by case basis. The charge does not include the cost for carers which is paid by the local social service agency.

- **Training, supervision and support**: OSLC certification enables Familjeforum to provide training and support to staff and carers directly. A member of the Familjeforum management board, not directly involved in case management, acts as a consultant to the team.

- **Foster care recruitment and support**: Familjeforum undertake media advertising promoting the project. However, carers are selected from those approved by the social service agency according to legal requirements. Familjeforum then assess their suitability to implement the model.
  - Humour is the ultimate test: it indicates the ability to distance oneself from problems.
  - Those who have experience with children, such as teachers, can be good at detaching themselves if foster carers.
Conditions for carers:
- One placement per family at a time
- There is no condition limiting other young children of the same age, in the family
- Abusing children will not be placed in a family where there are other young children

Fidelity to the programme: Familjeforum give a high priority to implementing the programme rigorously. That they are a single agency may make this easier.

Progress and evaluation: Since 2000, there have been 24 children through the project.
- Indications are that outcomes in terms of young people's long-term stability and the rate of breakdown in foster care placements are very positive.
- A randomised controlled trial (RCT) is being undertaken in the University of Lund under the direction of Professor Kjell Hansson.

Outline based on interview with Mr. Per Schuller, Professor Kjell Hansson and Ms Nicolena Fransson, Familjeforum, July 2005.
Norway: Bufetat, State Childcare Service, Tonsberg Pilot Treatment Foster Care Project

- **Structure:** This project has to be understood in the context of a decision by the Norwegian government to develop nationwide evidence-based interventions to support families in the management of difficult children.
  - The decision was made to invest in the parent management training programme (PMTO) developed in the Oregon Social Learning Centre.
  - Its focus is on prevention and treatment of serious behavioural problems with children aged 5 to 12, who generally live in the community.
  - It offers a structure and goals which are focused on helping parents directly address their child’s behaviour.
  - The Norwegian Centre for the Studies of Conduct Problems and Innovative Practice (The Behavioural Centre) coordinates the implementation of PMTO nationally. It has executive responsibility for the implementation of schemes and for training therapists.
  - The Behavioural Centre commissioned Bufetat, a statutory child care organisation, to commence a pilot project. Its object was to establish if PMTO might be used in work with children who could not be helped in their home.
  - A steering group composed of decision-makers in different parts of the childcare system was set up.
  - A programme was designed by consultants from OSLC.
  - It is similar to the MTFC model. However, it does not use the points and level system and it has a greater emphasis on parent training than behaviour management.
  - Instead, it follows the PMTO model which is suitable for younger children.
  - Bufetat implemented the scheme for four children from within a radius of 60 kilometres.
  - All the team were trained in PMTO which they worked at half-time, the other half being worked in the treatment Foster Care project.

- **System and agency commitment to the model:**
  - A PR exercise was necessary to overcome scepticism in the Child Welfare Service that initially inhibited referrals.
  - Inspection Agencies, other professionals, etc. can undermine the programme if not fully on board and committed to it.
  - Network meetings are necessary to clarify roles and ensure goals are not undermined.
  - The system should be designed so that it can continue independently of key people who may be ill or leave. Training and supervision are critical to ensure this.
  - Establishing relationships with a child’s school can be very difficult.
  - A school must see that there is a problem which is big enough for them to cooperate with the programme.
  - Moving at the school’s pace is important.
- **Funding**: Funding was obtained from the Behavioural Centre to implement PMTO on the basis of goals rather than costs. Funding was provided through the mainstream Child Care system.

- **Training, supervision and support**: The principle is that there should be consistency of supervision. Staff should be supervised as they supervise the carers and as the carers are expected to relate to the children.
  - This is provided through frequent group meetings and individual meetings.
  - The project leaders, trained by OSLC consultants, got continuing supervision from them.
  - Training of staff should be undertaken prior to the programme starting in order to maintain model fidelity.
  - Foster carers were trained in PMTO and supported by the project leaders.
    - Placements should be available immediately, alongside close supervision.
    - Training foster carers in a group is good and is ideal if there are different levels of experience or the availability of existing carers to participate in training.
    - Informal foster carer support groups, as sometimes develop in mainstream foster care, can undermine the programme.

- **Foster care recruitment and support**: Carers were recruited directly by the project through advertisement.
  - They were not paid significantly more than mainstream carers.
  - Conditions were that carers must:
    - be prepared to work as part of a team
    - work in a context of close supervision and direction
    - understand the foster child will need a different approach from their own child
    - accept that one carer must not work outside the home
    - faithfully apply the treatment model
    - attend all team meetings

- **Fidelity to the programme**: This was given high priority by the project leaders. It may be more difficult to achieve in an expanded programme if the system places too much reliance on the dedication of individual project leaders.

- **Progress and evaluation**: The trial is completed and the report of its progress recommends its continuation and expansion.

Outline based on interview with Ms. Mona Duckert, National Behavioural Centre, and Ms Tone Fiane Christiansen, Bufetat, Tonsberg, July 2005
A number of issues fundamental to the introduction and implementation of MTFC arise from the description of the schemes illustrated above:

1. The development of MTFC is greatly enhanced if championed by high-level decision-makers.

2. Funding sources should be clearly identified, be secure for the duration of any project and provide for:
   ➢ a contract with the OSLC for the training and supervision of staff implementing the project
   ➢ the start-up period, during which the placement of young people with carers is staggered and no savings can be set against costs
   ➢ the evaluation of the programme

3. An organisation structure should:
   ➢ have overall executive responsibility for the implementation and day-to-day management of the programme
   ➢ have clearly designated and identifiable levels of accountability
   ➢ give priority to ensuring that fidelity to the MTFC programme is maintained

4. Pre-startup planning should include:
   ➢ a decision on what combination of MTFC programmes to invest in
   ➢ consultation with service providers and referral agencies to explain the programme, and the importance of their commitment to its principles following referral
   ➢ consideration of legal and cultural issues that may require programme adaptation
   ➢ identification of, and policy development relating to, legal, ethical and philosophical issues such as:
     ❖ a child’s introduction to foster carers
     ❖ the relationship between foster carers and the child’s birth family
     ❖ clarification of the process by which the programme and the statutory referring agencies co-operate to ensure that required standards and legal obligations are met
   ➢ the nature and extent of the evaluation process to be adopted to confirm the outcomes from implementation of the programme

5. Training of staff should be undertaken prior to the start-up of the project.

6. Recruitment of foster carers should be undertaken in accordance with a clear strategy and in close cooperation with the regular foster care process. The following issues need to be addressed:
   ➢ Payment for foster carers.
   ➢ Potential for competition in recruitment of carers between regular foster care and the programme.
   ➢ Spinoff benefits for regular foster care arising from the implementation of the programme.
Summary

- Multi-Dimensional Treatment Foster Care is an intervention targeted at young people who present behaviour difficulties arising from traumatic early life experiences.
- The programme operates in the context of a rigorous design, which when implemented faithfully has an evidence base for positive outcomes in respect of young people placed in it.
- To provide it, a dedicated team of professionals implement a structured behaviour management programme, alongside trained foster carers, across multiple social domains of a child’s life.
- MTFC related programmes progress from prevention to treatment across stages of a child’s development from preschool, through latency, to adolescence.
- Apart from the United States, MTFC programs are being implemented in Canada, Sweden and England.
- The examination of the Swedish and English pilot schemes, together with a Norwegian adaptation of MTFC, was undertaken in the course of A New Chance-Cross-border Foster Care Project.
- This identified a number of important issues to be considered in implementing the programme relating to:
  - funding
  - organisation structure
  - planning

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Chapter 7 -
Introducing Multi-Dimensional Treatment Foster Care in The CAWT area
7. INTRODUCING MULTI-DIMENSIONAL TREATMENT FOSTER CARE IN THE CAWT AREA

Although the CAWT area crosses two jurisdictions and covers a diverse geographical area, it is very suitable to the introduction of Multi-Dimensional Treatment Foster Care. For example:

- The survey of children in care in the area indicates that there are a sufficient number of children capable of sustaining any one or combination of the MTFC programmes described above in each jurisdiction:
  ➢ the validated outcomes for MTFC meets a commitment to evidence based interventions.
  ➢ the MTFC focus on the needs of young people, birth family involvement, community connections and continuity in after care is consistent with both statutory and public policy requirements.
- Geographical distances are not large, facilitating the setup of programme sites with a radius of 20 to 30 miles.
- All sites targeting individual geographical areas could be managed along with the other sites by an Executive Group. This could take responsibility for implementation, support and training, while overseeing the maintenance of fidelity to the programme principles.

The issues to be addressed in undertaking this are the focus of this section.

Commitment to the programme at all levels

There are two aspects to this which the CAWT partners could influence:

- Decision Maker Commitment: The evidence from Norway and England points to the value of high-level commitment in influencing the adoption of, and investment in, new interventions. The CAWT Partnership is headed by the senior personnel in the statutory social services agencies in its area. Consequently, it is well-placed to stimulate the interest necessary for such commitment. A New Chance has commenced this process in meetings with staff and managers and through a consultative seminar. Should it accept this report and proposals, the opportunity now exists for the CAWT partners to initiate an application for funding to develop a new project to implement pilot MTFC schemes.
- Front-Line Staff Commitment: Experience in England and Sweden underline the importance of front-line staff fully understanding the programme and being closely involved in its planning and implementation. An adequate level of referrals to a scheme will depend on this. In addition, social workers and others are entitled to full information relating to their role in supporting the programme during the treatment period and in planning for and supporting the post-treatment phase. The consultation exercises engaged in with front-line staff identified particular areas in which more information was sought on the programme as follows:
  ➢ its approach to attachment
  ➢ the process of matching and introducing a child to her carers
  ➢ the impact of the programme on the recruitment of regular carers
  ➢ the possible development of a two-tier foster care system
➢ the process by which standards and legal obligations are met
➢ reasons for fidelity to the MTFC programme design

Detailed information in respect of these must be provided at the outset if difficulties are to be avoided following commencement of any programme.

**Recommendation**

The CAWT partners should actively consider promoting the development of Multi-Dimensional Treatment Foster Care.

**Structure and organisation**

A primary objective of the CAWT partnership is to target opportunities for cross-border co-operation. The survey already described has identified the management of young people with challenging behaviour as a cross border issue. The CAWT partnership is designed to identify, seek funding for, and commission suitable projects. Its role in relation to the development and implementation of MTFC could be:

- to identify areas of the CAWT region which are suitable for piloting MTFC programmes
- to select the type or combination of MTFC programmes appropriate to those areas
- to consult with OSLC regarding contracts for setup training and support to staff and carers together with possible programme certification
- to approve an organisation structure that would meet the needs for implementation, accountability and fidelity to programme requirements
- to draft and submit applications to funding agencies
- to consult with research agencies regarding contracts to evaluate pilot programmes
- to seek tenders from NGOs for the setup and implementation, by one agency, of the selected models in the identified sites across the CAWT area

Once tenders are accepted and contracts entered into, funds could be allocated to an NGO for implementation. The CAWT partnership would then have responsibility for monitoring the terms of those contracts. Executive responsibility would pass to the organisation structure established by the operation of the contracts.

**Partnership**

The suggestion of NGO responsibility arises from difficulties experienced in many high-support foster care programmes that are managed solely by statutory agencies. These were described earlier. Often, competing priorities and immediate crises cause a diversion of funds and staff resources. Sometimes, programme fidelity can be undermined. A structure combining that of the Belfast CPS and the National Treatment Foster Care Project-England, would address these issues.
If followed, that structure would give executive responsibility for programme implementation, training, and support to staff, to an Executive Implementation Group. Acting under the aegis of the CAWT partners, this would be composed of contracted NGO staff and seconded statutory agency staff. The size of the Implementation Group would depend upon the number of sites selected. It would be managed by an NGO appointed director and would have no less than two and no more than four members. Sites would be located in individual Trust and Community Care Areas located on each side of the border. They would have responsibility for the day-to-day implementation and rollout of programmes in keeping with the legal and statutory framework in that area. Each would be accountable to the Implementation Group. A possible management structure is illustrated in Figure 7.1 below.

**Figure 7.1: Proposed partnership organisation chart**

The structure illustrated above proposes that:

- An Executive Implementation Group would operate under the aegis of the CAWT Family and Child Care Subgroup.
- The Implementation Group, composed of two staff, would oversee four site teams. A larger number of site teams would require increased Implementation Group staffing.
- Commissioned by the Family and Child Care Subgroup, the Oregon Social Learning Centre consultancy would coordinate the training and support to management and site teams, including foster carers. This would be undertaken as part of the contract entered into with OSLC to support programme implementation, and to ensure fidelity to its design.
- Evaluation of the programme implementation is envisaged. This would be commissioned by the CAWT Family and Child Care Subgroup from a recognised research institution. In all likelihood, this would not be undertaken until relevant site teams were in full operation.
The front-line delivery of the programme through site teams would be as described earlier. It is this organisation structure, and site team composition, for which funding would be required to provide for programme delivery.

**Funding**

In both Northern Ireland and the Republic there is continual competition within and between agencies for funds to implement new initiatives. A New Chance was established to identify an evidence-based alternative to high-support and secure residential units. It is often the intention that such schemes should be funded by savings in those areas. The survey of children in care in the CAWT area indicated the numbers reported to present with challenging behaviour who used high-support (including secure) residential care. These are illustrated in Table 7.1 below.

![Table 7.1: Intensity of reported management difficulties presented by young people in high-support residential care](image)

A total of 23 young people in the area reported to present with management difficulties were in high-support care. The table also indicates that 160 children reported to present with management difficulties were not in high-support care. That number includes other children presenting with management difficulties whose care was supported through enhanced payments. Table 7.2 below illustrates the numbers of those children that the survey reported in the CAWT area.
The care of 29 children are supported by enhanced payments. These may represent any one or more of the following:

- additional payments to foster carers that reflect specific demands of the placement
- therapeutic and/or educational support to the child
- dedicated one-to-one staff support in the foster home, residential unit or school
- additional support to foster carers or residential unit for identifiable activities or treatments designed to meet the needs of the young person
- special arrangements for supporting/monitoring natural family contact

Undoubtedly, introduction of MTFC would reduce and in some cases eliminate such costs. However, desirable though it may be, it is not possible to quantify them. There are a number of reasons for this:

- The large capital funds invested in high support and secure residential care will only be reduced in the long-term. This will occur as implementation of the programme effects a reduction in demand for places.
- Enhanced payments are frequently provided from current budget allocations. They are not accounted for separately, making it difficult to identify savings incurred. During the consultation process anecdotal examples of such payments included:
  ➢ a wraparound programme for an individual child in foster care amounting to £1000 (£1500) per week
  ➢ two separate out of jurisdiction residential placements costing £2000 (£3000) and £6000 (£9,000) respectively per week
- Validated benefits from the implementation of MTFC may only be presented as costs not incurred (which will not be represented in any financial account), rather than savings made.

Nevertheless, the significant benefits for children and for the services which provide for their needs are the most important arguments supporting the provision of funds for MTFC. From an accounting
perspective, these may be best illustrated by a cost/benefit comparison. Thus, the cost for an individual child’s participation in a programme should be compared with the estimated costs and benefits of the alternatives. In both the Republic and Northern Ireland value for money criteria are increasingly used in public service investment decisions. Access to funds for any high-support foster care scheme will depend on an accurate estimate of its operating costs compared to its benefits.

Funding has been an important issue in respect of all the schemes examined. From the outset, funding should be secure. Predicted outcomes will be assured only if a scheme can implement the MTFC programme as designed and in its entirety. Those funds must provide for costs to be incurred at three separate stages:

- **Commissioning Period:**
  ➢ decisions on programme(s) to be implemented
  ➢ design and agreement on organisation structure
  ➢ negotiating and contracting with the Oregon Social Learning Centre
  ➢ decision on, and contracting of, an evaluation process

- **Start-up Period:**
  ➢ hiring and training of staff
  ➢ policy and procedure development
  ➢ recruitment and training of foster carers
  ➢ information to, consultation with, and preparation of referral agencies

- **Early operation period:**
  ➢ staggered acceptance of referrals
  ➢ implementation of programme
  ➢ ongoing training and support
  ➢ review and evaluation of progress and outcomes

Funding allocation must recognise the need for partial funding during the commissioning period of up to 80% funding during the setup periods. Finally, full funding will be required as the operation period commences. During the early operation period, there must be acceptance of a gradual referral rate. This is to allow practice competence to develop. Because of this costs will be reduced. Fewer foster carers will be employed. In addition, pending buildup to a full team caseload, it may be possible for some team tasks to be shared. This would temporarily reduce salary costs. Based on the experience in England, a timeline of approximately three years may be required. This is illustrated in Figure 7.2 on the next page.

The source of funds is relevant. Even if operational costs are to be met through payment by agencies for individual cases referred, this will not cover essential commissioning, setup and evaluation costs. The decision on sourcing of funds will be influenced by the organisation structure agreed. Nevertheless, the current social service structure that exists in the CAWT area is such that government funding will be required to cover those initial costs.
Figure 7.2: Funding requirements and timeline from commissioning to early operation of an MTFC scheme.
Recommendation

The CAWT partners should seek funding for the implementation of Multi-Dimensional Treatment Foster Care in its region on the basis that:

- there is an established need for a high-support foster care scheme in the CAWT region
- such a scheme would be consistent with statutory direction that young people should be provided for in the community
- it is consistent with public policy that interventions should be evidence based
- implementation of MTFC would reduce and in some cases eliminate significant costs currently incurred in the management of young people with challenging behaviour

Planning

Commissioning Phase

This would be the responsibility of the CAWT Family and Child Care Subgroup. Issues to be addressed are as follows:

- The initial design of the scheme should reflect the legal and cultural differences that exist on each side of the Irish border.
  - Consultation with inspection agencies in Northern Ireland and the Republic should establish that the programme complies with the appropriate standards of care. In particular, those relating to ethical and philosophical issues raised in the consultation processes should be clarified. These include:
    - the nature of choice for young people participating in the programme
    - the role of the young person’s birth family
    - foster carers involvement with the birth family
  - The differing legal frameworks in each jurisdiction will require that individual sites do not straddle the border. However, the Executive Implementation Group’s responsibilities would apply to all sites. Ideally, to maximise efficiency and consistency, it should coordinate the training of staff and carers.

- The type, or combination of MTFC programmes that are chosen, is important. In the consultation exercises undertaken in the context of “A New Chance,” concern was expressed at the lack of support for regular foster care. A study undertaken in all Scottish local authorities \(^1\) indicates the importance of support to foster carers from both social workers and their agencies. It is desirable that the introduction of MTFC should have a positive impact on the support available to regular foster carers. The research survey of children in care in the CAWT area indicates that the incidence...
of challenging behaviour is quite varied in the region. Some Trusts and Community Care areas would require a programme focused on adolescents. It is the case that the intensity of management difficulties in the region increases with age. However, as Figure 7.3 below indicates, younger children too present with difficulties in their behaviour. The rate of difficulties undoubtedly increases with age. However there are also a small but significant number of young people under 12 who are reported to present serious management difficulties.

The three MTFC programmes outlined earlier track young people at different stages of their development. Their focus is on prevention through treatment depending on the child’s age. The choice of programme or programmes adopted in a scheme has the potential to provide additional support to regular foster carers who may be managing very difficult children. This too, would have the advantage of reducing the potential problems such children may pose as they move to adolescence.

![Figure 7.3: Intensity of reported difficulties by age group](image)

**Recommendation**

Some Health and Social Service Trusts and Health Service Executive, Community Care Areas report low numbers of children who present with challenging behaviour. In these areas, consideration should be given to the introduction of Early Intervention or KEEP projects. These would benefit younger age children including those who are in regular foster care.
Educational support for children participating in MTFC programmes is important. The MTFC programme applied in England specifically includes a teacher in each team. In addition, the funding partnerships include both health and education authorities. This recognizes the shared interest different authorities have in positive outcomes for young people. The role of education in the introduction and development of MTFC in the CAWT area was raised during the consultation sessions. There is a case for:

➢ educational sector representation on the CAWT subgroup
➢ providing information to, and seeking consultation with, the school authorities during the commissioning period in areas where sites are to be introduced

**Recommendation**

Following a decision by the CAWT partners to implement Multidimensional Treatment Foster Care, consultation should take place with schools regarding the programme. Consideration should also be given to the inclusion of educational representation on the CAWT Family and Child Care Subgroup.

The positive outcomes which MTFC has demonstrated are dependent upon faithful application of the programme as it has been designed. Achieving this assumes close consultation with OSLC in relation to programme design and operation at all its stages. Fidelity to the programme is essential if desired outcomes are to be realized and to allow comparison with other schemes applying the model. To ensure that the programme design is consistent with MTFC criteria, close consultation with OSLC should be undertaken in respect of:

➢ the tendering and appointment of the lead NGO
➢ make up of site teams and programme adaptation necessary to meet legal and structural requirements
➢ the design of and tendering for the research evaluation study

**Recommendation**

In implementing the Multi-Dimensional Treatment Foster Care programme developed by the Oregon Social Learning Centre, fidelity to the programme design is essential to guarantee the desired outcomes. Consequently, the Oregon Social Learning Centre should be closely involved in all aspects of the design and implementation of a scheme in the CAWT area.
• If introduced, the training, supervision and support provided to staff and foster carers will be fundamental to the success of MTFC. In implementing MTFC, it would be necessary to commission a package of training, supervision and support from the Oregon Social Learning Centre. Such training should be undertaken and completed prior to the programme commencing. In doing so, the CAWT Family and Child Care Subgroup should anticipate that permanent programmes will follow the end of the pilot period. Consequently, it should establish the criteria, and plan for the certification by OSLC, of local staff to undertake the training and support of MTFC programmes.

**Recommendation**

To implement Multi-Dimensional Treatment Foster Care with fidelity to its design, it would be necessary for the CAWT partners to:

- enter into a contract with the Oregon Social Learning Centre to oversee and support the implementation of Multi-Dimensional Treatment Foster Care
- commission from the Oregon Social Learning Centre a package of training, supervision and support for the introduction of Multi-Dimensional Treatment Foster Care
- plan for the certification by the Oregon Social Learning Centre of local staff to undertake training and support for Multi-Dimensional Treatment Foster Care programmes in the future

• Foster carer issues which need to be clarified at the commissioning stage are as follows:
  ➢ the possible role of foster carers in providing continuing care, if an appropriate post-treatment placement has not been identified
  ➢ the fee to be paid to recruited foster carers prior to placement, during placement and following the end of the treatment period if they are to continue providing care to a child
  ➢ The relationship between the MTFC and regular foster care recruitment processes, particularly in relation to local foster care approval panels
• The availability of sufficient suitable foster carers was identified during the consultation processes undertaken during A New Chance. A resolution to the problem would assist the stability of regular foster care. It would also ensure the availability of post treatment placements for young people following MTFC. A possible role for the CAWT Family and Child Care Subgroup in addressing this issue is outlined in Appendix 2.

**Recommendation**

The possibility of post-treatment care being provided by foster carers and the fees to be paid to them should be clearly outlined in any proposed scheme.
• If implemented, evaluation of the programme’s outcomes is essential to confirm its value. A recognised research institution should be commissioned to undertake such a study. Consideration should be given to the type of study to be undertaken, its length and particularly whether it undertakes a randomised controlled trial or comparison with other research outcomes.

**Recommendation**

A recognised research institution should be commissioned to undertake a comprehensive evaluation of implementation and outcomes resulting from a proposed scheme.

**Setup Period**

Once the lead NGO agency has been appointed, the planning and day-to-day executive responsibility for the implementation of MTFC passes to it. The appointment of the Implementation Group is its first task. This and other functions would operate concurrently as follows:

• **Hiring of seconded statutory agency staff** would be undertaken following internal advertisement in the CAWT partner agencies:
  ➢ All recruitment processes in respect of both the Implementation Group and Site Teams should follow the contracted NGO agency’s criteria. There should be the proviso that recruitment processes are competency-based.
  ➢ The training of staff would be provided by OSLC. This would commence immediately following their appointment.

• **Policies and procedures** both in relation to professional and administrative matters should be available clearly and in writing:
  ➢ Their existence would provide for continuity of practice in the event of changes in staff, or during their absence on leave.
  ➢ Procedures should give priority to ensuring that all aspects of the evaluation research study are accommodated in the day-to-day implementation of the project.

• **The recruitment of foster carers** will be undertaken by Site Teams. This should follow ongoing consultation by both Site Teams and the Implementation Group with the regular foster care system. Some research evidence suggests that limited availability of carers is a widespread problem which affects both choice of placements and appropriate matching of carers with young people. In the consultation exercises this was also raised as an issue. Opportunities for collaboration should be investigated, both to maximise the sharing of expertise and to minimise the perception of competitive recruitment.
The training of foster carers would be provided by OSLC in conjunction with the Implementation Group, as would ongoing support to both them and Site Teams.

Information to, and consultation with, key stakeholders should be a priority. In undertaking this, both the Implementation Group and Site Teams could assist the growth of confidence and credibility in the scheme’s operation and ambitions. Consultation mechanisms should be established with:

➢ young people’s organisations
➢ foster care associations
➢ referral agencies

Recommendation

In implementing Multi-Dimensional Treatment Foster Care in the region, a lead NGO agency should be appointed to work in partnership with the CAWT associate agencies:

• The lead NGO agency should have authority to appoint an Implementation Group and Site Teams.
• The Implementation Group should draft clear and concise policies and procedures relating to the operation of the scheme, which give due emphasis to the requirements of the research evaluation study.
• Site Teams should undertake the recruitment of foster carers in consultation with the regular foster care system, and be responsible for the day-to-day implementation of Multi-Dimensional Treatment Foster Care.
• Training of foster carers should be undertaken by the Oregon Social Learning Centre in conjunction with the Implementation Group.
• Consultation forums should be established with young people, foster carers, referral agencies and other stakeholders.

Early Operation Phase

On completion of the Setup Period, the MTFC scheme will be ready to accept referrals. Experience in both Sweden and England suggests that these should be staggered to allow Site Teams, including foster carers, to bed in and develop their confidence. All of the issues addressed during the Commissioning and Setup Periods should be of practical assistance to them in their day-to-day management of cases. Most affected will be young people admitted to the scheme in the Early Operation Phase and beyond.

Figure 7.4 on the next page illustrates a young person’s progress through the system.
As can be seen, the focus is on maximising continuity. In all cases, where it is possible or appropriate, the programme will support the natural family in undertaking the post-treatment care. A young person’s post-treatment living arrangements may be influenced by the programme in which they have participated. For instance:
• participation in the preschool programme (3 to 6 year olds) may occur following a placement change, which would then become permanent
• a child participating in the KEEP programme (4 to 11 year olds) will be unlikely to change placement from either their birth family or existing foster carers
• the adolescent program is more likely to result in a placement change should the birth family not be available. However, depending on the circumstances the treatment carers may continue providing long-term care.

**Recommendation**

Following implementation of a Multi-Dimensional Treatment Foster Care scheme, acceptance of referrals during the Early Operation Period should be staggered in order to allow staff and site teams to develop their confidence and abilities.

**Summary**

• The CAWT area is very suitable for the introduction of Multi-Dimensional Treatment Foster Care.
• The nature of the CAWT Partnership and constitution is such that it could have a major role in relation to the introduction, development and implementation of MTFC programmes.
• Partnership between an NGO and statutory agencies in the CAWT area would provide a secure foundation for the establishment of an MTFC scheme.
• The survey of children in care in the CAWT area has identified possible savings that could result from the introduction of an MTFC scheme in the region.
• Procedures should be devised to account for costs incurred in the implementation of the programme balanced against the cost of alternative interventions not used in respect of each child.

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Chapter 8 -
The cost of implementing a Multi-Dimensional Treatment Foster Care scheme
8. THE COST OF IMPLEMENTING A MULTI-DIMENSIONAL TREATMENT FOSTER CARE SCHEME

This section sets out guideline costs for the development and implementation of Multi-Dimensional Treatment Foster Care in the CAWT area. It estimates the costs that would apply in each one of the three phases identified earlier as follows:

- Commissioning Phase
- Start-up Phase
- Early Operation Phase

The cost incurred per case, once a Multi-Dimensional Treatment Foster Care site is fully up and running, is also calculated. Costs can vary significantly within the CAWT area. Overall, costs are generally higher in the Republic of Ireland than Northern Ireland. For instance, salaries differ by between 20% - 30%. Since they are higher, cost estimations that follow are based on those that would be likely to apply in the Republic of Ireland. Figures are converted to GBP £ at the rate of £1 equals €1.48.

Commissioning Phase

Costs incurred at this stage relate to:

- Planning:
  - Consultation with the Oregon Social Learning Centre.
  - The scheme design.
  - Agreement on organisation structure.
- Agreement on and preliminary tendering for a research evaluation study.
- Preliminary tender for NGO partnership and Implementation Group.
- Application for funding.

The work of this phase will be the task of the Family and Child Care Subgroup of CAWT. These number approximately eight nominees from the CAWT partners. Members of the subgroup undertake this work in the context of their day-to-day responsibilities for the respective Board/Trust/HSE Community Care Area. Consequently, costs will mainly relate to travel, meetings and other incidental expenses. These are estimated in Figure 8.1 below. They are made on the basis of a subgroup membership of eight people attending 10 meetings over a six-month period. Included are estimated costs of travel to Oregon. This is in respect of consultation regarding planning issues to be addressed in the design of the scheme to ensure its fidelity to the MTFC programme.
In addition, and also included, are costs that may be incurred should a visit to one of the English MTFC sites be felt desirable. The advantage of this would be to identify design issues in a legal and structural environment similar to that of the CAWT area. If undertaken, it would be best to do so prior to the meeting with the Oregon Social Learning Centre. The costs outlined are once off. They are necessarily incurred prior to the appointment of permanent staff who would develop and implement the MTFC programme.

**Start-up Phase**

This phase commences once funding has been secured and is available for drawdown. Immediate tasks for the CAWT Family and Child Care Subgroup would be to:

- Enter into a contract with the Oregon Social Learning Centre.
• Appoint an NGO partner on the basis of the tender process initiated during the commissioning phase.
• Complete the tender process for a research study.

The NGO partner would take responsibility for appointing and recruiting staff, locating accommodation, setting up administrative systems etc. These would be undertaken within the framework of the Executive Implementation Group and the Site Teams. Their cost would be included in the tender agreed. Those costs are reflected in the estimates outlined in Table 8.2 below.

Agreement and funding for the research study should remain the responsibility of the CAWT Family and Child Care Subgroup. The contract with the NGO to provide MTFC would attach an obligation to cooperate enthusiastically with the study. However, it would be undertaken independently of the Implementation Group or the Site Teams. Consequently, the funding for the research project would not be administered through the Implementation Group allocation. That figure is estimated at approximately €250,000. It would be applied over a four-year period - two years of the treatment programme and two years follow up. The CAWT Family and Child Care Subgroup would commission the research and administer the funding directly. As Site Teams would not be in full operation until year three, it is likely the research survey would commence at that point.

Executive Implementation Group

Once a director of the Implementation Group is appointed by the NGO, the recruitment of the other members would follow. The director would have the duty to cooperate with the Oregon Social Learning Centre. It is likely that this would include OSLC participation in the recruitment of Site Teams. Once they are recruited, their training undertaken by the OSLC would commence. This would be closely followed by the recruitment and training of the first group of carers. The estimate outlined in Table 8.2 on the next page provides for two group members including the director. This should be sufficient to support up to four teams. Beyond that, additional members would need to be recruited to the Implementation Group.
Notes:

1. In relation to the appointment of the Implementation Group Director, the post should be advertised as suitable to the grades indicated. The salary paid to the successful candidate would be at the grade to which their experience entitles them. The salary listed is for Principal Psychologist (ROI).

2. In relation to non-pay expenses, recruitment costs will be once off in relation to initial hiring of staff. However, provision should be made for staff turnover in subsequent years at a rate of 20% of total recruitment costs.

3. In relation to programme costs, miscellaneous expenses are a provision against overruns. They are calculated on the basis of 20% of operational non-pay costs.

4. In relation to the research evaluation costs, these have not been added to the annual costs as it is anticipated that they will be funded separately.

<table>
<thead>
<tr>
<th>Table 8.2: Implementation group - cost estimate</th>
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</thead>
<tbody>
<tr>
<td><strong>Accommodation and Fittings</strong>:</td>
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<tr>
<td>Accommodation: 1 director, 1 professional staff, 1 admin officer</td>
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<td>• Rent: £9,000</td>
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<td>• Insurance: £1,000</td>
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<td>12 months: 14,400, 9,730</td>
</tr>
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<td>1 Professional staff: £6,100</td>
</tr>
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<td>12 months: 14,400, 9,730</td>
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<tr>
<td><strong>Salaries:</strong></td>
</tr>
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<td>Director: Principal Social Worker (ROI) / Assistant Principal Social Worker (NI) / Principal Psychologist (either NI or ROI) grade</td>
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<tr>
<td>12 months: 99,290, 60,090</td>
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<td>1 Professional staff: Social Work Team leader (ROI)/Senior Psychologist/Assistant Principal Social Worker (NI) grade</td>
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<td>12 months: 82,410, 55,680</td>
</tr>
<tr>
<td>Administrative officer, Grade 5 (ROI)</td>
</tr>
<tr>
<td>12 months: 44,950, 30,070</td>
</tr>
<tr>
<td><strong>Non-Pay Expenses:</strong></td>
</tr>
<tr>
<td>Travel expenses</td>
</tr>
<tr>
<td>Heat, light and phone</td>
</tr>
<tr>
<td>PR, office materials, (£3,600 per staff member)</td>
</tr>
<tr>
<td>Recruitment costs: Staff Executive Board - (three days interviewing)</td>
</tr>
<tr>
<td>Advertising: £4,500</td>
</tr>
<tr>
<td>Travel: £1,300</td>
</tr>
<tr>
<td>Fees: £1,800</td>
</tr>
<tr>
<td>Subsistence: £800</td>
</tr>
<tr>
<td>12 months: 15,000, 8,780</td>
</tr>
<tr>
<td>Recruitment Costs: Site Teams -- (5 days interviewing)</td>
</tr>
<tr>
<td>Advertising: £5,400</td>
</tr>
<tr>
<td>Travel: £800</td>
</tr>
<tr>
<td>Fees: £560</td>
</tr>
<tr>
<td>Subsistence: £1,280</td>
</tr>
<tr>
<td>12 months: 10,200, 6,890</td>
</tr>
<tr>
<td><strong>Programme Costs:</strong></td>
</tr>
<tr>
<td>Research Evaluation (£250,000 over 4 years)</td>
</tr>
<tr>
<td>Training venue hire (four days)</td>
</tr>
<tr>
<td>Miscellaneous</td>
</tr>
<tr>
<td>12 months: 1,000, 880</td>
</tr>
<tr>
<td>12 months: 6560, 4,297</td>
</tr>
<tr>
<td><strong>Total</strong></td>
</tr>
<tr>
<td>£345,064, £233,151</td>
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</table>
These estimates represent upper end payscale costs. They will reduce depending on the experience of staff appointed. In addition, some of the costs are, as indicated, once-off set up costs which will not be repeated on a year-to-year basis. This applies as follows:

- **Furniture and Equipment.** This is a capital item. The provision for replacement at 20% a year will reduce the yearly budget beyond the first year.
- **Recruitment Costs.** These apply to recruitment for the Implementation Group and for the Site Team in order to establish the scheme. In future years recruitment to Site Teams will be undertaken by the Team in question. Provision for staff turnover should be made a yearly basis at 20% of recruitment costs.
- **Training Costs.** Implementation Group members will participate in Oregon Social Learning Centre Training alongside Site Team members. The cost for this is included in the Site Team estimate rather than that of the Implementation Group.

**Early Operation Phase**

Table 8.3 outlines an estimate of Site Team costs. This estimate is in respect of one Site Team's first-year costs. These reduce similarly, as do the costs for the Implementation Group, in the second and subsequent years. It would take some time for the scheme to come into full operation. Therefore, in the first two years at least, full operating costs will not be incurred.
Table 8.3: Multi-Dimensional Treatment Foster Care - Site Team costs

<table>
<thead>
<tr>
<th>Salaries</th>
<th>€</th>
<th>£</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Programme Supervisor (Social Work Team Leader Role) Senior Social Worker NI</td>
<td>82,406</td>
<td></td>
</tr>
<tr>
<td>1 Teacher (Degree and, H.Dip.), 1 Foster-Care Recruiter (Social Worker) 1 Family Therapist (Social Worker/Counselor/Psychologist) 1 Individual Therapist (qualifications as above) 1 Skills Trainer (Childcare Leader/Youth Worker) 1 Secretary Grade 5 (Role) Psychiatrist (20 sessions@£390)</td>
<td>59,950</td>
<td>52,859</td>
</tr>
<tr>
<td>74,044</td>
<td>74,044</td>
<td>47,918</td>
</tr>
<tr>
<td>44,979</td>
<td>6,000</td>
<td>441,200</td>
</tr>
<tr>
<td></td>
<td></td>
<td>53,050</td>
</tr>
</tbody>
</table>

Accommodation

Furniture and Equipment
Programme Supervisor
Five staff members (including PDR caller@£6,100 pp)
Secretary
Office equipment

Office Materials
Usage per person@£2600 for 7 people

Other Non-Pay Costs
Staff travel (5000 miles × 6 team members)
PR and foster care recruitment costs
Training and meeting venue hire
Furniture equipment replacement, and
Staff turnover costs

OSLC Training: Year One
Year 2 cost: £47060 (£31,800)
Year 3 cost: £8,770 (£5,930)

Foster Carers:
Fees (10 x £38,480)
Maintenance per child (10 x £13,000)
Foster carer incidental expenses (10 by £1000)
Break care (12.5% of fees)

Other Programme Costs
Miscellaneous Costs (10% office materials/and other non-pay costs)
Catering for meetings
Skills Trainer activities

Total

Tale 8.4 on the next page illustrates the breakdown of funding required by the Implementation Group and a Site Team during each of their first three years of operation. Because development will not be even, adding together the figures will not give an accurate total of the amount required.
Table 8.5 divides these costs into the first three years of operation as they are incurred concurrently by the Implementation Group and a Site Team.
Once set up, a Multi-Dimensional Treatment Foster Care Scheme must have a secure funding base that will allow it to give priority to the development and implementation of the programme. Its priorities should be focused on:

- ensuring that the best possible outcomes for young people are achieved
- providing the guidance and support to foster carers that the programme demands
- maintaining fidelity to the programme design

This will not be possible unless there is a guaranteed funding source, particularly during the Setup and Early Operation phases. If funding is provided by referring agencies on a fee per case basis, then serious problems could arise should referrals be slack. In the initial phases, a scheme would probably depend upon the availability of either EU or partnership funds. A long-term solution may be for statutory agencies to pay a scheme’s operational costs by an annual lump sum payment to the NGO. Foster care fees and allowances would be paid separately to the NGO, by the referring agency on a case-by-case basis as a youth enters a programme.

Table 8.7 demonstrates what this would involve. It further details the costs outlined above by separating the fostering element from the operational costs.
Thus, a referral agency would pay a standard fee per case of €57,000 (£39,000). The appropriate operational costs would be allocated yearly through a lump sum budgetary transfer to the lead NGO agency.

### Summary

- For the development of Multi-Dimensional Treatment Foster Care in the CAWT area there are three identifiable funding phases:
  - Commissioning
  - Start-up
  - Early operation
- If implemented, the costs for the commissioning phase would be the responsibility of the CAWT Family and Child Care Subgroup. These would be met from the funds allocated to the project.
- Once funding has been obtained for a proposed scheme, the CAWT Family and Child Care Subgroup should agree a contract with the Oregon Social Learning Centre to advise and provide training for the implementation of MTFC.
- Following their recruitment, the development and implementation of the scheme would be the responsibility of the Implementation Group and Site Teams.
- Estimates for the funding required should recognise that the amounts will vary during each of the three funding phases.
- Funding required for the development phases should be secure and should not depend on fees paid for cases referred.
- As the scheme moves to full operation, a means of protecting it against funding problems arising from referral variations should be considered.
- Depending upon the number of sites in operation, the cost for a child to participate in a programme will vary between €147,000 / £99,000 and €126,000 / £81,000 per year.

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<table>
<thead>
<tr>
<th>Number of Site Teams</th>
<th>1 Team</th>
<th>2 Teams</th>
<th>3 Teams</th>
<th>4 Teams</th>
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</thead>
<tbody>
<tr>
<td>Total Cost</td>
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<td>€2,324,000</td>
<td>€3,486,000</td>
<td>€4,648,000</td>
</tr>
<tr>
<td></td>
<td>£785,000</td>
<td>£1,570,000</td>
<td>£2,355,000</td>
<td>£3,141,000</td>
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<tr>
<td>Operational costs</td>
<td>€589,000</td>
<td>€1,178,000</td>
<td>€1,767,000</td>
<td>€2,356,000</td>
</tr>
<tr>
<td></td>
<td>£398,000</td>
<td>£796,000</td>
<td>£1,194,000</td>
<td>£1,592,000</td>
</tr>
<tr>
<td>Foster Care Costs</td>
<td>€573,000</td>
<td>€1,146,000</td>
<td>€1,719,000</td>
<td>€2,292,000</td>
</tr>
<tr>
<td></td>
<td>£387,000</td>
<td>£774,000</td>
<td>£1,161,000</td>
<td>£1,549,000</td>
</tr>
<tr>
<td>Foster Care Costs per Case</td>
<td>€57,000</td>
<td>€57,000</td>
<td>€57,000</td>
<td>€57,000</td>
</tr>
</tbody>
</table>
Chapter 9 -

Some questions and answers
9. SOME QUESTIONS AND ANSWERS

The programme

Why is fidelity to the programme important?

The evidence base which supports the outcomes that MTFC predicts depends on it being implemented as it was designed. It is a comprehensive programme. Applying it faithfully will give young people in adversity a real prospect of a stable future. In addition, it will allow accurate comparisons with programmes which operate elsewhere. Local circumstances which may create variations in outcomes will then be easier to identify and respond to appropriately. Conversely, validated outcomes from its application will create a compelling case for its extension. In both Northern Ireland and the Republic of Ireland, it is public policy to invest only in projects which can produce evidence-based outcomes that can demonstrate good value for money. Fidelity to the programme is necessary to ensure this.

How many children are placed in one home and what caseload would a case manager hold?

Unless there are siblings, and then only if it is clearly appropriate, one MTFC child would be placed in a foster home at a time. A principal of the programme is to eliminate or severely restrict the likelihood of negative peer influences. Placing children with similar difficulties would not be consistent with that. In addition, the implementation of the programme is focused and rigorous. It would require intense commitment of foster carers to implement it in respect of more than one child at a time.

The case manager who leads the Site Team will have responsibility for up to 10 cases managed by the team. As outlined already, every team member has a role to play in relation to each case. The case manager is the main liaison person with each foster carer. In addition, he coordinates the work of the team, reviews with them progress or otherwise being made and ensures that agreed plans are adhered to. Finally, he is the liaison person between the team and the Implementation Group and between the team and other agencies.

What is the definition of successful outcomes?

The desired outcome of MTFC is for young people who enter the programme to be prepared for a stable adult life. Confirmation of that would depend on longitudinal research. However, the successful completion of the programme is a predictor of that outcome. This is especially the case if:

- the young person’s behaviour has stabilised
- stable behaviour has continued post-treatment in a placement where the carers participated in the programme
- the young person’s educational experience was both stable and successful
- the young person had developed social networks which were both stimulating and involved positive relationships with other people
Is MTFC an argument against residential care?

This report proposes the introduction of MTFC in the CAWT area as an option for young people with challenging behaviour. Many of those may be in residential care. The research evidence\(^1\)\(^2\) is that those who do well in MTFC would not have done as well in residential care. The main reason for this is positive peer influences and stable and consistent parenting. These are key predictors of successful outcomes which are difficult to provide for in residential care. In addition, those who do make progress in residential care often cannot sustain that following discharge. This is a problem that relates to mainstream foster care also and has been identified in Britain, Northern Ireland and the Republic\(^3\). A solution which MTFC addresses is a throughcare plan which incorporates into a treatment programme work with post-treatment carers. The object is to provide continuity of care for the young person in which the consistency of the treatment programme is replicated.

There will be children for whom residential care is the most suitable option. However the issue is as for MTFC that:

- their needs should be comprehensively assessed
- their placement in residential care addresses those needs
- their care is provided in the context of a throughcare plan that identifies and prepares them for their post-placement care

What does 24/7 cover mean and involve?

The ethos of MTFC is a team approach to the care of a young person. The foster carers have the practical responsibility on a 24/7 basis. The team approach requires that there should be access to other team members when issues arise needing a decision.

The programme also recognises the importance of carers being supported in times of tension. Unless other team members are available, spirals of negative interaction may arise. This could have the potential to retard progress. Thus it is team members who provide 24/7 cover on a rota basis. They will know the carers and because they are part of the team, will be familiar with the children’s issues. However, because of their roles, it may not be appropriate for all team members to be on the rota. For instance, the young person’s therapist might have her role compromised if she had to make specific decisions relating to a young person’s behaviour. Generally, 3 - 4 members share the task on a week-on week-off basis. They are paid additional allowances for it which may be the subject of local agreement. In the CAWT area this is something that should be agreed with staff associations at the outset. This is particularly the case in the Republic of Ireland where there is as yet no system of after-hours social work cover.
How does the programme organise the necessary cooperation with statutory referral agencies?

Cooperation with statutory authorities is essential. Their responsibility for the child does not cease following referral. The detail and accuracy in the information they provide will be crucial in the initial assessment. Throughout the programme, they will retain their statutory responsibility for the child in respect of care plans, reviews etc. In addition their statutory duty to monitor and review foster carers continues. Finally they will have the task of identifying follow-on care arrangements and supporting the child on completion of the treatment programme.

Unless there is agreement at the outset, the scope for role duplication between statutory agencies and the MTFC team has the potential to undermine the programme. A number of measures in its design should mitigate against this:

• the CAWT Family and Child Care Subgroup will have liaised with the respective Social Service Inspectorates in Northern Ireland and the Republic of Ireland; issues that the programme needs to address in the context of standards will have been identified.
• The partnership structure represented by the involvement of the CAWT associate agencies and the makeup of the Executive Implementation Group will promote mutual cooperation.
• Active promotion by the Implementation Group and subsequently Site Teams of MTFC among statutory referral agencies will clarify issues and uncertainties.
• Routine agreement at the referral stage of every case will set out how mutual responsibilities are to be undertaken in respect of a child and in a manner that does not undermine progress.

What support is provided after the programme is completed?

From the start, the programme is targeted at the young person’s future following the end of treatment. Her future carers, ideally her parents, are active participants. Following her return, there will be up to six months aftercare from the Site Team. Then, the statutory agency resumes support. As already outlined it will be involved in the programme, albeit not intensively. It will provide support in the context of its statutory aftercare responsibility. The difference now should be that the young person will not display the same difficulties that characterised her behaviour previously. Consequently, the intensity of support required will be less than at the outset.

What about girls?

The programme is suitable for both girls and boys. Outcomes are equally positive across genders. However, girls do present different issues that require specific responses and interventions. In a study examining gender differences in initial risk factors and responsiveness to MTFC, girls showed more evidence of family disruption and chaos than boys who had more total offences and felonies at the time of the referrals. Carers revealed that they preferred providing placements for boys because it was less
stressful. This reflected a finding that boys began the programme with a higher daily rate of problem behaviours which decreased over time, while girls had the opposite pattern.

It is recognised that girls have multiple and complex needs in addition to controlling their criminal anti-social and often self-destructive behaviour. This is consistent with reported studies that, different to boys, severe anti-social behaviour emerges the first time in girls during adolescence. Long-term outcomes for girls are poor; they may become prostitutes, attempt suicide, engage in substance abuse or enter abusive relationships. Undoubtedly, for their children too, the prognosis is not good.

The MTFC programme individualises the treatment process for girls on a gender basis. Interventions are tailored to their specific problems to set the groundwork for the adjustment required for their stability. A particular issue relates to the treatment of trauma. A gender focus is followed very deliberately in approaching sensitive matters such as sexual abuse or physical violence. This consciously diverges from a trauma therapy approach. In designing the programme, OSLC was aware of a lack of randomised clinical trial evidence that shows positive outcomes from trauma-focused therapy with severely anti-social and multiply victimised girls. Instead, girls are encouraged to identify themes and topics to work on in the context of the individual therapy. Undertaking trauma work is only encouraged when a substantial period of stability has occurred and the girl has had some successes and experienced positive accomplishments.

A primary goal of the intervention with them is to stop the pattern of moving from one placement to the next, especially when placement changes are unplanned and are a reaction to a negative set of circumstances. The initial focus is on providing girls with a stable, safe, living environment and giving them emotional and practical support for coping with daily challenges. The emphasis then expands to include fostering a planning orientation aimed at countering their pessimistic life views and feelings of hopelessness.

Recruitment of Carers.

How are carers recruited, approved and placements monitored?

To some extent this depends on the structure adopted in the system design. The recruitment scheme proposed in Appendix 2 suggests a dedicated system across all fostering needs, which include:

- adoption
- break care (respite)
- short-term care
- long-term care
- high-support

Recruitment processes depend upon the local agreements. In Sweden, MTFC carers are drawn from those approved by the local statutory agency. If assessed as appropriate for MTFC by the Site Team,
they are then given specific training in the programme. In England and in Oregon, Site Teams do their own recruitment. However, in England Site Teams must have the approval of the local authority fostering committee that the carers are suitable. In all cases, just as in private fostering agencies, standards of care and the regulations associated with them have to be adhered to.

It is a task of the referral agency to identify a long-term placement in the absence of the natural family. A problem can arise if there is not a sufficient pool of carers available. In order to meet the programme objectives, long-term carers need to be identified at least three months into the programme. In England, some sites have directly recruited long-term carers themselves. Another possibility is for MTFC carers to agree at the outset to follow through as long-term carers. This latter option does have the effect of those carers being no longer available for MTFC placements.

Typically, high-support carers applying to be MTFC carers undergo standard foster care training. In addition, they receive specific training in the application of the programme. That training, depending on the programme, may vary from 12 to 20 hours and includes:

- an overview of the model
- a review of policies and procedures
- a four step approach to analysing behaviour
- techniques for dealing with challenging behaviour
- procedures for implementing an individualised daily behaviour management program
- techniques for reinforcing and encouraging progress

Who takes on the statutory “Link worker” role?

This remains the duty of the statutory social work service. As referred to above, this function does have the potential for duplication and to undermine the programme for an individual child. Preventing this would be accomplished by:

- the design stage agreement with the respective Social Service Inspectorates and statutory agencies as to how those duties should be undertaken
- agreement at referral on how the functions would be applied in each case
- frequent consultation with statutory agencies regarding the programme, its value and outcomes

Is the MTFC Programme Team composition sufficient to undertake all the recruitment, training, and support functions necessary for foster carers?

The initial recruitment of foster carers will be undertaken prior to young people being placed. The recruitment drive will seek to employ from 10 to 12 carers (depending on whether Break care is also to be provided for). The key team members who provide support to the foster carers are the Programme Supervisor and the Foster Carer Recruiter/Trainer. They will be the main coordinators of a recruitment
campaign, but they may also be assisted by other team members. Once the initial recruitment is completed, less intensive recruitment drives will continue on the basis of a provisional estimated foster care dropout rate of one per year.

Foster carer training is an essential component to the delivery of the programme. While the key team members again would be the Programme Supervisor and the Foster Care Recruiter/Trainer, both the Implementation Group and the Oregon Social Learning Centre will be central to the coordination of the training programmes for foster carers, at least in the early years of the programme. In subsequent years, certification of the local programme by the OSLC would reduce its involvement.

When the programme is fully operational, the Programme Supervisor and the Foster Carer Recruiter/Trainer will provide continuing support of foster carers. This will include daily contact, one-to-one meetings and group supervision. In addition, the group supervision is video recorded to facilitate additional review and support by the Oregon Social Learning Centre.

This recruitment, training and support structure is quite different to that which operates in regular foster care. However, the structure it involves is successfully applied in the United States and in England.

**What assessment and review is done on foster carers?**

Foster carers relate directly to the Programme Supervisor. She meets with them as a group once a week, she has contact with them on a daily basis through the Parent Daily Report and she is always available to them on request. Progress in each case is reviewed on a weekly basis by the team as a whole including the foster carers. Consequently, the design of the programme is based on continuous assessment and review of the foster carers and progress with the child.

This does not detract from or interfere with the statutory requirement of the referral agency to review the children in care and foster carers. As already outlined, processes for these functions being undertaken will have been agreed at the programme design stage and at the point of a young person’s referral.

**The foster care experience.**

**What is the occupancy level for foster carers?**

MTFC carers have one child placed with them at a time. An exception may be in the case of siblings and then only if it is appropriate. A child will generally stay between six months and a year, at which point he will either move back home or to his permanent carers. A different child may then be placed with them. As outlined above, circumstances may arise where MTFC carers continue as long-term carers. In such a situation other MTFC children will not be placed with them.
What are foster carers paid and do they still get the same when children move on?

MTFC carers are paid significantly more than regular carers. In Britain that varies between £300 and £500 per week. (€450-€750). Maintenance allowances for the child will be paid in addition. The fee continues to be paid, less the maintenance allowances, when the child is on a break or when they are between placements. Similarly, should they continue providing the post-treatment placement, they will continue to get a fee, albeit at a lesser rate. This would be a reflection of their differing situation which would now allow both carers to work outside the home. The detail of fee structures is an issue that would be clearly outlined in the programme design.

In recruiting carers, what are the competencies and capacities required to work with a multidisciplinary team?

Qualities sought from carers are:

- A demonstrated ability to work with children which may be reflected by:
  - their understanding of and responses to their own children
  - their experience of working with children in other settings
- An ability to work as part of a team and implement team decisions reflected by:
  - a willingness to attend and participate in meetings
  - acceptance of team decisions even if not the preferred one!
- A sense of humour which indicates
  - an ability to have a distance from problems
  - to learn from situations that have occurred

What support is offered to biological children?

The question is whether young people should be placed in families where foster carers also have children. The presence of foster carers’ own children does add a dimension for those children, the foster carers and the children placed with them. Research suggests that these can be positive and negative in their effects. Foster children can feel that they are treated differently by other children in the family. In one study, it was reported that foster carers’ children could suffer distress or conversely benefit from the presence of others less fortunate than themselves. In that study, the difference in age was important. The children placed were on average two years younger than the birth children. It may be, in the case of children placed on an MTFC programme, that it would be more desirable if there were not other children in the family. Alternatively, if there are, the carers’ children should be older and have a significant age difference from the children placed. In addition, the natural children should be prepared for the placement of a foster child and what it may involve.
The young people.

What children are excluded from the project?

There are very few exclusion criteria. The focus is on inclusion criteria, namely that the behaviour is so serious that it poses a risk to themselves, or others, and to the stability of their future lives. Young people who are not capable of understanding the routines and procedures, or who are unable to relate actions to consequences, will have difficulty participating in the programme. This would apply to individuals:

- with serious mental health conditions
- who are active substance or alcohol abusers
- who have moderate or severe learning disabilities
  ➢ the programme has worked well with children who have autistic tendencies

To what degree are children partners in the process? What about children’s rights and issues of participation and consultation?

The essence of the programme is a duty to meet children’s rights for assistance in dealing with difficulties that have arisen from their adversity. Because they are children, they cannot reasonably be expected to deal with these on their own. The programme aims to undertake this task in cooperation with the child’s parents whose primary duty this is. If parents are not available, the programme acts on behalf of society to which that duty then falls.

At the time of referral children are fully informed about the programme, how it works and the need for their active and committed participation. They have the right to refuse to participate in the programme; this right is based upon the reality that if uncommitted, their actions will inevitably undermine it. Once they have agreed, they are accepting the programme as a package. This includes the foster carers with whom they will have a very short introduction prior to placement. This underlines two things:

- The programme is a team operation, all the members of which, including the foster carers, are given.
- The young person’s difficulties are sufficiently serious that she will be unlikely to have a choice about alternatives either in respect of the type of programme, or the nature of care.

The structure of the programme is such that children are consulted at all times. Their opinions will be considered with respect to every decision made by the team. The programme provides a secure base in which children will be helped develop the ability to build relationships with other people. They progress in an environment which respects them, encourages them, and accepts their positives and negatives, 12. Influenced by the example of others, they gradually develop the capacity to make sensible decisions for themselves. This prepares them for the realities of life in an adult world where rational decisions are influenced by a balance between their own needs and the opinions, actions and examples of others.
Where do children go who don’t work out on the programme?

The programme is not a panacea. For some children it does not work out as planned. For them the alternatives that were available at the outset may come into play.

Does the model address attachment issues sufficiently? Will there be an expectation that the programme can heal the child?

This model is aimed at young people who have experienced serious difficulties and trauma in their early lives. It would be unrealistic to try to turn the clock back, so to speak. Without this programme, these young people would be likely to move from placement to placement. In the programme, the object is to help them to develop the ability to form attachments. Progress which they make on the programme is achieved in the context of a throughcare plan. This targets key relationships and social networks. Progress achieved in these domains is designed to provide a foundation for continuing progress beyond the end of the programme. The object is to help them lead a stable adult life. In doing so the focus is on social learning, but in the context of a secure environment which will positively reinforce both their efforts and progress.

As their behaviour improves, so does their ability to develop and maintain relationships with other people. The importance of developing the capacity to engage in close relationships, which is the foundation of behaviour improvement, cannot be understated. Comparatively brief opportunities for relationships may have long-lasting effects. The extent of their positive influence does not have to be related to their depth or length. Their effect may be to increase the possibility of more enduring relationships and social networks.

The programme is designed to make use of the positive attachments a child has already developed. First and foremost, where possible, his parents are an integral part of the programme. Work with them and their son is designed to help improve their relationship and build upon what may be shaky attachments. This is helped by the positive reinforcement that each member of the team gives the young person. The programme helps to increase a young person’s capacity to take risks in social interactions that increase both his confidence and security in making new relationships.

The benefits that MTFC can offer is supported by research. A study was undertaken to compare the secure and insecure attachment behaviour between children in regular foster care, in the Multi-dimensional Treatment Foster Care - Preschool programme and a community comparison.

Figures 9.1 and 9.2 outline the results.
Children in MTFC display high levels of insecure behaviour at the outset. This diminishes over time and at the end of 15 months approximates that of children in the community. Children in regular foster care do not show significant change. Over the 15 months, although the rate of behaviour is unchanged, it is more twice that of the children in MTFC preschool.
Figure 9.2 illustrates that children at the outset, when referred to MTFC, display very low secure attachment behaviour. Over the 15 months it increases significantly. While it does not reach the levels displayed by children in the community, it is nearly twice as high as that of children in regular foster care. For children in regular foster care, the change is not significant, but if anything secure attachment behaviour has decreased.

These results sustain the objectives underpinning MTFC. It supports foster carers in maintaining a consistent environment which emphasises both encouragement of positive behaviour and clear limits for problem behaviour. This enhances children’s ability to rely on foster carers to provide them with a secure base.

Mainstream foster care

*With investment in existing services would the same outcomes not be achieved?*

A study of mainstream foster care in Scotland considered whether foster carers’ expectations of the fostering task were met. It reported that nearly 50% of foster carers experienced serious and unexpected behavioural problems with the children in their care. These were associated with:

- a poor relationship with the fostering agency
- foster carers’ preparation for the task
- the support they received
- the unavailability of a social worker

It is undoubtedly the case that greater investment is required to support regular foster carers undertake the work they do. Investment in the KEEP programme described earlier is designed to do that. In addition, the scheme proposed in the CAWT area, through its close links with statutory agencies, will have the potential to assist the mainstream foster care system.

Nevertheless, as society becomes more complex it is inevitable that there will always be young people who present with difficulties that need a more intensive approach. Regular foster care would not be in a position to do this. Indeed it may be the case that many mainstream foster carers would not be comfortable with the team approach and shared decision-making that MTFC requires.

*Why is there an issue relating to the recruitment of mainstream carers post-treatment?*

The programme operates on the basis of a throughcare plan. This is targeted at a young person’s post programme placement, ideally with his parents, but if not, with alternative long-term carers. They will be available to provide care for him beyond 18 and until he is capable of living independently. They must be identified at least three months into the programme. This is because their participation in the programme is essential if the care they provide post-treatment is to mirror its consistency. Since the referral agency takes over responsibility for the young person post-treatment, it is generally their task to
arrange the post-treatment carers. This has been a problem for some referral agencies who have had difficulty recruiting carers. It is an issue that must be addressed if implementation of the programme is to be successful.

**Does the scheme not undervalue existing carers?**

The programme provides an option in addition to those already existing for children who present with challenging behaviour. As it is, other options are quite limited. For many of those children, regular foster care will not have been successful. The team approach, and the decision-making which underpins it, makes it quite different to existing regular foster care arrangements, and indeed those offered by private agencies. Because of the central position that carers occupy in the team, it values foster care.

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Chapter 10 -
Conclusion
10. CONCLUSION.

A New Chance - Cross-Border Foster Care Project was briefed to identify a high-support foster care scheme that would be suitable to introduce into the CAWT area.

It is the case that a large number of high-support schemes exist. Many of these offer high-support care to young people with challenging behaviour. The project brief specified such young people as its target group. High-support schemes typically fall into two groups:

- Those where foster carers are the primary agent for effecting change in the child and who have access to a range of supports to assist them in so doing.
- Those where a dedicated team, including foster carers, are the primary agents of change; it delivers as one unit a predetermined programme addressed to meeting the child’s needs.

It is the second group which has demonstrated the best results. Of those, the one which stands out is Multi-Dimensional Treatment Foster Care. This programme has been developed over a period of 20 years by the Oregon Social Learning Centre. The evidence of evaluation studies show very impressive outcomes compared to other schemes. In addition, the programme has been implemented in other countries, proving its durability and effectiveness across cultural boundaries.

This report has demonstrated that MTFC could address identified needs of young people in the CAWT area. Should it be implemented it could be expected to deliver the following benefits.

Young people

They would participate in a programme where:

- there would be a realistic prospect in a high-quality care environment to promote lasting and positive change in the cycle of disruption they have experienced in their lives
- there would be a definite and attainable plan for their ongoing care
- they would see clear progress in their ability to develop social skills and positive relationships with other people
- important personal relationships and social networks would be integrated into the programme to provide for the prospect of continuity of care and future stability in their lives
- emphasis is placed on their educational ability and prospects in a positive and encouraging environment

Social workers

They would refer to a programme in which:

- there are highly validated outcomes for a structure providing strong operational supports
- all of the child’s needs are provided for directly by the team implementing the programme
• their own role is clearly defined and limited in a manner which would free them to give
greater attention to the needs of other children not on the programme

Foster carers

Both regular and high support foster carers could expect to benefit:

• Regular Foster Carers
  ➢ by the existence of an alternative which may be suitable for a child in their care who
  presents serious management difficulties, and which offers the prospect of meeting
  his needs
  ➢ if the KEEP programme is available, from direct support available to them to manage
  a child in their care who is difficult
  ➢ from the knowledge and expertise resulting from the application of MTFC that will
  enhance the quality of care provided in the area where it is implemented

• High Support Foster Carers
  ➢ from the specific training provided to implement a rigorous programme that on the
  basis of sound evidence, promises to effect a positive change in a child’s life
  ➢ from the team approach to delivery of the programme which involves a sharing of
  knowledge, skills and responsibility
  ➢ from the rewards which result from achieving positive outcomes in the face of challenging
  tasks

Statutory agencies

Agencies which invested in MTFC would:

• be confident that the programme, when implemented faithfully, would deliver good
  outcomes in respect of many children whose previous care arrangements proved highly
  unsatisfactory
• have available to it a comprehensive programme within which all of a young person’s
  needs for specialist support would be met within the total budget allocated for the
  programme
• overtime, as the benefits of implementation produced positive outcomes, reduce their
  need for highly expensive residential and other alternatives for young people with
  challenging behaviour
• particularly if there was investment in the complete family of MTFC programmes (preschool,
  latency and adolescent), lead to increased satisfaction for foster carers, and consequently
  their retention rate could be expected to improve. This would be a direct result of the
  support that these programmes would give them in the management of children in their
  care.
The decision to invest in MTFC would require enthusiasm and commitment at the highest level. There are significant initial costs attached to its introduction, but which increasingly could be set against its benefits. These costs are necessary to ensure that a programme is established to be implemented according to its design. Failure to do this would run the almost certain risk of the promised outcomes not being met, with the consequent waste of the funds invested. The attraction of the scheme is that it does have a sound evidence base. In addition, it has as objectives a focus on a young person’s family and building up his ability to engage in social relationships and networks. This is consistent with statutory and public policy priorities in both Northern Ireland and the Republic of Ireland.

Summary

• Of many high-support foster care schemes that operate, Multi-Dimensional Treatment Foster Care stands out in terms of validated outcomes it has achieved in respect of the care of young people with challenging behaviour.
• These outcomes are dependent upon MTFC being implemented with fidelity to its design.
• Uniquely, a dedicated team as the primary agent of change that includes foster carers, delivers as a unit, a predetermined programme addressed to meeting the child’s needs.
• The significant cost associated with investing in MTFC should be set against the benefits that will accrue to young people, foster carers, social workers and statutory agencies.
• Once the programme is implemented as designed the promised benefits to them will be achieved.
APPENDICES
APPENDIX 1

Research survey method

In each Trust/Community Care Area front-line managers familiar with the children in care in their area were identified. The survey involved a once-off interview with each manager in order to provide non-identifying information about each of the young people for whom they had responsibility.

In asking about children in care presenting with management difficulties managers were asked to examine a list of young people in care and identify, without reference to individual files, the young people who were presenting with difficulties of such severity that they were likely to undermine their current placement. The assumption was that if the manager was not aware of a young person having such difficulties then he/she did not so present.

The aim of the survey was to identify:

- The number of children thought to require high support because they presented serious management difficulties.
- The number of children whose care provides the greatest challenge to their carers because they presented with intense management difficulties.
- The difficulties presented due to the following dominant behaviours.
  - Physical violence and/or seriously aggressive behaviour towards others.
  - Predatory sexual behaviour.
  - Persistent running away.
  - Persistent absconding from school.
  - Persistent serious offending.
  - Chronic disruptive behaviour during school or while participating in social activities.
  - Serious, chronic or persistent self-harming behaviour.
  - Serious social inadequacy reflected by withdrawal or severe social isolation.
  - Alcohol addiction or substance misuse.
  - Severely inappropriate behaviour.
  - Other specified reasons.

- The difficulties presented due to the child’s experiences of the following:
  - Persistent, serious or invasive sexual abuse.
  - Clinical psychiatric diagnosis that requires special arrangements.
  - Severe communication difficulties.
  - Chronic emotional difficulties arising from traumatic experiences or attachment difficulties.
  - Major physical or intellectual disability that requires special arrangements.

- The demographic and care profile of the children identified as presenting problems.
Reservations

It is reasonable to believe that the survey has fulfilled its objective in identifying "ballpark figures" for the number of children who may require high-support foster care in the CAWT region. Furthermore, it is likely that information relating to the profile of young people obtained may inform the provision of services across Trust/Community Care Areas. Nevertheless, there are a number of qualifications that need to be stated:

• The survey was conducted over an extended period between May to September 2005. Consequently, the analysis does not pretend to achieve the accuracy that would have been provided through a once-off census.

• The survey revealed significant differences across Trust and Health Service Executive Areas in the nature and rate of behaviours and experiences that create management difficulties for children in care. A more in-depth study to profile the children presenting such behaviours would clarify if these differences are due to demographic factors, varied levels of support available, or shortage (or otherwise) of resources.

• It is a surprising finding that significantly more girls than boys present with predatory sexual behaviour. Again, a more in-depth profile of those children is necessary to explain the reasons for this finding.

• Similarly, it is likely that there were variations between participants in their judgment of the behaviour that was categorised as serious, both in terms of its degree and type. Interviewers were rigorous in asking participants if the behaviour "was likely to undermine the placement". Nevertheless, examination of the results may suggest differences due more to individual interpretation rather than demographic trends. For instance, a very large number of behavioural difficulties were attributed to "attachment difficulties and traumatic experiences". While it is undoubtedly the case that issues of attachment and trauma have significance for a majority of children who are in care, further analysis of individual cases surveyed would establish whether such experiences were a major contributing factor to their presentation of serious management difficulties.
## Research Grid template

<table>
<thead>
<tr>
<th>No.</th>
<th>Gender</th>
<th>Status</th>
<th>Behaviour</th>
<th>Experience etc.</th>
<th>Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>50</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Name: ___________________  Title: ___________________

Trust/Community Care Area: ___________________

Date: ___________________
APPENDIX 2

Proposal for a Foster Carer Recruitment System

Introduction

Multi-Dimensional Treatment Foster Care operates in the context of a throughcare plan. This necessarily identifies the care arrangements for a young person on his admission to care and at his exit from it. This plan organises the programme in accordance with the young person’s needs. The essence of throughcare is that those responsible for his care during the programme and after it will be intimately involved in the delivery of the programme. The object of this is to ensure continuity of care for the young person so that the progress achieved during the treatment period will be maintained afterwards.

Young people entering the MTFC adolescent programme will be placed with carers recruited and specially trained to deliver the programme. If returning to their family homes is not an option, then long-term carers must also be available to provide post-treatment care and who will participate in the programme. The recruitment of adequate carers is essential. However, some of the high-support foster care schemes described earlier reported difficulty in accessing long-term carers. This is an issue which it is important to resolve. What follows is a proposal to organise the recruitment of all foster carers from a dedicated multidisciplinary team. This team could potentially service several Trusts/HSE Community Care Areas. If adopted it could recruit carers for:

- emergency foster care
- short-break foster care
- pre-adooption
- regular foster care,
- high-support foster care

What can make for successful recruitment

A marketing approach. A variety of approaches have been established as yielding positive results in attracting applicants to foster care. Some agencies employ a full-time worker to implement a recruitment strategy, to design marketing materials, nurture relationships with the local press, deliver information packs and follow-up expressions of interest within a guaranteed timeframe. A marketing approach may be said to concentrate on positive aspects of foster care in order to initially attract carers, then expand on the fostering task as challenges that when overcome give enormous satisfaction. Of critical importance here is the need for honesty in the presentation of foster care as a positive task.

Targeted campaigns. Findings in Britain identified the value of campaigns targeted at those employed in social care occupations (which provide 40% of all carers) and those aged between 41 and 55 (who were undertaking some of the most challenging cases). Foster carers in Belfast suggested that fostering agencies should target specific groups of people such as those involved in churches whose Christian
commitment would be a motivation to foster. Another suggested that there is a huge market in single female “fortysomethings” who are not aware that single people can foster3.

Full and open information to applicants. Each model placed considerable emphasis on giving foster carers full information on what was promised and expected of them from the outset. This included:

- information on fees to be paid
- the support they would receive
- the maximum number of children that would be placed
- the different ages targeted
- the numbers of children placed in each model

Introduction and training of carers. Many models use the recruitment and selection stage as a preparation and screening process for prospective carers. This involves meetings with the carers and members of their family, self-assessment techniques and pre-assessment training.

MTFC goes beyond the preliminary training offered by the other models at this stage. Thus, prospective applicants are introduced to the detail of the very structured programme that it involves. Apart from expediting their training, it is designed to test how prospective applicants measure up against the indicators that have been identified as appropriate for suitable candidates. In Sweden, the MTFC programme selects carers from those already approved and trained as regular carers by the local statutory agency. It then trains those carers specifically to implement MTFC.

Assessment of Carers. Because behavioural, attitudinal and social issues are equally important in the fostering task, the assessment should be multidisciplinary. It should include a behavioural profile of applicants, together with a full social assessment.

Involvement of foster carers’ children. There is longstanding evidence, often ignored, that the presence of foster parents’ own children near in age to the foster child makes breakdown more likely4. Studies report the negative impact of relationships between young people fostered and children of their carers on placement outcomes5. Evidence from a major study undertaken in Scotland suggests that it is only in the last 10 years or so that the impact of fostering on carers’ own children has been looked at from those children’s perspective. 40% of carers in that study said that their own children found the current foster child more difficult to get on with than expected6. Other research suggests that the psychological and emotional needs of foster carers’ own children should be given greater recognition in the recruitment process, at reviews, and in general that their views and what they can contribute to the foster child should be recognised7.

Foster care recruitment should involve the natural children of applicants in the assessment process. Not only does this give them an opportunity to inform and assess the reasonableness of their fears, but it respects their views as important partners in the fostering task.
A proposed recruitment process

A proposed process is illustrated in Figure Appendix 2.1. It is composed of a centrally-based team that will coordinate total recruitment for a wide geographical area. That team will be composed of PR/marketing professionals, social workers, psychologists, foster carers and if possible, young people. Its aim would be a positive promotion of foster care as a challenging and rewarding activity. Using recognised marketing strategies, it would target specific groups of people and design promotion campaigns to appeal to them.

Local fostering team members would participate in the induction and training programmes. The assessments would be undertaken and submitted to the relevant Foster Care Committee by the central recruitment team.
Appendix 2.1: Proposed recruitment assessment and foster care approval system

<table>
<thead>
<tr>
<th>Issue Promotion</th>
<th>Process</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Promotional Literature</td>
<td>• Strategic commercial marketing strategy.</td>
<td>• Coordinated by recruitment team</td>
</tr>
<tr>
<td>Media Advertising</td>
<td>• Continuous low-level promotion with periodic concentrated campaigns.</td>
<td>• Designed by marketing expert team member</td>
</tr>
<tr>
<td>Targeted Promotion</td>
<td>• Focus of marketing campaign to emphasise positive aspects of fostering.</td>
<td></td>
</tr>
<tr>
<td>Foster Carers Introductory Meeting</td>
<td>• Promotion invites applications to foster children.</td>
<td></td>
</tr>
<tr>
<td>Children’s issues</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Birth Family Issues</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support for Carers and Young People</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Familiarisation</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Offered to those responding to promotion. Delivered over 3/4 sessions.</td>
<td>• Coordinated by recruitment team</td>
</tr>
<tr>
<td></td>
<td>• Constitutes introductory training programme for foster carers.</td>
<td>• Includes:</td>
</tr>
<tr>
<td></td>
<td>• Outlines practical realities of fostering.</td>
<td>&gt; members of mainstream foster care team</td>
</tr>
<tr>
<td></td>
<td>• Discusses the main issues presenting for foster carers and young people.</td>
<td>&gt; foster carers</td>
</tr>
<tr>
<td></td>
<td>• Style and presentation is interactive.</td>
<td>&gt; other professionals</td>
</tr>
<tr>
<td></td>
<td>• Focus emphasises rewards to be gained from addressing challenges.</td>
<td>and stakeholders</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Induction Training</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foster care specific issues relating to:</td>
<td>• On conclusion, applicants are invited to consider what they have learned and apply to participate in the next stage.</td>
<td></td>
</tr>
<tr>
<td>• Short Break Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Emergency Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Relative Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Pre-Adoption Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Mainstream Care Only</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Mainstream and High-Support Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• High-Support Care Only</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Assessment | | |
| Family Social Assessment | • Offered to those who applied following completion of stage two. | • Coordinated by recruitment team |
| Psychological Profile | • A more thorough training programme for foster carers over 3/4 sessions. | • Undertaken by social work and psychologist team members. |
| Consultation with Carers Children | • Style of presentation practical and interactive. | |
| | • Details the nature of challenges and rewards for carers undertaking different types of foster care. | |
| | • Participants are observed and indicators of suitability, strengths and weaknesses for fostering noted. | |
| | • Participants invited to consider what they have learned, type(s) of care preferred and apply to participate in assessment process. | |

| Decision | | |
| Foster committee members: | | |
| • Partnership Representatives | • Consideration of assessment report. | • Coordinated by service director. |
| • Psychologist | • Interview with applicant foster carers. | • Director conveys decision to each applicant as appropriate. |
| • Foster Carer | | |
| • Other Disciplines (2) | | |
The model outlined above attempts to rationalise the recruitment, assessment and induction process for foster carers in one team. Its object is to:

- attract potential applicants to participate in the process
- facilitate them to self-select in or out of the process as their knowledge of what is involved increases
- use the induction process as initial training and as part of the assessment of suitability
- free up other foster care teams to target support to carers and young people, while still utilising their expertise in the induction process

The issue of training for foster carers is very important. There are a number of training models for foster carers in operation which are of a high standard. The model proposed does not attempt to distinguish between them or comprehensively outline the areas they should cover. Indeed, applicants may have decided before the assessment stage the type of foster care they prefer. It is arguable that their continued involvement in the assessment process should focus on the area of their choice. Nevertheless, at the end of the assessment stage that preference should be clearly identified, and in turn should be stated in the panel approval. This issue is of crucial importance for the matching of young people and the possible planning for high support in the future.

**Recruitment team**

The recruitment team will be composed as follows. The cost of its operation should be set against the savings in mainstream foster care teams who will no longer have responsibility for recruitment.

<table>
<thead>
<tr>
<th>Recruitment Team</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Composition</strong></td>
</tr>
<tr>
<td>Team leader</td>
</tr>
<tr>
<td>Marketing/media expert</td>
</tr>
<tr>
<td>Social worker/trainer (2)</td>
</tr>
<tr>
<td>Clinical psychologist/trainer (2)</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
A possible role for the CAWT Partners

Currently, the 10 Trusts and HSE Community Care Areas, comprising the CAWT partners, operate separate recruitment and selection processes for foster carers. Often the geographical areas are not large and the same or very similar processes are undertaken by a number of teams. In some areas limited staff resources may negatively impact on the success of their recruiting strategy. However, under the auspices of the CAWT partners, a cross-border Recruitment and Assessment Team could be established. It could undertake centralised recruitment and promotion and link in with the local Fostering/Family Placement Teams for the purpose of joint training and placement of young people. The advantage of such a structure would be to:

- maximise the use of resources
- free up staff in existing Family Placement Teams to increase the support offered to foster carers and young people
- bring a dedicated focus to recruitment with the object of increasing the availability of carers
- develop a high-quality recruitment and training process across Trusts and Community Care Areas

Summary

- Recruiting foster carers is a selling task which must be presented in a positive manner if it is to attract applicants. The professional expertise for this lies in commercial marketing rather than social work.
- An honest presentation of the realities of foster care requires a combination of skills which includes marketing, social work and foster parenting.
- Because the high support and mainstream systems are interdependent, staff from both should be closely involved in the delivery of foster care induction.
- A proposed recruitment process is designed to introduce and give preliminary, and then comprehensive, training to prospective foster carers in a staged manner. Applicants then self-select themselves prior to the assessment stage. Those who reach that stage are likely to be more highly motivated.
- Because behavioural, attitudinal and social issues are equally important in the fostering task, assessment should be multidisciplinary. It should also include involvement by, and serious consideration of, applicant children’s views on their parent’s intention to foster.
- In the proposed model, statutory Foster Care Committee approval would be in respect of specific types of foster care. A high-support scheme would only have responsibility for carers recruited exclusively for it. All others will be allocated to the appropriate teams i.e. Pre-Adoption to Adoption Team; short break and mainstream care to the mainstream Fostering Team.
- The CAWT partners could have a potential role in establishing a cross-border Foster Care Recruitment and Assessment Team that would service multiple Trust and HSE Community Care Areas.
## APPENDIX 3

### Cost calculations

#### Office Equipment and Schedule

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Camcorder</td>
<td>788</td>
</tr>
<tr>
<td>Display stands</td>
<td>257</td>
</tr>
<tr>
<td>Trimmer</td>
<td>450</td>
</tr>
<tr>
<td>Date stamp</td>
<td>40</td>
</tr>
<tr>
<td>Postal scale</td>
<td>150</td>
</tr>
<tr>
<td>Heavy duty stapler etc</td>
<td>60</td>
</tr>
<tr>
<td>Punch</td>
<td>22</td>
</tr>
<tr>
<td>Photocopier</td>
<td>1670</td>
</tr>
<tr>
<td>Shredder care kit</td>
<td>481</td>
</tr>
<tr>
<td>Printing calculator</td>
<td>50</td>
</tr>
<tr>
<td>Shredder</td>
<td>2051</td>
</tr>
<tr>
<td>Multimedia projector</td>
<td>956</td>
</tr>
<tr>
<td>Overhead projector</td>
<td>621</td>
</tr>
<tr>
<td>Screen</td>
<td>156</td>
</tr>
<tr>
<td>Multimedia trolley</td>
<td>165</td>
</tr>
<tr>
<td>Flip chart stand</td>
<td>137</td>
</tr>
<tr>
<td>White board</td>
<td>104</td>
</tr>
<tr>
<td>Binder</td>
<td>431</td>
</tr>
<tr>
<td>Laminator</td>
<td>300</td>
</tr>
<tr>
<td>Kettle</td>
<td>40</td>
</tr>
<tr>
<td>Tea coffee flask</td>
<td>122</td>
</tr>
<tr>
<td>Microwave</td>
<td>362</td>
</tr>
<tr>
<td>Fridge</td>
<td>226</td>
</tr>
<tr>
<td>Fire extinguishers</td>
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<tr>
<td>Four bookcases</td>
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</tr>
<tr>
<td>Fax</td>
<td>544</td>
</tr>
<tr>
<td>Conference telephone</td>
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<tr>
<td>Crockery</td>
<td>112</td>
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<tr>
<td>Cutlery</td>
<td>53</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>13149</td>
</tr>
</tbody>
</table>

#### Staff, Furniture Suite

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 laptop/peripherals</td>
<td>2630</td>
</tr>
<tr>
<td>One printer</td>
<td>185</td>
</tr>
<tr>
<td>Swivel chair</td>
<td>201</td>
</tr>
<tr>
<td>Coat stand</td>
<td>124</td>
</tr>
<tr>
<td>Clock</td>
<td>30</td>
</tr>
<tr>
<td>Memory stick</td>
<td>112</td>
</tr>
<tr>
<td>Dictaphone recorder</td>
<td>106</td>
</tr>
<tr>
<td>Desk</td>
<td>450</td>
</tr>
<tr>
<td>Bookcase/cupboard</td>
<td>700</td>
</tr>
<tr>
<td>Filing cabinet</td>
<td>363</td>
</tr>
<tr>
<td>Briefcase</td>
<td>91</td>
</tr>
<tr>
<td>Dustbin</td>
<td>40</td>
</tr>
<tr>
<td><strong>VAT @ 21%</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>5042</td>
</tr>
</tbody>
</table>

#### Office Materials per Person

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post its /</td>
<td></td>
</tr>
<tr>
<td>Paper Clips etc</td>
<td>50</td>
</tr>
<tr>
<td>Staplers etc</td>
<td>30</td>
</tr>
<tr>
<td>Paper and envelopes</td>
<td>500</td>
</tr>
<tr>
<td>Files and packaging</td>
<td>350</td>
</tr>
<tr>
<td>Punch</td>
<td>20</td>
</tr>
<tr>
<td>Computer printer ink</td>
<td>300</td>
</tr>
<tr>
<td>Photocopier toner</td>
<td>250</td>
</tr>
<tr>
<td>Flip chart pads</td>
<td>100</td>
</tr>
<tr>
<td>Flip chart markers</td>
<td>20</td>
</tr>
<tr>
<td>Videotapes</td>
<td>130</td>
</tr>
<tr>
<td>Binding spines</td>
<td>50</td>
</tr>
<tr>
<td>Binder covers</td>
<td>100</td>
</tr>
<tr>
<td>Laminating pouches</td>
<td>60</td>
</tr>
<tr>
<td>Diary/calendar/year planner</td>
<td>40</td>
</tr>
<tr>
<td>Health/safety items</td>
<td>150</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>2150</td>
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</table>

#### Total

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>VAT @ 21%</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>2600</td>
</tr>
</tbody>
</table>
### Secretary Furniture Suite

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>One printer</td>
<td>1830</td>
</tr>
<tr>
<td>One scanner</td>
<td>180</td>
</tr>
<tr>
<td>One desktop</td>
<td>1600</td>
</tr>
<tr>
<td>Desk</td>
<td>520</td>
</tr>
<tr>
<td>Coat stand</td>
<td>120</td>
</tr>
<tr>
<td>Clock</td>
<td>30</td>
</tr>
<tr>
<td>Dictaphone recorder</td>
<td>430</td>
</tr>
<tr>
<td>Workstation</td>
<td>150</td>
</tr>
<tr>
<td>Table</td>
<td>250</td>
</tr>
<tr>
<td>Shelving</td>
<td>1000</td>
</tr>
<tr>
<td>Dustbin</td>
<td>40</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>6350</strong></td>
</tr>
<tr>
<td><strong>VAT@ 21%</strong></td>
<td><strong>1330</strong></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>7680</strong></td>
</tr>
</tbody>
</table>

### Director/Programme Supervisor Furniture Suite

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 laptop/periherals</td>
<td>2630</td>
</tr>
<tr>
<td>One printer</td>
<td>180</td>
</tr>
<tr>
<td>One scanner</td>
<td>180</td>
</tr>
<tr>
<td>Conference table</td>
<td>600</td>
</tr>
<tr>
<td>Dictaphone recorder</td>
<td>110</td>
</tr>
<tr>
<td>Memory stick</td>
<td>110</td>
</tr>
<tr>
<td>Six chairs</td>
<td>600</td>
</tr>
<tr>
<td>Coat stand</td>
<td>120</td>
</tr>
<tr>
<td>Clock</td>
<td>30</td>
</tr>
<tr>
<td>Bookcase cupboard</td>
<td>700</td>
</tr>
<tr>
<td>Briefcase</td>
<td>90</td>
</tr>
<tr>
<td>Dustbin</td>
<td>40</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>5410</strong></td>
</tr>
<tr>
<td><strong>VAT@ 21%</strong></td>
<td><strong>1140</strong></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>6550</strong></td>
</tr>
</tbody>
</table>

### Site Team Accommodation etc.

- 1 programme supervisor, 5 staff, 1 secretary
- 2 single rooms, 3 double rooms, 1 conference, 2 consultation rooms

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rent</td>
<td>40,000</td>
</tr>
<tr>
<td>Insurance</td>
<td>1,000</td>
</tr>
<tr>
<td>Cleaning</td>
<td>3,000</td>
</tr>
<tr>
<td>Service Charges</td>
<td>700</td>
</tr>
<tr>
<td>Heat and Light</td>
<td>5,000</td>
</tr>
<tr>
<td>security</td>
<td>350</td>
</tr>
<tr>
<td>Telephone</td>
<td>3,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>53,050</strong></td>
</tr>
</tbody>
</table>
Treatment Foster Consultants Training
(Oregon Social Learning Centre)

Year One

OSLC Costs
Three-person, two-day site visit. (Including travelling: four days).
Three-person, 2-day consultation visits. (Including travelling: 12 days).
1. Three-person subsistence: 16 days 6,260
2. Airfares: three people by four visits @ €1250 15,000
3. Training etc. fee. 35,000
4. Incidental costs: local travel, parking etc. 1,200 57,460

Site Team Costs
Training in Oregon
1. Nine person, four-day site visit. (Including travelling: six days) 7,043
2. Airfares: Eight persons 11,250
3. Incidental Costs: local travel, parking etc. 700 18,993

Year Two

OSLC costs (50% year one) 28,730
Site Team costs (assume one staff turnover per year) 1,870
OSLC fee 15,000
Programme certification expenses 1,460 47,060

Year

Three.

OSLC costs (33% year one) 1,900
Site Team costs (assume one staff turnover per year) 1,870
OSLC fee 5,000 8,770
Bibliography


McDonald, G. (2003). “Helping foster carers to manage challenging behaviour: an evaluation of cognitive-behavioural training programme for carers.” In Stability in Foster Care, papers from a seminar funded by the Nuffield Foundation and organised by members of the Centre for Research on the Child and Family, University of East Anglia.


SSI Northern Ireland (2003). *Determinants of Residential and Foster Care Placements.* DHSSPSNI

