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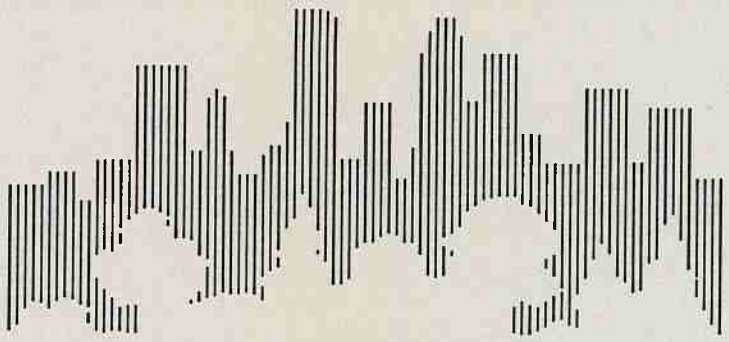

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MASTERS IN SOCIAL WORK THESIS

Sheila M. Schmaltz

Treatment Foster Parents' Perceptions of Their Role with the Primary Family of Foster Youth

1995

TREATMENT FOSTER PARENTS' PERCEPTIONS OF THEIR ROLE WITH THE PRIMARY FAMILY OF FOSTER YOUTH

BY

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CERTIFICATE OF APPROVAL

This is to certify that the Master's thesis of:

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DEDICATION

This is dedicated with much love and gratitude to

my grandparents, Edwin and Miriam Waa

and

my great-uncle, Theodore Waa;

who taught me what family was all about

and

to my daughters; Anne Marie, Alexa and Amy Jo,

who I hope to show that it is possible to accomplish your goals

in life, despite the obstacles that may arise.

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LKJ, who has shown me that family goes beyond blood, legal or even geographic ties;

And most of all;

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TREATMENT FOSTER PARENTS' PERCEPTIONS OF THEIR ROLE WITH THE PRIMARY FAMILY OF FOSTER YOUTH

EXPLORATORY RESEARCH DESIGN

SHEILA M. SCHMALTZ

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This study provides a description of treatment foster parents' perceptions of their role with the primary family of foster youth. This study also identifies a baseline measure of treatment foster parents' perceptions which can be utilized for agency program planning, policy and administration. The study sample includes 98 treatment foster parents licensed by the state of North Dakota, and supervised by Professional Association of Treatment Homes (PATH). A mail survey explores different levels of involvement between the treatment foster family and the foster child's primary family, whether or not treatment foster parents believe they can impact the primary families of foster youth, how they might impact the primary families of foster youth and what they consider to be important elements of a treatment foster care program.

Study findings with a 60% response rate, indicate that 98% of the treatment foster parents believe they can impact the foster youth and their primary families. Findings show that 57% of the respondents believe that the most effective ways they can impact the foster youth and their primary family are by role modeling or mentoring and 52% by having frequent, open communication.

A total of 56% of the respondants believe the most important element of a treatment foster care program is the ability to individualize treatment plans. Only 5% of the respondents believe that treatment plans should be family-focused compared to 51% who believe that treatment plans should be child-focused. This is incongruent with their other perceptions, which indicate at least moderate of foster parent involvement with the primary families of foster youth. This incongruency implies a need for agency program planning, policy and administration that reflects a family based service approach to treament foster care to maximize reunification efforts.

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SECTION I

INTRODUCTION

The United States has reached a state of crisis with the number of children living in out-of-home placements at an all time high. Not only is this nation serving more children, these children present with more complex problems and issues, and they are being served by fewer numbers of foster families at a greater cost than ever before, as indicated by the following paragraph.

North Dakota is not exempt from this crisis. The child welfare system needs to adopt a new way of thinking about serving children and their families. System changes need to be implemented that focus on the needs of children within the contexts of their families and communities. Treatment foster parents can play a critical role in enhancing the connection of children with their families. The Professional Association of Treatment Homes is committed to providing treatment foster care services to children and their families and ensuring that they receive quality services to meet their individualized needs. The goal of this research project is to expand the treatment foster care knowledge base in order to strengthen practice, program planning and policy development to keep that commitment within the context of social work practice.

Statement of the Problem

In the United States, approximately 600,000 American children lived in detention centers, hospitals, foster homes and mental health facilities on any given day in 1993. The majority, 464,000 children, were served in the foster care system alone (Edna McConnell Clark Foundation, 1994). The number of

children in foster care continues to rise. According to the American Public Welfare Association, an estimated 444,110 children lived apart from their families in out-of-home care in 1993, a 9% increase from 407,000 children in care in 1990 (Tatara, 1994). The National Commission on Foster Care (1991) reports that the number of family foster homes decreased from 147,000 in 1984 to about 100,000 in 1990. The number of children in out of home care increased from 276,000 to 444,110 during the same period.

The 1990 Census of Population and Households indicated that North Dakota had a total population of 638,000 people; 175,385 of whom were children between the ages of 0 and 17. Foster care figures from the North Dakota Department of Human Services indicate that there was a total of 1,469 children in care in 1993. The monthly average number of youth in care was 756, a number which has increased every year since 1985. The average length of stay in foster care in 1993 was 15 months. The percentage of children returning to foster care was 23% in 1993. This recidivism rate has also shown a steady increase since 1985 (N. D. Department of Human Services, 1994).

In response to the number of youth in need of services, North Dakota, in May, 1993, established an implementation plan for a multi-agency system of care for youth with severe emotional disturbances. The plan had considerable input from public and private service providers, organizations, clients and family members across the state. The plan stressed human dignity in that services be delivered: in partnership with parents; culturally relevant; provided in the

community; individualized; and integrated across agencies (Ismir & Ronnigen, 1993).

Purpose of the Study

In 1987, the U.S. Department of Health and Human Services designated unsuccessful family reunification as a child welfare system's outcome failure, citing national figures regarding the high proportion (29% to 33%) of children reentering placement (Federal Register 1987).

Previous research effort in this area has demonstrated a positive correlation between continued contact with the primary family during placement and both the adjustment of the child to the foster home and the probability of returning home (Weinstein, 1960; Sherman, Neuman, and Shyne, 1973; Thorpe, 1974: Holman, 1973; Fanshel and Shinn, 1978; Fanshel, 1982; Milner, 1987). Past research efforts have also shown that when parents are not effectively involved, the gains that children make in foster care are often negated or reversed if they return to an unchanged home environment (Maluccio, Fein and Olmstead, 1986).

A survey identifying the needs and attitudes of licensed foster parents in the state of Utah reported that 43% were dissatisfied with the extent to which their input was sought on reunification decisions (Lewis, 1991). In addition, Fish (1984) cites reasons for foster parent resistance to reunification. These reasons include a tendency to reject parents who have inadequately parented a child, feelings of fear for the child's safety and situation and of being powerless

to help if the child is returned to his/her family.

Scope of the Study

The Professional Association of Treatment Homes, (PATH), is a private, non-profit treatment foster care agency that was founded in Minnesota in 1972 by a group of foster parents who sought a more personalized and dignified approach to specialized family-based foster care for children and youth (Professional Association of Treatment Homes, 1994). In January, 1994, North Dakota's state administered treatment foster care program merged with PATH and is referred to as PATH - ND. By September, 1994, PATH - ND had reached it's capacity of thirteen social workers providing services to between eighty- five and one hundred youth across the state. Given the number of youth continuing to enter the foster care system, and the shortage of alternate care settings available, this could easily have been viewed as a dilemma. PATH - ND chose to view this as an opportunity to more closely examine the quality of services provided, particularly in the area of family reunification. Because family reunification is a successful outcome measure of foster care services, and because treatment foster parents play an essential role in reunification efforts, it was important that PATH - ND explore foster parents' perceptions of their role with the primary family of the youth in care. A baseline measure of current foster parent perceptions is necessary for future social work practice, program development, policy and administration that would meet the highest quality of care standards.

This study attempts to focus on:

1. Treatment foster parents' perceptions of their role with the primary family of the youth in care;

2. Treatment foster parents' perception of their impact on the foster child or his/her primary family;

3. Treatment foster parents' perception of important components to stress or include in the design of a therapeutic foster care program.

SECTION II

LITERATURE REVIEW

Historical Context

Historical Perspective of Foster Care

In 1972, Lela B. Costin traced the earliest examples of legal child-placing as a way of caring for dependent children to the Old Testament scriptures and in the Talmud. The practice of placing orphans in selected family homes was a special duty under law and was carried over into the early Christian Church. Children were boarded with "worthy widows" and the child's care was paid for by collections taken in the various congregations. By the second and fourth centuries, orphanages and "houses for infant children" began to grow and continued in much the same way for over a thousand years. England began the system of child placing for profit under indenture, which was given national sanction in 1562. This system was also taken to the American colonies and lasted until about 1875. In 1853, in the United States, Charles Loring Brace began the practice of taking needy and homeless children from the city and placing them with farmers and tradesmen in the rural areas. Other agencies soon joined in this practice of "placing out" and by 1929, 150,000 children had been placed in this manner in the United States. In the 1940's and 1950's, healthy Caucasian babies were placed in adoptive homes, but most children in need of care were primarily maintained in foster homes or institutions (Costin, 1972).

In 1961, Dr. Ray Helfer and Dr. C. Henry Kempe referred to "the battered

child syndrome" to describe the condition of children injured by their parents. The discovery of child abuse had a major impact on child welfare as states began to mandate professionals to report any suspicion of child abuse. The child welfare system responded with a strong emphasis on investigation, protection and removal and the number of children in foster care and institutional care escalated (Costin, 1972).

By 1977, there were more than 520,000 children living in foster care. The concept of "permanency planning" was developed as a process of helping a child live in a home where lifetime family relationships would be established (Terpstra & McFadden, 1991).

Large-scale research studies (Maas & Engler, 1959; Fanshel & Shinn, 1978) were documenting that foster care placement was no longer the temporary measure it was initially intended to be and children were "drifting" in care. Another influencing factor of the development of permanency planning was the child advocacy movement of the 1960's and 1970's, which was an outgrowth of the civil rights movement. There was an outcry for change and reform of the child welfare system. After a decade of criticizing the family, Americans in the mid-1970's felt a new concern about the family. Everything from political campaigns to television programs tapped into people's fundamental sense of the central importance of family. The academic world in general and field of social work in particular experienced an increased respectability of family sociology and family studies. Family therapy as a way of

helping was born. By the 1970's , the deinstitutionalization movement stressed caring for people in the "least restrictive environment", which in child welfare arenas meant "the most family-like" environment. With the enactment of Public Law 96-272, The Adoption Assistance and Child Welfare Act of 1980, child welfare agencies were mandated to be more family centered with the belief that every child had a right to be with a family. Reasonable efforts were to be made to prevent the removal of children from their homes, or to facilitate their return home. The permanency planning movement that initially focussed on adoption, experienced the unexpected outcome of reuniting many children with their biological families (Hartman, 1993).

Historical Perspective of Treatment Foster Care

Robert P. Hawkins (1989), relates the development of treatment foster care to the almshouses of the 1800's, which were gradually replaced by orphan asylums and state institutions serving only children. By the turn of the century, special institutions were being established for special groups of children including those labelled as mentally retarded, physically handicapped, delinquent and so on. These were probably the precursors of residential treatment centers, which have then contributed to the development of treatment foster care programs (Hawkins, 1989).

The residential treatment centers of the 1940's were somewhat more homelike and therapeutically oriented than earlier institutions. Children resided in cottages or similar living units. These smaller homes were staffed by child

care workers who would participate with professional staff in some form if milieu treatment. The professional staff would then also usually provide direct, office-based weekly counseling sessions, group therapy or family therapy. Child guidance clinics were established as a service for delinquent youth. They were even more highly professionalized than earlier services with staff psychiatrists, psychologists and social workers involved with each case. These clinics developed the practice of individualized assessment and treatment, usually based on psychoanalytic concepts, but also recognizing the influence of the environment to the child's problems. By the 1960's, there was increasing awareness of that the treatment of children focused too much on the child and not enough on other contributing factors in the child's environment. This is also when there began an emphasis on maintaining family involvement with regular weekend visits and the premise that therapeutic interventions can occur in a variety of settings. The deinstitutionalization movement of the 1970's and 1980's emphasized minimizing the restrictiveness of treatment programming, especially for people with mental health issues. Client advocacy groups added pressure for community-based services. The element of cost and cost effectiveness has also influenced the development of treatment foster care as it was less expensive, as well as less restrictive to residential and institutional care (Hawkins, 1989).

Historical Perspective of Family Preservation

Elizabeth Cole and Joy Duva (1990) trace the early roots of family preservation in the United States to President Theodore Roosevelt's first White House Conference on Dependent Children in 1909. The conference set forth the principles that home life is the highest and finest product of civilization and that children should not be deprived of it except for urgent and compelling reasons. After the conference, financial aid legislation authorizing "mother's pensions" was passed in many states. This assistance preserved the home and prevented the placement for a substantial number of children. The concept of mother's pensions took hold and turned in to the Aid to Dependent Children provisions of the Social Security Act of 1935 (Cole & Duva, 1990).

Foster care also continued to expand during this time and by the 1940's, some were beginning to question the benefits of foster care. A large-scale, national study by Maas and Engler in 1959 confirmed certain weakness of the then existent foster care system. They found that foster children had parents who seldom visited and seemed not to have plans for their return. The agencies that served the children also had vague and indefinite plans for the children's future. Two-thirds of the children were growing up in what was supposed to be a temporary foster home. After this study, the Child Welfare League of America called for the consideration of adoption for the children who would not be returning home, and the development of home-based services that would eliminate the need for many of the placements. During the 1970's, the findings

by Maas & Engler regarding long term foster care were confirmed by several other researchers including: Fanshel 1971; Fanshel & Shinn 1978; Gruber 1978; Wiltse & Gambrill 1974. Each study urged a reappraisal and restructuring of child welfare to include family preservation, reunification and adoption services (Cole & Duva, 1990).

During the 1970's, several federal laws were passed that were to redirect and initiate services to children and their families and to increase the number of families to be helped.

The Child Abuse Prevention and Treatment Act of 1974 required statewide systems of reporting and investigating child abuse and neglect complaints, which then dramatically increased the number of cases that came to the attention of child welfare agencies.

The Juvenile Justice and Delinquency Prevention Act of 1974 encouraged improvements in juvenile justice systems and stimulated experiments in alternatives to incarceration. To be eligible for federal funds, states had to use incarceration and detention as a last resort.

The Education for all Handicapped Children Act of 1975 granted children the right to be educated in the least restrictive environment possible, rather than having to be placed in special schools away from their homes. Fiscal incentives were offered to states choosing to participate, binding them to follow federal standards if they did.

The Indian Child Welfare Act of 1978 gave Native Americans control

over adoptions and foster care placements of their children, and encouraged alternatives to placement.

The Adoption Assistance and Child Welfare Act of 1980: Public Law 96-272 had the greatest impact on the creation of family preservation services. To be eligible for federal funding, states were required to have a plan that provided that reasonable efforts must in each case be made to prevent or eliminate the need for removal of children from their homes, or to make it possible for them to return home.

By the mid-1970's the Children's Bureau of the Office of Human Development began to stimulate the creation of services by targeting grants for the development of models of home-based services and focusing training grants on the reduction of family breakdown and the provision of supportive and preventive services (Cole and Duva, 1990).

Historical Perspective of Family Based Services

Beth Stroul (1988) looked at the beginnings of family based services, which has also been referred to as home-based services and in-home services. The concept of providing services in the home with a focus on strengthening families is not new. School systems have provided home tutoring programs, visiting nurses have provided home health care since the end of the nineteenth century and churches have historically ministered to the disabled in their homes. However, social service and mental health interventions did not share this history of family based services (Stroul, 1988).

In American society, family problems were often solved by placing "problematic" family members in out-of-home care, typically in restrictive institutional settings. Removing a child from his or her family was seen by child welfare agencies as the best means of protection and the mental health system believed that treatment could only occur in a hospital or other specialized residential setting (Stroul, 1988).

However, as early as the 1940's and 1950's, the St. Paul Family Centered Project in Minnesota experimented with home-based services and found that families experiencing even the most dysfunction and multiple problems began to improve. This project was instrumental in shifting the focus of services from the individual to the family. The key beliefs that evolved from this pilot project were: direct outreach to even resistant families, conviction that families can make positive changes, open communication, attention to the needs of the parents, focus on what the family wanted, extensive outreach to fathers and one case manager provider practical and tangible services. Many of these basic beliefs exist in current approaches (Rodenhiser, Chandy & Ahmed, 1993).

The Crisis Intervention Model, often referred to as The Homebuilders Model was developed in Tacoma, Washington in 1974 under the auspices of Catholic Community Service. It was specifically developed to prevent the out of home placement of children, who could remain at home safely with the provision of services. Based on social learning theory, the intent is to resolve the crisis that led to a child's referral for out of home care and to improve family

functioning (Wells, 1994). Basic components of this model include: therapist availability, flexible scheduling, location of services, flexibility in services delivered, intensity, worker caseload, brevity, limited objectives, staffing and evaluation (Rodenhiser, Chandy & Ahmed, 1993).

The Home-Based Model began in the Midwest also in the mid 1970's, and used family systems as its theoretical base. Families, Inc., a program developed in Iowa with the Iowa Department of Social Work is typical of this model. Its purpose was to provide an alternative to placement for adolescents. The family was the target for change, and services were provided in the home. Therapists use family systems theory to focus on the whole family and its interactions within and with the community. Concrete and supportive services are also included in this model (Rodenhiser, Chandy & Ahmed, 1993).

The Family Treatment Model, is a less intensive model used in either a home or office setting. There is greater emphasis on therapeutic interventions and less on the provision of concrete or supportive services. It was first used in 1980 in Oregon as an alternative to out of home care when a child was at risk of placement. Assessment, treatment and termination were the three stages of intervention. The therapeutic approaches were typically structural, strategic, brief, communications-based and multi-impact therapy (Rodenhiser, Chandy & Ahmed).

The Omnibus Budget Reconciliation Act of 1993, Public Law 103-66 will provide one billion dollars to states, over a five year period, for early

intervention, prevention and family support services. This bill provides for a range of services to address the needs of children and their families while maintaining the maximal level of connection possible (Wells, 1994).

Changing Demographics

A Changing Society

Jake Terpstra and Emily Jean McFadden (1991) describe the United States in the beginning of the 1990's as facing an unparalleled state of crisis in foster care. Not only are more children entering the foster care system, they are entering with more intense needs. Terpstra & McFadden (1991) and Barbell (1995) explain some of the reasons for the increased numbers of children in out of home care, their characteristics and severity of problems including:

The increase in the number of child abuse and neglect reports - About 2.9 million children were reported as abused or neglected in 1992, and increase of 50% since 1985 and 347% since 1976.

The increase in re-entry rates - Statistics documenting the flow of children in and out of foster care show that anywhere from 3% to 27% of children discharged to their families return to foster care.

The increase of continuous time in care - Beginning in 1990, there has been a rise in the average length of time children spend in foster care. If children are not discharged within a short time of placement, they are likely to remain in care for longer periods of time.

The impact of placements through other systems, mental health and juvenile justice systems in particular - Children previously served in mental health and correctional facilities are now being served in the foster care system.

The increase in the intensity and complexity of problems is attributed to factors such as:

Children entering care with more emotional and behavioral problems - Prevention services which enable many children to remain at home tend to screen out those children with the less severe problems, thus the percentage of those with "special needs" coming into care is greater. In addition, efforts of deinstitutionalization has meant that many children would otherwise have been cared for in group or residential care settings are now placed in family foster homes. These also tend to be children with greater needs.

The increase in the number of people living in poverty, also related to the increase of homelessness - While many factors can lead to the need for foster care, the most common denominator of families of foster care children is poverty.

The increase in alcohol and other drug related difficulties - Substance abuse is a factor in the placement of three-fourths of the children currently entering foster care. An estimated 375,000 babies are born each year exposed to drugs; approximately 5,000 infants are born yearly with documented fetal alcohol syndrome; and another 35,000 are born with other alcohol related birth defects.

The increase in HIV/AIDS related placements - An estimated 7,000 children are born annually to HIV - positive mothers. It is also projected that by the year 2000, between 72,000 and 125,000 children who will have lost their

parents to AIDS. There is also an increase in the number of children in foster care who are themselves HIV infected.

The increase of medically fragile and/or physically challenged children - Between 1984 and 1990 there was a 12% increase in the number of children entering foster care because of their own handicap or disability (Terpstra & McFadden, 1991; Barbell, 1995).

North Dakota's Children's Services Work Group also describes the problems that children in North Dakota face today as more widespread and complex than at any other time in history. The willingness and capacity of communities to meet the challenge has not kept pace with the ever growing complexity of needs. Both public and private systems have been unable to handle the increased numbers of children and families needing support, intervention or treatment. The nature of problems and issues are more complex than ever before, and often trained expertise is simply not available to respond adequately to those needs. A multi-faceted approach to supporting children and families must be emphasized. Adequate resources, both public and private, must be available to meet the needs of children and families. Resources include financial, technical, and knowledge assets as well as the human resources of parents, extended families, neighbors and other community members. Collaboration and partnerships provide a way to increase the capacity of existing resources and improve the effectiveness of the support and service systems (Children's Services Work Group, 1994).

A Changing Economy

The cost of out-of-home care is rapidly increasing. The federal and state governments spent an estimated $14.3 billion on foster care in fiscal year 1993, an increase from about $12.5 billion in 1992 (Terpstra & McFadden, 1991). North Dakota spent $7,676,000 on foster care in fiscal year 1993, an increase of over $1 million from 1992 (ND Department of Human Services, 1994).

The concept of permanency planning helped the number of children in out of home care reach a low of 275,000 in 1984. 137,000 of these children were living in foster family homes. However, by the end of fiscal year 1993, it was estimated by the American Public Welfare Association that 464,000 children were in foster care, an increase of 66% from fiscal year 1986. While the number of children entering the foster care system with more intense needs is steadily increasing; the number of family foster homes to provide care for these children is decreasing. The National Foster Parent Association reports that the 142,000 family foster homes in 1978 had decreased to 101,000 in 1992. This reflects a reduction of 29%. One of the reasons as to why the number of foster homes has declined is employment of women. With decreased earning power, many American families have found it necessary to have two incomes. Since regular foster care rates are less than the actual costs of caring for children, foster care cannot compete with the labor market. (Terpstra & McFadden, 1991).

Theoretical/Conceptual Framework

An Ecological Perspective

The ecological, or systems perspective is concerned with understanding the forces in the social field, and using those forces to effect changes in behavior. The language stresses connection and interaction. It recognizes that social systems are complex, and that there are multiple forces that may be mobilized. The aim is to expand the alternatives for behavior, so that more adaptive patterns can emerge (Minuchin, 1990).

While all families function as a social system, each family develops its own way of interacting. These family patterns are recurrent and serve to organize the behavior of family members. Boundaries define territory and function, regulating closeness and distance among members. Patterns of interaction make up the life of any family, and they shape the identity of individual family members. As families develop, the needs of its members change, and the family must accommodate to new realities. Negotiating transitions and developing new patterns is part of family life, and they happen to be major themes of the foster care experience (Minuchin, 1990).

From an ecological viewpoint, the foster child would be seen within a system of multiple care, in which foster parents, primary family and agency staff form a cooperating network around the child. Foster parents share responsibility and serve as partners with the primary family while the child is in care. To engage the primary family in reunification efforts, agency staff need to help them find

ways to help the service providers. It needs to be possible for them to stay connected to their child. For the child welfare system in general, this requires ecological thinking, flexibility, improving skills for supporting families and for mediating among the elements of a complex network. With the help of agency staff, foster parents will be relating more directly with the primary family, seeking and sharing information, empowering the family, and helping the child maintain a meaningful relationship with the primary family while adapting to the foster home environment (Minuchin, 1990).

Family preservation and foster care are naturally linked from the ecological perspective. It is critical for foster parents to understand and to blend the two modalities. First, the goal of placement typically is reunification, as soon as the family can safely care for the child. Secondly, the family probably will not be successfully reunited unless the sense of family has been preserved which is usually done through family contact during placement. Foster parents need to understand that the primary family is the natural long term environment of the child, and that they have an important role in preserving the connections so that the family can reunite successfully (Minuchin, 1990).

Treatment Foster Care Approach

Meadowcroft, Thomlinson & Chamberlain (1994) describe treatment foster care as an expanding alternative child welfare and child mental health service for meeting the needs of children with serious emotional and behavioral disturbances and their families. Treatment foster care programs provide

intensive, foster family-based, individualized services as an alternative to more restrictive residential placement options. Children and their families receive coordinated, multisystemic services while the child lives in the normalizing environments of a protective family, school and community. Treatment foster care programs were developed in response to the limitations of the current child welfare system, the crisis in traditional foster care services and the lack of family-based mental health interventions for children who are not able to live with their own families (Meadowcroft, Thomlinson & Chamberlain, 1994).

The Foster Family-based Treatment Association is an agency-led organization of treatment foster care providers established in 1988 with the initial purpose of defining and refining treatment foster care practice . FFTA identifies certain core values and principles which lie at the heart of treatment foster care. These include a strong belief in normalization as a treatment principle and in the power of family living as a normalizing influence. Kinship plays an important role in the formation of identity and self-worth. All relationships which give a sense of family belonging to children and youth are supported. All children and youth have a right to a permanent family. Family reunification, adoption, kinship care and other long term stable family living arrangements are supported to achieve that end. Values that are more specific to treatment foster care include a strong commitment to "do whatever it takes" to maximize the child's chances to live successfully in a family and community. Treatment foster care providers serve children and youth who typically would otherwise be treated in more

restrictive institutional settings, but do so in the larger community environment. Because providers must deal with so much more of the child's world than is usually addressed in traditional residential treatment, they must have a high degree of flexibility, innovation and responsiveness to individual needs and circumstances. There is a strong commitment to individualized care and services are designed to fit the particular needs of each child, rather than the institutional or administrative convenience of the program itself (Foster Family-based Treatment Association, 1991).

Family Preservation Approach

Family preservation services are defined as a specialized modality of serving families, which evolved from the broader categories of "Home-Based Services" (serving families in their homes and communities) and "Family-Based Services" (which focused on the whole family, and the interconnections between individuals) (Pecora, Haapala & Fraser, 1991). The family, as a dynamic and interacting unit and its relationship to the community in which they live constitute the basis of assessment and treatment. Services are family focused, with the interaction among family members, and the associated behaviors, as the point for change. An individual's problems and changes in the behavior affect the whole family in some way. Families are also seen and treated as part of a larger community that can weaken or support them. Effective family preservation services use and work with the social environment and explore a variety of formal and informal support options (Cole & Duva, 1990). Specific

characteristics of family preservation services are: clinical and concrete services delivered in the home, the therapist's availability to clients 24 hours a day, small case load for therapists and short duration of services from 4 weeks to 6 months (Pecora, Haapala & Fraser, 1991).

A central value in family preservation services is the belief that all children need stable families and that many families in trouble, even those with serious problems, can change and often want to do so on behalf of their children. Instead of being overwhelmed by the complex problems of families, crises are viewed as an opportunity for families to learn new skills. These skills will then enable them to better cope with stressful situations in the future. Family preservation services give families the chance to learn and adopt new behaviors and help them make better choices for their children. Agency staff respect families' values and beliefs, treat parents as colleagues and clients, and build on their strengths. Such collaborations can produce more far-reaching and lasting change than focusing on weaknesses and pathologies. This respect is an even added impetus to change (Edna McConnell Clark Foundation, 1994).

Family Based Service Approach

The National Resource Center on Family Based Services defines family based services as an approach which views the family as the client, emphasizing both the interdependence of family members within the family and the crucial connections between the family and its larger environment. Seeing the family as a social system that functions and transacts within its environment

evolved from General Systems Theory which focused on the relatedness and interdependencies of the parts and the whole (National Resource Center on Family Based Services, 1988).

Marcia Allen (1994), has identified 10 common elements that define a family based service approach. These include: a) families are valued as partners and colleagues, b) programs work toward family empowerment, c) services focus on strength and competencies of family members, not their deficiencies, d) services are culturally responsive, e) services are accessible and available, f) the needs of all family members are assessed, g). staff help families set their own goals, h) resources for solutions are identified both inside and outside of the family, i) programs help families identify and build their own support networks, j) services are terminated when goals are achieved. Treatment foster parents can provide the lead support and empowerment to families in reunification. The two key elements in facilitating this process are 1) treatment foster parents should be recruited from the same geographic communities where the family lives, and 2) the job of the treatment foster parent is to support the family unit, not just the child; like extended families, or parenting partners (Allen, 1994).

Blumenthal and Weinberg (1984) stress that foster parents are in a position to play a significant part in maintaining ties between children and their parents, rebuilding the parent-child relationship, and reestablishing the family unit. They have an important role in helping parents resolve the problems that led to

placement. Foster parents are invaluable resources to agencies and parents. Two of the most important roles they have are team member and "family aide". They do not assume parenting responsibility; they share it. They serve as supporters, teachers, models and advocates to the primary family. These new roles may be more difficult, challenging, and time consuming than in the past, but are also potentially more rewarding and satisfying (Blumenthal and Weinberg, 1984).

SECTION III

RESEARCH QUESTIONS

To aid in the strategic planning for future program development, policy and administration, it is important that PATH - ND ask several questions of it's foster parents. By exploring treatment foster parents' perceptions of their role with the primary family of the youth in care, PATH - ND can gather a baseline measure of its family centered approach to treatment foster care. Do PATH - ND foster parents even believe they can impact the foster child and his/her primary family? What do they believe are important components to include in the design of a treatment foster care program?

SECTION IV

METHODOLOGY

To explore the research questions relating to treatment foster parents' perceptions of their relationship with the primary family of foster youth, an exploratory design study was used. Treatment foster parents were invited to participate in a mail survey. The questionnaire was designed by this investigator to explore treatment foster parent perceptions of: 1. their role with the foster child's primary family, 2. their impact on the primary families, and 3. elements that are important to include in a treatment foster care program. Questionnaire responses provided both qualitative and quantitative data. All available data were analyzed to identify recurring patterns and themes. The findings are summarized in narrative form and illustrated with tables in the Findings section of this study. Prior approval for this study was granted by the Augsburg College Institutional Review Board (Appendix A), and by the Professional Association of Treatment Homes Research Committee, (Appendix B).

Definition of Terms

Family Preservation - A unique and powerful set of interventions at the point of a family crisis when removal of a child from the home is imminent. The goals of service are to keep the family safe, avoid unnecessary placement of children in substitute care and improve family functioning so that the behavior that led to the crisis is less likely to occur. It is also known as Intensive In-home Services (Cole & Duva, 1990).

Family Reunification - The planned process of maintaining the connection of children in out-of-home care with their families by means of a variety of services and supports to the children, their families, and their foster parents or other service providers. It aims to help each child and family to achieve and maintain, at any given time, their optimal level of connection - from full reentry of the child into the family system to other forms of contact that affirm the child's membership in the family, such as visiting (Maluccio, Warch & Pine, 1993).

Parent Involvement - the inclusion and/or participation of parents in activities, tasks, services and decision making throughout the time the family is involved with the foster care process. Foster parents take an active role and are significant contributors in the reunification process (Blumenthal, 1984). Different levels of involvement can be classified as minimum, moderate and maximum involvement, depending on the specific tasks and activities of the foster parents.

Primary Family - The terms "parents" and "families" are used in a generic sense to refer to those parents or care givers who are meaningful to the child and with whom reunification is being considered. For the most part "primary" refers to biological parents or families; however, connections can also include adoptive parents and families, grandparents and other extended family members, primary caregivers, or other significant attachment figures the child may have, including foster parents (Warsh, Maluccio & Pine, 1994).

Outcomes - A change (or lack of change) in the condition, functioning, or

problems of a client that can be attributed to the program interventions.

Respite - A service provided to allow treatment foster parents relief for a designated period of time from the stresses of caring providing treatment foster care. Respite may also be provided to allow primary families from the similar stresses of caring for their child.

Treatment/Therapy - This involves deliberate attempts to produce a change in viewpoint or action leading to solution.

Treatment Foster Care - The Council on Accreditation of Services for Families and Children defines treatment foster care as an intensive system of supportive and clinical services for emotionally disturbed and behaviorally disordered clients for whom foster care is the appropriate placement. The Foster Family-based Treatment Association defines treatment foster care as a program for children, youth and their families whose special needs can be met through services delivered primarily by treatment foster parents trained, supervised and supported by agency staff. It is also known as Therapeutic Foster Care, Specialized Foster Care.

Population Characteristics

The sample for this study was taken from the population (N = 161) of all foster parents licensed on December 1, 1994 by the North Dakota Department of Human Services to provide therapeutic foster care under the supervision of the Professional Association of Treatment Homes - North Dakota Division. PATH - ND is licensed as a child-placing agency by the North Dakota Department of

Human Services and accredited by the Child Welfare League of America Council on Accreditation.

According to the 1994 PATH Annual Report, North Dakota PATH foster parents range in age from 21-65, with the average age being 40 years old. Almost 97% of North Dakota parents are Caucasian, 2% Native American and 1% Multiracial. The average years of education completed by North Dakota foster parents is 15 years. Over 74% consider themselves to be living in urban areas and 26% live in the rural areas of North Dakota (PATH, 1994).

Sampling Method

A list of 161 eligible study subjects was compiled by the PATH North Dakota Division Administrative Coordinator and the Fargo Area PATH Office Manager. All PATH - ND foster parents that were licensed on December 1, 1994 were mailed a letter of explanation and invitation to participate in this voluntary study (Appendix C). These foster parents were located throughout the state, and clustered by PATH offices located in Williston, Minot, Devils Lake, Grand Forks, Fargo/ Wahpeton, Jamestown, Bismarck and Dickinson. A total of 98 foster parents responded to the mail survey within the designated time frame of December 7, 1994 through January 7, 1994. This 30 day time frame was chosen to insure timely completion of this MSW thesis project. It did provide a 60% response rate.

Data Collection Instrument

All study subjects were asked to complete a twenty-four item questionnaire

(Appendix E), which was developed by this investigator for this study to obtain treatment foster parents perceptions of their role with the primary families of foster youth. The questionnaire consisted of both open-ended and multiple choice questions. Questions were designed using the 1994 Family-Centered, Community-Based discussion paper by Berlin, Allen and Robinson and their suggested "role of the treatment foster parent" as a guide. Questions were also included that would provide demographic data. The questionnaire was pre-tested first by the PATH - ND State and three Area Directors and social workers. It was pre-tested a second time by North Dakota non-PATH related foster parents and a Minnesota PATH foster parent and finally, a third time by Augsburg College MSW students in Research Methods II-A.

Data Collection Procedures

On November 16, 1994 a PATH-ND Area Directors' meeting was held in Fargo, ND. This research proposal was presented at that time. Information was provided which was then taken to social work staff so that they understood the research project and were more prepared if foster parents had any questions about this study. On November 22, 1994, the Augsburg College IRB granted approval for the research project. On December 3, 1994, the research proposal was reviewed and approved by the PATH Research Committee and the full PATH Board of Directors. On December 9, 1994, 161 packets containing the questionnaire (Appendix E), a cover letter of explanation and invitation to participate (Appendix C), and a request for education credit (Appendix D) were

mailed. If foster parents chose to participate, they were instructed in the cover letter to complete the enclosed questionnaire and return it in the enclosed self-addressed stamped envelope. It was estimated that the survey would take no more than 60 minutes of their time to complete. Foster parents were offered one hour of training credit because of the time and thought required for participation. They were offered 1/2 hour of credit for completing 1-12 questions and 1 hour of credit for completing 13-24 questions. To be utilized for this research project, questionnaires had to be returned by 01-07-95. The toll-free telephone number for the PATH-ND state office in Fargo, as well as local numbers were provided if anyone had questions or concerns.

Protection of Human Subjects

Treatment foster parents were informed of the voluntary nature of this study in the letter of explanation. They were also informed and assured that confidentiality and anonymity would be maintained throughout the study. Treatment foster parents were informed of potential emotional risks of participating in this study. They could skip any questions they chose. Coding techniques were used rather than any identifying information. The individual data gathered for this study were not made a part of any record at PATH, other than recording the education credit if the foster parent elected to receive it. They consented to participate in the study by completing the questionnaire and returning it in the envelope provided.

Data Analysis

D H Research, Fargo, ND used the Statistical Analysis Program (SAS) to tabulate the frequencies of responses. Univariate analysis examines the distribution of responses for one variable at a time to provide a description of the characteristics of the sample (Rubbin & Babbie, 1993). The sample population characteristics examined for this study included regional geographic location, area geographic location, gender, age group, marital status, race, education, total years of foster care experience, and total number of foster children provided care. Individual responses to the questionnaire were also examined to identify recurring patterns and themes. The findings are summarized in narrative form and illustrated with charts in the Findings section of this study.

SECTION V

FINDINGS

Sample Characteristics

Foster parents from all eight regional offices responded to this survey, as shown in Figure 1. At 30%, Fargo represented the highest percentage of the sample which could reflect its higher population. Grand Forks had the lowest percentage of the sample at 3%, which could be attributed to its August 1994 transition date.

FIGURE 1

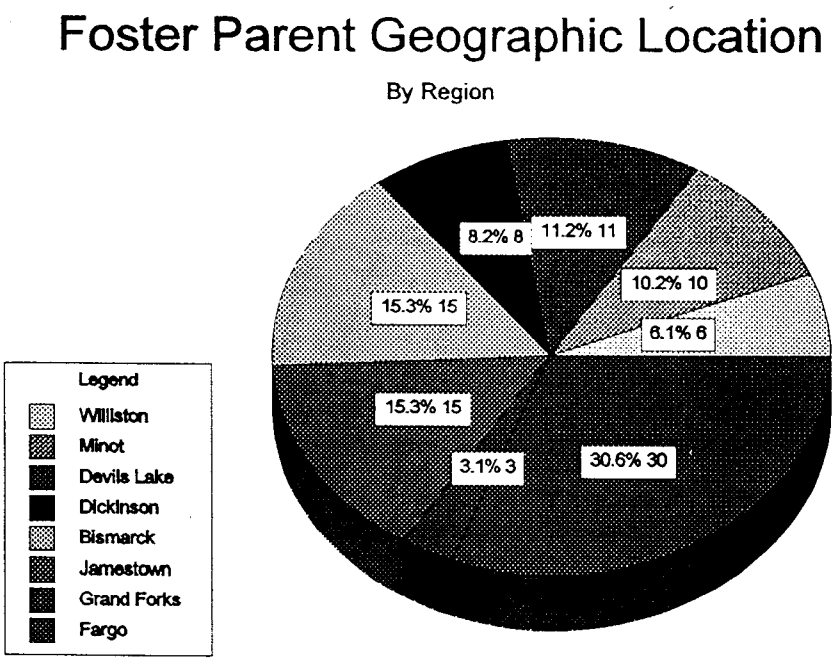

Figure 1. Foster parent geographic location. (n = 98)

Regional PATH offices are grouped according to their geographic location are supervised by an Area Director located in the area office. The Williston, Minot and Devils Lake offices make up the North Western Area, with Minot serving as the area office. The Dickinson, Bismarck and Jamestown offices make up the South Western Area with Bismarck serving as the area office. The Grand Forks and Fargo/Wahpeton make up the Eastern Area with Fargo serving as the area office. The foster parent sample was fairly equal in it's distribution by area, with the South Western Area having 38% of it's population respond, as shown in Figure 2.

FIGURE 2

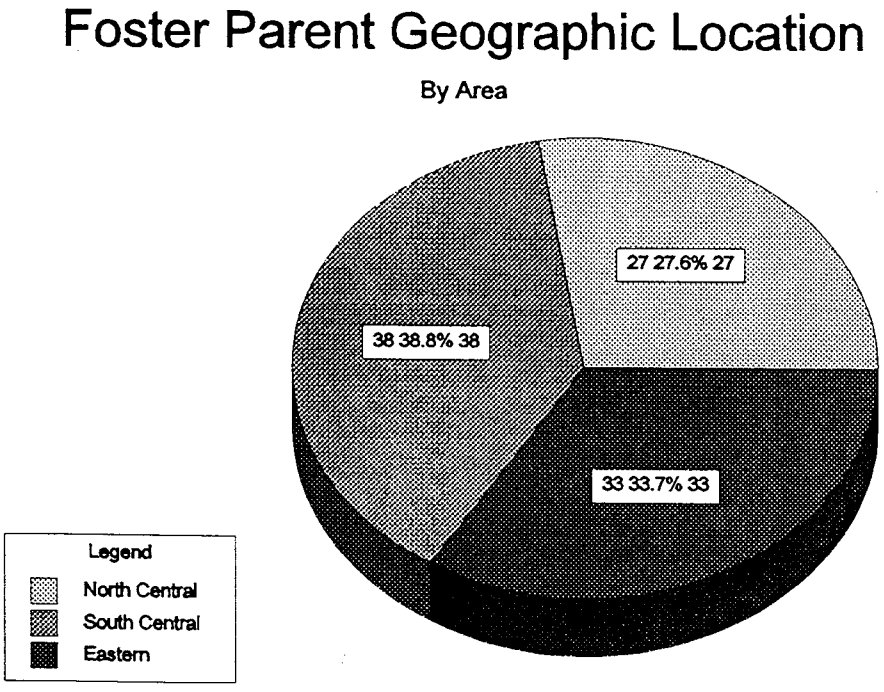

Figure 2 Foster parent geographic location by area. (n = 98)

The sample was divided almost equally by gender, with 46% of the foster parents being male and 54% being female. This is reflective of the total population which has a slightly higher percentage of single female foster parents. The largest percentage of the sample, 43%, was in the 41-50 year age group, followed by 33% of the sample in the 31-40 year age group, as depicted in Figure 3.

FIGURE 3

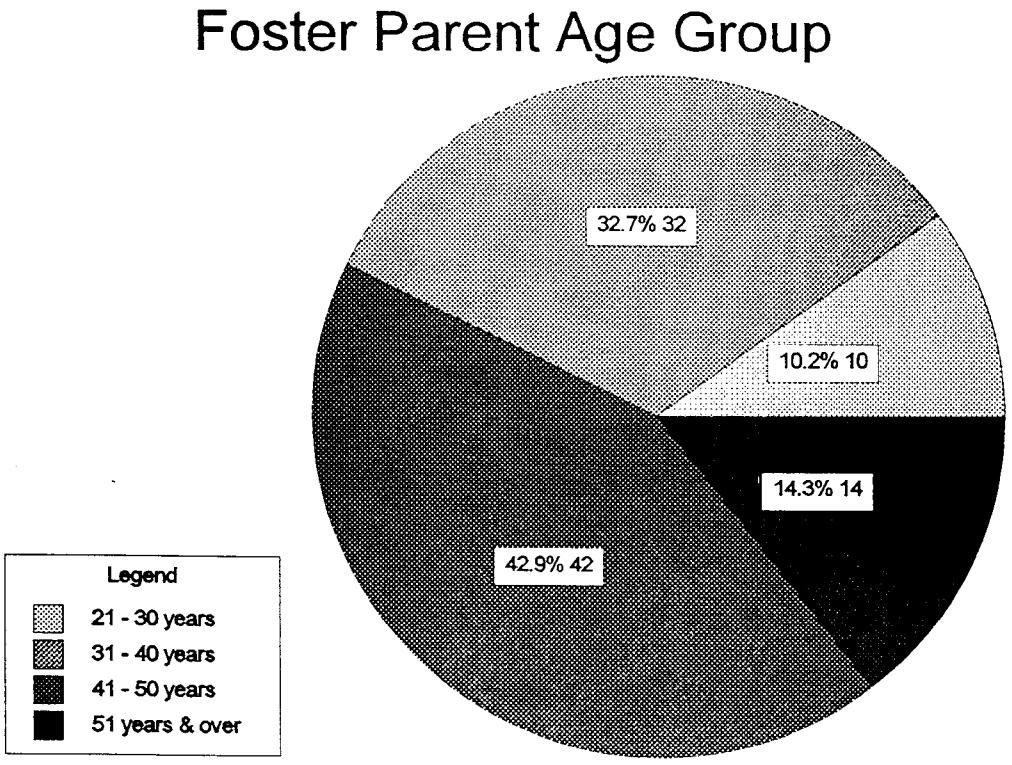

Figure 3 - Foster parent age group. (n = 98).

The largest percentage of the sample, 37%, had 12 years of education. A combined total of 36% of the foster parents had 16 to 18 years of education, as shown in Figure 4.

FIGURE 4

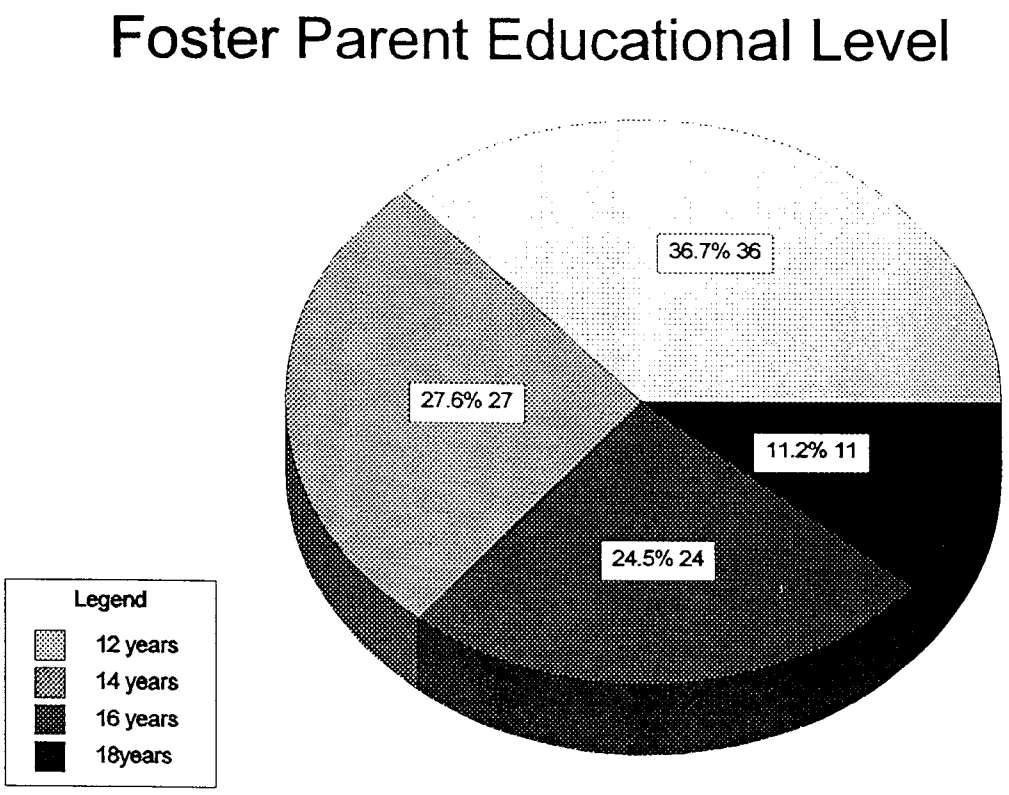

Figure 4 - Foster parent educational level. (n = 98)

The race of the foster parent sample included 92% Caucasian, 6% Native American and 1% Multiracial. This could reflect the fairly homogenous population of the state of North Dakota.

Over 43% of the sample had 1 to 3 years of foster care experience, as depicted in Figure 5. This can largely be attributed to the short time that PATH has existed in North Dakota and the new foster parents that were recruited when the program began.

FIGURE 5

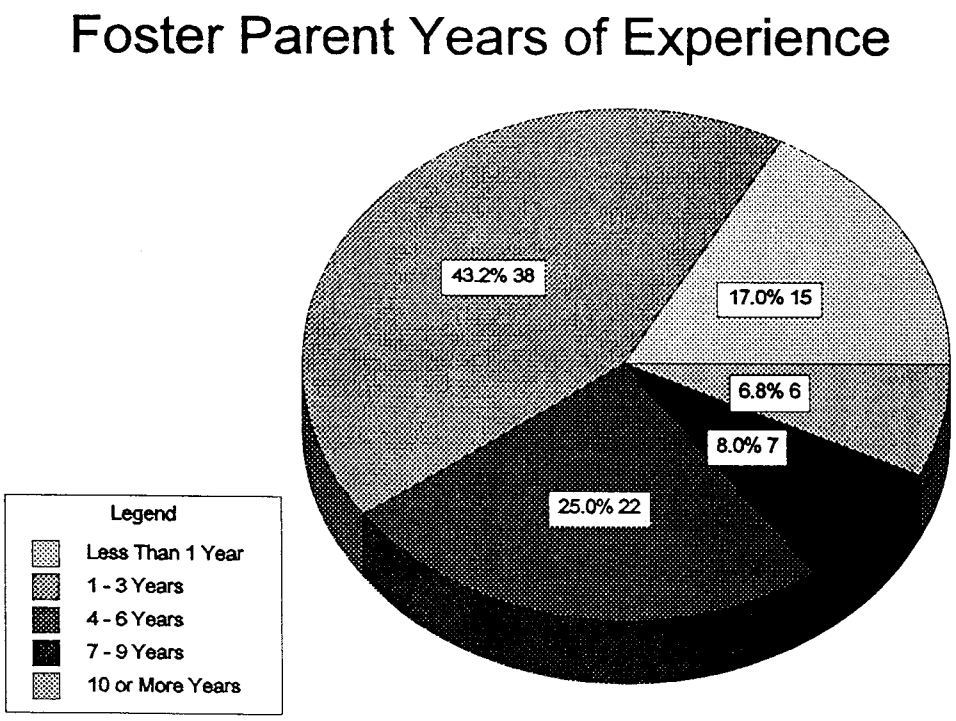

Figure 5 Foster Parent Years of Experience. (n = 98)

The largest percentage of the sample, 38%, had provided foster care to 2 to 4 youth. The combined percentage of 50% of the sample had provided foster care to a total of 5 or more youth, as shown in Figure 6.

FIGURE 6

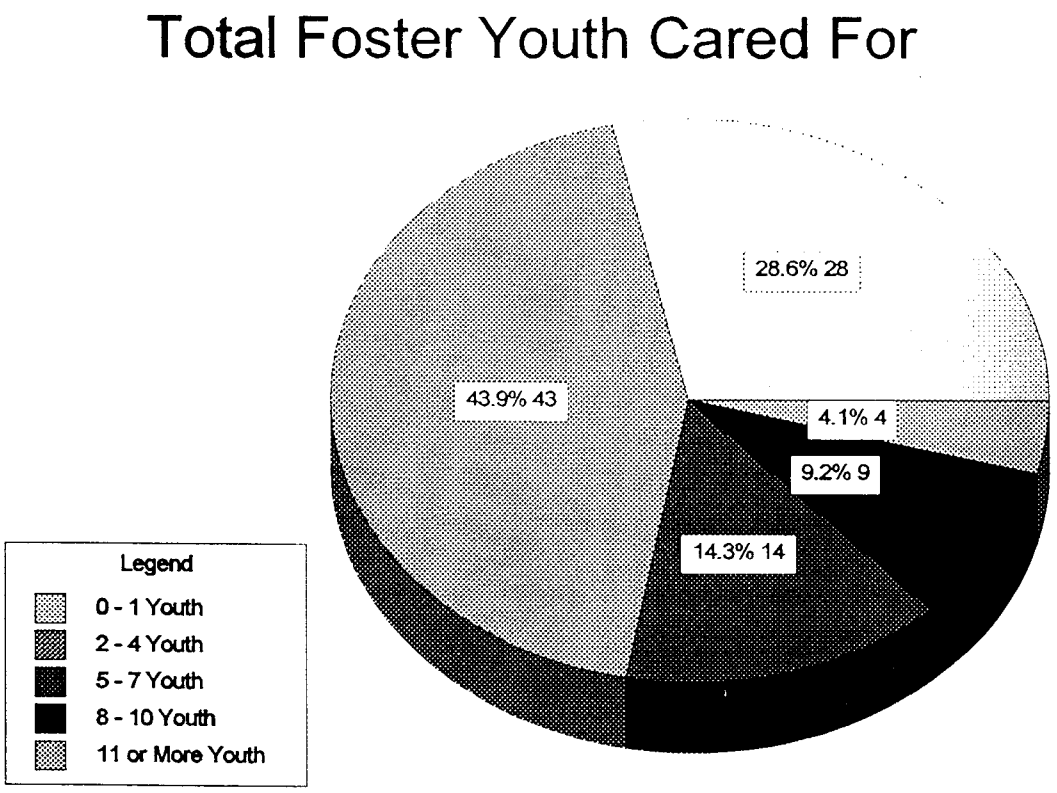

Figure 6 Total number of youth cared for. (n = 98)

Questionnaire Results

The research questions posed in this study will be addressed in this section. Frequencies of responses were tabulated to identify recurring patterns and themes. Sixty percent of all eligible subjects contacted responded to the questionnaire (98 out of 161).

1. Who do you consider to be the family of your foster child - The majority of the respondents include a variety of people in their definition of family as depicted in Figure 1. The majority of the respondents consider the biological and adoptive parents as family and almost half included extended family members in their definition of family. Ten percent of the foster parents commented that family should include any significant others that the foster child views as important, including the foster family.

2. When do you most often meet the foster child's family? The combined percentage of 64% of the sample meets the primary family at the time they meet the child or within the first 30 days of placement. Most of these parents also commented on their preference, desire or willingness to meet the family as soon as possible, but say that each case is different. Thirteen percent never meet the family and commented that they preferred not to or that the primary family did not want to meet. Other reasons stated for not meeting the family was that the custodian did not allow contact between the child and primary family.

3. Where do you get specific information about your foster child's

strengths, needs, habits and characteristics? The majority of the sample indicated that they received information about the foster child from their PATH worker, the child, the legal custodian, and by reading the referral application. Parents consistently commented that it is helpful to have as much information as possible, from as many sources as possible. Even so, information is often lacking and they still will do their own assessments based on their own observations and interactions with the child. Almost 38% include the primary family as a source of information. Some foster parents commented that this can be difficult because of parent/child conflicts or if the parent is not comfortable with the foster parents.

4. **When setting up your household rules, who do you accept input from?** Only 2% of the sample accept input from no one, with the reason being that it's their home and they set the household rules. Most of the foster parents think of rules as needing to be consistent, but flexible enough to change along with the child's growth and progress. Twenty-one percent of the foster parents who responded accept input on rules from the primary family. Almost every respondent expressed frustration that household rules were not consistently followed or supported when the child was at home with their primary family.

5. What is the average type of contact you would prefer for your foster child and his/her family? Only 3% of the sample preferred no contact and 12% phone calls only. Over 43% of the foster parents preferred weekend visits to not only support the primary family relationship, but also as a way of providing

respite for themselves. Almost every foster parent commented that the type of contacted varies with child and family.

6. How often would you prefer that your foster child and his/her family to have contact? Nearly 40% prefer weekly or bi-weekly family contact. Only 2% preferred yearly or no contact, because it made their job more difficult. Other foster parents referred to visits as sabotaging to the child's progress. Almost every foster parent commented that they defer to the social worker's judgement of whatever is in the best interest of the child and family.

7. Where do family visits most often occur? A combined percentage of 95% of the sample respond that family visits occur in the primary family home or foster home. Comments ranged from wanting visits to occur as little as possible in their home to inviting siblings for overnights. Over 33% indicate that family visits occur in an office and many commented that they prefer visits to occur on "neutral ground". The majority again stated that it varies with each child and family and that whatever is in the best interest of the child should be done.

8. Who most often provides transportation for family visits? The largest percentages of the responses show that the foster parents (63%) and primary family (50%) provide transportation. A very few number of foster parents commented that they believed this to be the primary family's responsibility, or that they would transport if it didn't require a special trip, but most commented that they work together to coordinate transportation.

9. If your foster child has supervised visits, who typically supervises

the family visit? Only 16% of the responses indicate the foster parents and 5% of the primary families provide supervision of family visits. Thirty-three percent indicated that the PATH social worker supervises visits and a combined total of 35% of the responses show that the legal custodian or therapist supervises family visits. Only 5% indicate that the primary families supervise their own visits.

10. How often do you communicate with parents regarding concerns, issues, progress, etc., about the foster child? Seventeen percent of the respondents say they never communicate and 8% say they communicate quarterly, typically at permanency planning or treatment planning meetings. A combined total of 29% indicate that they communicate weekly and bi-weekly, or as often as necessary. Many commented that they communicate with the PATH social worker, who then talks to the primary family or that the primary family is not open to talking to the foster family. Almost everyone indicated that it depends on individual circumstances.

11. **How do you communicate with parents regarding concerns, issues, progress, etc., about the foster child?** The largest percentage of respondents, 70%, indicate that they communicate at formal meetings. Sixty-one percent communicate by phone calls and 34% with informal visits. A very small number preferred communicating through letters or through the social workers.

12. When there is a meeting regarding the child, how do you respond

to the family? Only 10% of the foster parents responded that they do not attend meetings or prefer letting social workers handle it. A total of 48% of the responses indicate that foster parents and primary families are going together, sitting together or visiting afterwards.

13. In what ways do you acknowledge to the parent their parenting skills? Ten percent of the foster parents responded that they do not acknowledge to the parent their parenting skills, and 20% said they point out the negatives the primary parents do. Although 40% say they share the techniques that work well for themselves, only 6% will point out the positive things the primary parents do.

14. How much do you let the child know about your feelings toward their family? Five percent of the respondents indicate that they do not discuss their feelings about the primary family with the child. Eight percent say they would express their positive feelings and twenty percent would express their negative feelings. Over 33% would focus on and remind the child of their family's strengths and successes.

15. If the foster child refers to you as mom or dad, how do you respond? Not every foster parent (39%) has had to address being referred to as mom or dad by the foster child. Of those who have, 7% would forbid or discourage it commenting that they do not want to take the place of the child's mom or dad. Four percent would encourage it and say that it gives the child a sense of belonging. The 54% who accept being called mom or dad do so also

because they want to provide a sense of belonging. They comment that it's easier and often less embarrassing for the child to call them mom or dad.

16. Which areas of the child's daily living do you expect the child's family to help with or be responsible for? Over 50% of the sample indicated an expectation or desire for primary families to be responsible for the child's drivers license and liability insurance. Twenty-eight percent responded that the family should be involved with the child's therapy and 20% wanted the family to be involved with the child's religious education. Many foster parents commented that they would like as much involvement as possible but that in reality, they expect very little involvement. Some foster parents said that as long as the child is in their home, they will be responsible for meeting all of the child's needs as the foster parent.

17. Which celebrations do you share with the child's family? The largest percentage of responses, 44%, share no celebrations with the primary family and many commented that they had separate celebrations. Thirty percent will share birthdays and graduations with the primary family and 24% will share holidays. Some foster parents indicated that they offer to share celebrations with the primary family, but that they are usually declined.

18. Of the foster children you have cared for, how many do you consider having successful or positive outcomes after leaving your home? The highest percentage of responses (42%) indicate one child has experienced a successful outcome after leaving their home. This could be related to the

higher percentage of parents who have only had one foster child leave their home up to this point. A combined total of 24% of the foster parents indicate that 5 or more children have experienced successful outcomes after leaving their home. Some foster parents commented that as long as the child learns something or leaves better off than when they came, the placement was a success.

19. What do you attribute the successful outcomes too? Over 78% of the foster parents attribute successful outcomes to the treatment team's contributions. Sixty-four percent consider their own contributions and 63% consider the child's contributions related to successful outcomes. Thirty-seven percent attribute the primary family's contributions to successful outcomes after leaving the foster home.

20. Of the foster children you have cared for, how many do you consider failed placements or negative outcomes? Fifty-one percent responded that they have had one child experience a negative outcome. Twenty-nine percent indicate that two to four children have experienced a negative outcome after leaving their home. Three percent indicate that 11 or more youth have experienced a negative outcome after leaving the foster home. One parent commented that "there are no failed placements; just some have better results than others".

21. What do you attribute failed placements or negative outcomes to? Forty-three percent attribute negative outcomes to the primary family's

contributions and 41% attribute negative outcomes to the child's contributions. Ten percent consider the treatment team's contributions and 6% attribute their own contributions to negative outcomes.

22. How would you define a successful outcome? Over 88% consider the child's return home a successful outcome to placement. Eighty-one percent indicate that the child living independently is a successful outcome. Thirty-three percent consider a transfer to regular foster care and 9% consider a transfer to group or residential care a successful outcome. Several parents commented that "as long as a child learns something, it's a success.

When looking at the child's behaviors, 88% of the foster parents consider positive behaviors increasing to be a success and 80% consider negative behaviors decreasing to be a success. Seventy-eight percent believe that exposing the child to another way of life is an indicator of success and 69% consider a successful placement when the child completes the recommended treatment.

When looking at the primary parent's abilities, 79% of the foster parents consider positive parenting skills increasing to be an indicator of success. Sixty-four percent consider a successful outcome to be when the parent completes the recommended treatment and 57% think of the parent's negative parenting skills decreasing to be a measure of success. Fifty-three percent of the foster parents believe that exposing the primary parents to another way of life is a successful outcome.

23. Do foster parents have an impact on the foster child or his/her family? Only 1% of the respondents believed they did not make any impact at all. Two percent believed they could only have an impact on the child. Five percent believed that they could only impact the child's family and 92% believe that they can impact the child and his/her family.

24. What are some ways that foster parents can have an impact on his/her family? Over 57% of the foster parents believe that they can have an impact by role modeling or mentoring the primary families. Fifty-two percent thought that sharing their insights, feelings and opinions through open communication was a way to impact families. Twelve percent felt that nurturing the foster child and 4% believed providing respite were also ways to impact the primary families.

25. If you were designing a therapeutic foster care program, what components would you stress or include? Many of the foster parents, 27%, commented that low social worker caseloads, ongoing support, training and structure to the program were important components to include in the program design. Twenty-seven percent of the respondents would stress a family focused approach and primary consideration given to the family's needs. Twenty-six percent view the child's needs as primary so that treatment should be child-centered. Twenty-three percent would stress the importance of open communication, team effort and intense involvement and commitment by all team members. Ten percent see the need for individualized treatment as an important

SECTION VI

DISCUSSION

Relevance to Research Question

In answer to the study question of how do treatment foster parents perceive their role with the primary families of youth in care, it very generally seems to be secondary to their role with the foster child. There were numerous comments about "it's not my job" or "not my place" and many issues were left for the social workers to handle. Ironically, there were also many references to "I'd like to....." or "I've never had the opportunity to...." which seems to imply a desire for a higher level of involvement with primary families. This is also reflected in the question of do treatment foster parents have an impact on the foster child or his/her family by the combined total of 97% who believe that they can impact the child and his/her family. When asked about the ways they could have an impact on the child's family, 56% answered by role modeling or mentoring and 51% said by frequent and open communication. Once again, a desire for a higher level of involvement is implied just because role modeling, mentoring and frequent and open communication require the foster parents to assume a closer and more supportive role with the primary families. To the question of what elements are important to include in a treatment foster care program, 56% stressed the importance of individualized treatment based on the needs of a particular child and his/her family. Many respondents added the comments "just like PATH" or "as we do in PATH". This is consistent with PATH's philosophy of a family-based approach to treatment foster care services. Finally, it is this investigator's

personal opinion that many foster parents highly involved and working closely with primary families, but that they do not necessarily perceive that to be their role. What they've done to support families, they've done very naturally, based on what made the most sense to do and needed to be done at the time. Treatment foster parents need to be recruited with the expectation of working not only with children, but also their families. Treatment foster parents need to be provided with clear agency policy that promotes their involvement and empowers them to work with primary families and finally, they need social worker support and training and education specifically on working with primary families and issues of reunification.

Implications for Social Work Practice

Foster parents, primary families and social workers need to recognize that reunification represents a continuum of outcomes, from return home to less extensive forms of contact. It is a level of reconnection or rejoining with whomever constitutes family for a particular child (Maluccio, Warsh, & Pine, 1993). Social workers have a responsibility to address the questions and incongruities that have come to light as a result of this study. It is the philosophy of PATH to provide a family-based approach to treatment foster care services; but are we really involving the primary family at every opportunity? Foster parents indicate that they would like to have more involvement with primary families, but that it isn't their job or their place. What do social workers do to give that message? What can we do to change that message so that foster

parents feel more comfortable in assuming a more involved role with primary families. Are social workers feeling empowered enough to empower the foster parents? Is agency policy or administration inhibiting social workers, who in turn might be inhibiting foster parents. Ninety-seven percent of the foster parents responding to this survey believe they can impact a child and his/her family. What role do we play in preventing treatment foster parents from becoming maximally involved with the families of the children in their care? Social workers in direct practice, as well as administration, need to evaluate their own values, beliefs, attitudes and knowledge regarding children and families and reunification issues. This should be an ongoing effort which continuously strives for competency-based social work practice and quality treatment foster care services.

Implications for Further Research

This study represents only a beginning stage for treatment foster parents in North Dakota by providing a description of who they are and what some of their perceptions regarding their involvement with children and families are. A whole range of issues for further research exists; only some of which could include: a comparison of foster parent attributes with their levels of involvement; foster parent involvement as it relates to outcome measures; social worker attitudes regarding reunification issues; and social worker influences on parental attitudes are just a few. PATH - ND is already participating in an important longitudinal study of children and youth being undertaken by the Child Welfare League of

America to look at the outcomes of different types of settings and services, relative to the different problems and behaviors of the children and families served.

SECTION VII

LIMITATIONS

The fact that a mail survey was used provided some limitations in itself. There was no direct control of the survey being delivered, who actually completed the survey or the circumstances under which it was completed. The voluntary nature of this study may have resulted in the sample subjects not being representative of all PATH - ND foster parents, all North Dakota foster parents or of all foster parents associated with this tri-state treatment foster care agency. Given the increasing number of treatment foster care programs in the United States and throughout the world, generalizations may be difficult.

CONCLUSIONS AND RECOMMENDATIONS

To effectively and efficiently respond to the current crisis in foster care, the child welfare system faces a major challenge: reconceptualizing foster care. Traditional service approaches, which have guided child welfare practice for several decades, do not meet the demands of the current overburdened system. The new way of thinking that has been emerging has been referred to as "family-centered", "family-focused" and "family-based" (Barbell, 1995).

PATH - ND is already steps ahead in this paradigm shift. It identifies itself as a "family-based" treatment foster care agency serving children and their families. The agency views the role of the treatment parent as central to the treatment process of the foster youth and primary family, it was unclear exactly how the treatment foster parents viewed their role. This was the reason for this particular study. What became most apparent in the findings was that foster parents have mixed perceptions of their role with primary families, which may be due in part to receiving mixed messages from social workers, supervisors and administrators. PATH - ND treatment foster parents believe that they can impact the primary families of the youth in care, they believe that a way to make an impact is to communicate and mentor, yet they do not always feel that it is their job to be involved or even that they are allowed to be involved with primary families.

An important way to clarify mixed messages and misperceptions is through education. PATH - ND needs to teach all of it's staff, from foster parents to

social workers to supervisors, the five broad themes that provide the basic structure to the reconceptualization of foster care: the importance of family to children; children's lifelong connections to their families; the uniqueness of families; the shifting availability of family members; and the need to broadly define family or family-like support (Barbell, 1995).

Education, along with clear policy and protocol supporting the same themes of the primary family, will empower treatment foster parents to do what they already believe they can. Treatment foster parents will not only be family oriented and maximally involved; they will also perceive that as their role in treatment foster care.

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APPENDICES

Appendix A

Rec 11/15/94

REQUEST FOR APPROVAL FOR THE USE OF
HUMAN SUBJECTS IN RESEARCH
Social and Behavioral Sciences

1. Project Title: (Use same title as grant application, if applicable)
Perceptions of Therapeutic Foster Parents on Reunification

2. Principal Investigator Sheila M. Schmaltz, DS, BSW
(first, mi, last, degree)

Telephone number 701-280-9545

College department name Dept. of Social Work

Investigator's address 6811-52nd Ave. North
Harwood, ND 58042

(For IRB Use Only)
Approval #: 94/13/3

3. Check one:
____ Faculty / staff research
____ Fellow / post doctoral
X Student Research
____ Undergraduate
X Graduate

4. If principal investigator is a student:
Advisor's Name. Vincent Peters MSW
Address Social Work Dept.
Augsburg College
Telephone 330-1633

5. Applications for approval to use human subjects in research require the following assurances and signatures to certify:

- The information provided in this application form is correct.
- The Principal Investigator will seek and obtain prior written approval from the IRB for any substantive modification in the proposal, including, but not limited to changes in cooperating investigators, agencies as well as changes in procedures.
- Unexpected or otherwise significant adverse events in the course of this study will be promptly reported.
- Any significant new findings which develop during the course of this study which may affect the risks and benefits to participation will be reported in writing to the IRB and to the subjects.
- The research may not be initiated until final written approval is granted.

This research, once approved, is subject to continuing review and approval by the IRB. The PI will maintain records of this research according to IRB guidelines.

If these conditions are not met, approval of this research could be suspended.

Signature of Principal Investigator _____ Date 11-14-94

Student Research: As academic advisor to the student investigator, I assume responsibility for insuring that the student complies with College and federal regulations regarding the use of human subjects in research:

Signature of Academic Advisor _____ Date 11/15/94

Faculty/Staff Research: As department chair, or designee, I acknowledge that this research is in keeping with the standards set by our department and assure that the principal investigator has met all departmental requirements for review and approval of this research.

Signature of Department Chair _____ Date _____

Signature of IRB Chair _____ Date 11/25/94

1

Appendix B

MEMO

Date: December 5, 1994

To: Sheila Schmaltz

From: Bill Metcalfe, State Director

re: Project Approval

I received your November 23, 1994, memo requesting approval on your thesis subject. I presented your request to the PATH New Services/Research Committee. The committee approved your project on the issues of foster parent roles and relationships with the natural families of children they provide care for.

Appendix C

Dear _____

I am a student at Augsburg College in Minneapolis, MN, pursuing a Master of Social Work degree. For my thesis, I want to answer the question "How do therapeutic foster parents in North Dakota perceive their role with the families of the foster children in their care?" To do this, I am surveying currently licensed PATH foster parents in North Dakota to identify what kinds of contact and interaction you have with the foster child's family, as well as your opinion of the impact your relationship and role with the families of the foster children you care for. I would like to take this opportunity to invite you to be part of this research study, but before you decide please read this letter and ask any questions that you may have.

Procedures:
You have been selected as a possible participant for this study because on December 1, 1994 you are a PATH foster parent licensed by the state of North Dakota.

If you agree to participate in this study, I will ask you to complete the enclosed survey, which should take no more than 60 minutes of your time. I have enclosed a self-addressed, stamped envelope to return the survey to me. On December 15, 1994 I will send a reminder notice to all foster parents, in case they would still like to participate.

Risks:
Because I am asking you to confidentially disclose your personal and individual opinions, observations and experiences; you may feel some discomfort or risk with disclosing information of this nature. You are the best judge as to the likelihood of risk to yourself. You are free not to answer any and all questions that may make you uncomfortable for any reason. There are no consequences for not participating in this survey, and you are under no obligation to do so.

Benefits:
The benefit to participating in this study is that <u>your</u> perceptions may directly impact program planning for PATH, North Dakota.

Compensation:
Because of the thought and time required for this survey, I will offer training credit that you may or may not choose to receive. I will offer one-half hour of training credit for answering 12-18 questions and one hour of training credit for answering 19-24 questions. If you would like to receive credit, simply return the separate credit request form to me which remains unattached to the survey and is used **only** for recording the training credit. Your training credit will be recorded the day your completed survey is received by me, but no later than December 31,1994. I will not offer training credit for surveys returned to me after December 31, 1994.

Confidentiality:
Individual data and information will remain private and confidential. The actual surveys will be kept in a locked file drawer to which only I have a key, in an office at the Fargo PATH office. The individual data will be destroyed after the completion of this study, approximately June 30, 1995. The findings of this study will be used for my MSW Thesis at Augsburg College, and may also be shared with the PATH Board, Directors, social workers and foster parents. Any findings that are published or presented elsewhere will also not include any identifying information.

Voluntary:
Your decision to participate will not affect your current or future relationships with Augsburg College, PATH or the North Dakota Department of Human Services. By completing and returning the enclosed survey, you are consenting to participate in this study. This letter is your copy of your informed consent, which you should retain for your records if you choose to participate.

Questions:
If you have any questions regarding this survey, please contact me during the day at the Fargo PATH office at 701-280-9545 or 1-800-376-6608, in the evening at my home number at 701-282-2996, or contact my Augsburg College Thesis Advisor, Vincent Peters, MSW at 612-330-1633.

Thank you for your consideration of this opportunity.

Sincerely,

Sheila Schmaltz, LSW

enc

Appendix D

REQUEST FOR EDUCATION CREDIT

I wish to receive education credit for the time I have spent exploring my relationship and role with the families of the foster youth I care for.

I will receive one half credit hour of education credit for answering 12-18 questions and one hour of education credit for answering 19-24 questions.

I understand that my completed survey remains private and confidential and that I am providing my name here only to ensure that I receive the education credit.

_____

Name of Foster Parent

_____

Name of PATH Social Worker

Appendix E

PATH - NORTH DAKOTA FOSTER PARENT SURVEY
"Foster parent perceptions of their role and relationship to the families of the foster children in their care"

PLEASE DO NOT WRITE YOUR NAME OR THE NAME OF THE FOSTER CHILD ON THIS SURVEY.

1. Who do you consider to be the family of your foster child? (Please check all that apply.)
   - ___ No one
   - ___ Biological or adoptive mother, father and siblings.
   - ___ Biological or adoptive grandmother, grandfather and aunts, uncles or cousins.
   - ___ Stepmother, stepfather and step-siblings.
   - ___ Parents live-in partner.
   - ___ Other _____

2. When do you most often meet the foster child's family?
   - ___ I never meet the child's family.
   - ___ Before I meet the child.
   - ___ At the same time that I meet the child.
   - ___ Within the first 30 days of the child's placement.
   - ___ Sometime before the child leaves my home.
   - ___ Other _____

   Comments_____
   _____
   _____
   _____

3. Where do you get specific information about your foster child's strengths, needs, habits and characteristics? (Please check all that apply.)
   - ___ I read it in the application for referral.
   - ___ From my PATH social worker.
   - ___ From the county or Division of Juvenile Services worker.
   - ___ From the child.
   - ___ From the child's family.
   - ___ Other _____

Comments_____

_____

_____

_____

4. When setting up your household rules for the child, who do you accept input from? (Please check all that apply.)

___ No one
___ The child
___ My PATH social worker
___ The county or Division of Juvenile Services worker
___ The therapist, psychologist or psychiatrist
___ The child's parents
___ Other _____

Comments _____

_____

_____

_____

5. What is the average type of contact you would prefer for your foster child and his/her family?

___ None
___ Phone calls only
___ 0-2 hour visit
___ 3-8 hour visit
___ 9-24 hour visit
___ Weekend visit
___ Week long visit
___ Other

Comments _____

_____

_____

_____

6. How often would you prefer that your foster child and his/her family to have contact?

___ Never
___ Daily
___ Weekly
___ Bi-weekly
___ Monthly
___ Bi-monthly
___ Yearly
___ Other

Comments _____

_____

_____

_____

7. Where do family visits most often occur? (Please check all that apply.)

___ Shopping Center
___ Restaurant
___ Park
___ PATH office, County, or Division of Juvenile Services office
___ My Home
___ Parents' Home
___ Other _____

Comments _____
_____
_____
_____

8. Who most often provides the foster youth with transportation for family visits?

___ I do
___ County or Division of Juvenile Services worker
___ PATH social worker
___ The child's family
___ Other _____

Comments_____
_____
_____
_____

9. If your foster child has supervised visits, who typically supervises the family visits? (Please check all that apply.)

___ I do
___ PATH Social Worker
___ DJS or county worker
___ The child's parents
___ The therapist
___ Parent aides
___ Other _____

10. How often do you communicate with parents regarding concerns, issues, progress, etc., about the foster child?

___ Never
___ Daily
___ Weekly
___ Bi-weekly
___ Monthly
___ Bi-Monthly
___ Quarterly
___ Yearly
___ Other _____

Comments _____
_____
_____
_____

11. How do you communicate with parents regarding concerns, issues, progress, etc., about the foster child?

___ Letters
___ Phone calls
___ Informal visits
___ Other_____
___ Formal meetings (permanency planning and contracting)
___ Court reviews

Comments _____
_____
_____
_____

12. When there is a meeting regarding the child, how do you respond to the family? (Please heck all that apply.)

___ I don't attend meetings with the family.
___ I don't do anything, I let the social workers handle it.
___ I schedule it so we all can attend.
___ I remind and encourage them to attend.
___ We go together.
___ We sit by each other.
___ We visit after the meeting.
___ Other _____

Comments _____
_____
_____
_____

13. In what ways do you acknowledge to the parent their parenting skills? (Please check all that apply.)

___ I don't acknowledge their parenting skills.
___ I point out the negative things they do.
___ I point out the positive things they do.
___ I share with them things that work well for me.
___ Other _____

Comments _____
_____
_____
_____

14. How much do you let the child know about your feelings toward their family? (Please check all that apply.)

___ I don't discuss my feelings at all.
___ I express my negative feelings.
___ I express my positive feelings.
___ I try to focus on and remind the child to focus on their parents strengths and successes.
___ Other _____

Comments _____
_____
_____
_____

15. If the foster child refers to you as mom or dad, do you: (Please check all that apply.)

___ Discourage it
___ Forbid it
___ Tolerate it
___ Encourage it
___ Accept it
___ I've never been called mom or dad

___ Other _____

Comments _____
_____
_____
_____

16. Which of the following areas of the child's daily living do you expect the child's family to help with or be responsible for? (Please check all that apply.)

___ Extracurricular school activities
___ Haircuts
___ Medical care
___ Dental appointments
___ Eye appointments
___ Private lessons (music, dance, karate, etc.)
___ Shopping for clothes
___ Drivers license and liability insurance
___ Homework and tutoring
___ Therapy sessions
___ School conferences
___ Church
___ Religious education
___ Other _____

Comments _____

17. Which celebrations do you share with the child's family? (Please check all that apply.)

___ None
___ Holidays
___ Birthdays
___ Religious events
___ Graduations
___ Award/Recognition events
___ Other _____

Comments _____

18. Of the foster children you have cared for, how many do you consider having successful or positive outcomes after leaving your home?

___ 0-1
___ 2-4
___ 5-7
___ 8-10
___ 11 or more

19. What do you attribute the successes or positive outcomes to? (Please check all that apply.)

___ Nothing in particular.
___ Child's contributions.
___ My contributions.
___ Child's family is contributions.
___ The treatment teams' contributions.
___ Other _____

Comments _____
_____
_____
_____

20. Of the foster children you have cared for, how many do you consider failed placements or having negative outcomes after leaving your home?

___ 0-1
___ 2-4
___ 5-7
___ 8-10
___ 11 or more

21. What do you attribute failed placements or negative outcomes to? (Please check all that apply.)

___ Nothing in particular
___ Child's contributions
___ My contributions
___ Other _____
___ The treatment team's contributions
___ Child's family's contributions

Comments _____
_____
_____
_____

22. How would you define a successful or positive outcome after a child leaves your home? (Please check all that apply.)

A. <u>Living Arrangements</u>:

___ Child returns home to parents or extended family.
___ Child lives independently.
___ Child transfers to regular foster care.
___ Child transfers to group or residential care.
___ Other _____

Comments _____
_____
_____

B. Child's Behavior:

___ Child has been exposed to another way of family life.
___ Child completes recommended treatment.
___ Child's negative behaviors decreased.
___ Child's positive behaviors increased.
___ Other _____

Comments _____

_____

_____

C. Parent's Behavior:

___ Parents have been exposed to another way of family life.
___ Parents complete recommended treatment.
___ Parents negative behaviors or parenting skills decreased.
___ Parents learn positive behaviors or improved parenting skills.
___ Other _____

Comments _____

_____

_____

23. Do foster parents have an impact on the foster child or his/her family?

___ They do not have an impact.
___ They can impact the child only.
___ They can impact the family only.
___ They can impact the child and his/her family.
___ Other _____

Comments _____

_____

_____

24. What are some ways that foster parents can have an impact on his/her family? _____

_____

_____

_____

25. If you were designing a therapeutic foster care program, what components would you stress or include?_____

_____

_____

_____

_____

Thank you for participating in this survey regarding PATH foster parents' roles and relationships with the families of the foster children they care for. Your input is greatly appreciated.

FOR FOSTER PARENT DEMOGRAPHIC PURPOSES, PLEASE INDICATE YOUR:

A. SEX

Male _____ Female _____

B. AGE

21-30 _____
31-40 _____
41-50 _____
51-60 _____
61 & older _____

RACE

Caucasian _____
Native American _____
African American _____
Asian _____
Latino _____
Multi Racial _____
Other _____

C. EDUCATION

8 years _____
12 years _____
14 years _____
16 years _____
18 years _____

D. What are the total number of years you have you been a foster parent?

Less than 1 year _____
1-3 years _____
4-6 years _____
7-9 years _____
10+ years _____

E. How many foster children have you cared for all together?

0-1	_____
2-4	_____
5-7	_____
8-10	_____
11 or more	_____

F. What are the total years you have been with PATH or other therapeutic foster care programming?

Less than 1 year	_____
1-3 years	_____
4-6 years	_____
7-9 years	_____
10+ years	_____

G. How many PATH or therapeutic foster children have you cared for?

0-1	_____
2-4	_____
5-7	_____
8-10	_____
11 or more	_____

H. For the foster youth you currently provide care for, please indicate:

		Child 1	Child 2	Child 3
1.	Sex	_____	_____	_____
2.	Age	_____	_____	_____
3.	How long residing with you?	_____	_____	_____
4.	Current permanency plan is: (return home, long-term foster care, independent living, other)	_____	_____	_____
5.	Legal status (Parental rights terminated, not terminated, don't know)	_____	_____	_____