Best Practices in Children's Mental Health:

A Series of Reports Summarizing
the Empirical Research on Selected Topics

Report #3
"Group Care for Children and Adolescents"
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Best Practices in Children's Mental Health: Report #3
Outcome Studies of Group Care for Children and Adolescents

About one child enters out-of-home care every 35 seconds (Gershenson, 1990). A national study commissioned by the U.S. Children's Bureau approximates the total population of children in substitute care in the mid-1990's at 500,000. However measured, in view of the disturbing number of children removed from their families, it is imperative that "best practices" guide those entrusted with the care of these children.

The majority of children in out-of-home care are in family foster care placements. Less than 25% are in non-family settings, such as group homes (Melton, Lyons, & Spaulding, 1998). According to Pecora, Whittaker, Maluccio, Barth, & Plotnick (2000), all of the following services fall under the general heading of group child care: "A group home for adolescent status offenders; a residential treatment center for emotionally disturbed children; a state training school for adolescent delinquents; a sheltered care facility for street children; a respite care group home for developmentally disabled adolescents; a group residence for 'dependent/neglected' children; and a boarding school for troubled adolescents" -(p. 419).

As early as 1974, Wolins said:

> Group care of normal children is, for all intents and purposes, off the professional's agenda either as a solution to some type of problems or even as a theoretical concern. Like ... the demon theory. of mental illness, it had been laid to rest. (p. 2).

Many of the best thinkers in foster care believe Wolins would now likely drop the qualifier ***normal*** and simply admit that group care for *any* children is "off the professional's agenda" (Pecora, et al, 2000). After a lifetime of working in residential group care and advocating for high-quality services, Morris Fitz Mayer (1971) dubbed residential group care "Pariah Care," largely to describe the stigmatization of acting-out youth and the field's inability to accord empirical attention to residential group care.

"Many child welfare professionals today view residential group care of any kind with suspicion and even antipathy. More often than not, it is seen as part of the problem, not part of the solution. The high cost, questionable effectiveness, and presumed negative social and psychological effects on children are among the reasons for this prevailing attitude" (Levine, Brandt, & Whittaker, 1998, p. 31). Perhaps the reason residential group settings continue to be viewed with skepticism in the professional domain rests in the concerns such as:

a) Lack of clear diagnostic indicators for residential placement.

b) The idea that some service systems use residential placement too freely.

c) Perception that residential group placement is intrusive and disempowers families.

e) Difficulty in identifying key components of residential services in the form of treatment models.

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f) Lack of hard evidence for comparative treatment efficacy, especially long-term (Pecora, et al, 2000, p. 410).

Despite this professional skepticism, ambivalence about group care exists. The placement proportions of 75% family foster care and 25% group care have remained constant since the late 1970's (Melton, et al, 1998). In the face of dominant, negative attitudes, one wonders what dynamics have maintained group care at these consistent proportions for over 20 years. Some possibilities could be a lack of sufficient family foster care providers to serve the needs of children or a belief that some children are better off in group care. Perhaps some organizations providing residential group care are guided by a philosophy that the stability of non-profit organizations should be maintained.

Various articles have noted a need for additional research in certain areas such as: effectiveness of group care, comparative research as to where residential group care services fit in an overall continuum of care, information about how subgroups are best served, longitudinal research, and which group settings best promote transition to the community. The topic of populations best served in residential group care has received little attention. Lessons learned from the experience of a National Health Initiative designed to place children during the AIDS epidemic in New York (Levine, et al, 1998) suggests some populations for whom some form of group living might be appropriate: adolescents alone who cannot be placed in family foster care, children in short-term crisis, and siblings groups. Additionally, professionals generally believe that children with more severe emotional, behavioral or physical problems are more likely to be admitted to residential group care although no empirical literature documents that they are better served.

With these thoughts in mind, answers to the following three questions were sought in this analysis:

1) Is there empirical literature that supports the "best practices" idea that family foster care is better than group home care?

2) Is there empirical literature that says some certain types of children do better in group homes than in family foster homes?

3) If group homes might be better for some children, or if we are always going to have group homes due to "nowhere else to go," which types of group home programs (treatment models) have been shown to be effective for which types of children?

Methodology

The criteria for study inclusion were: Empirical studies, adequate design, sample size, degree to which questions of interest and calls for needed research were addressed, content that provided new insight, and promising models of care.

The present review examined 11 empirical studies appearing in 12 articles in the literature from 1983 through 2001, relative to the above three questions. Included in this report are:

A) One analysis of findings, published in 2001, that includes six outcome studies from 1982 to 1998.

B) Ten additional studies not included in "A," one published in 2001, three published in 2000, one in 1999, one in 1998, two in 1996, one in 1994, and one in 1983.

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Results for Question One

To determine if empirical evidence exists that supports the "best practices" idea that family foster care is better than group home care, this report summarizes six articles. Two companion articles are pretest/post-test designs with random assignment to comparison groups (1 & 2). One study is a comparison of two matched groups in two placement settings with stratified sampling (3). One study is a pretest/post-test design with comparison groups and random sampling (4). One is a follow-up survey assessment (5) and one is a longitudinal follow-up survey (6). Of the six articles, four gave follow-up measures.

The body of outcome research on Question "1" is strengthened by:

- One extraordinarily well designed study that included random assignment to matched comparison groups with a population that had not previously been studied with this degree of rigor. Findings from this study were published in two companion articles based on different outcomes and varied time periods.

- One study that compared matched groups of children, ages six to seven who had been placed in continuous foster care prior to the age of 12 months.

- One study that interviewed 1,100 child participants, those who best know about their experiences in care settings.

The body of outcome research on Question "1" is limited by:

- A lack of true experimental designs.

Conclusions for Question One

The answer to question one, "Is there empirical literature that supports the `best practices' idea that family foster care is better than group care?" is a strong YES, on a wide number of outcomes. The empirical base found family foster care significantly more effective than group care for a variety of groups of children.

- Multidimensional Treatment Foster Care was significantly more effective than group care based on the Positive Peer Culture Model in reducing delinquent behavior of violent, chronic, male juvenile offenders and improving contact with biological family members (1).

- Chronic, serious, male juvenile offenders in Multidimensional Treatment Foster Care felt more liked and understood by adults than those in group care. This connection between adults was significantly related to positive outcomes and indicated adults as powerful positive influences (2).

- Increased affiliation with delinquent peers was correlated with negative outcomes, indicating peers as powerful influences (2).

- Children in group care demonstrated significantly higher levels of disruptive behavior, hyperactivity, emotional difficulties, and unsociability than those in family foster care placement, which was likely a function of placement rather than biological background or experiences in early infancy (3).

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• Group Care may predispose children to hyperactivity/inattention (3).

• Group Care may predispose children to hyperactivity/inattention (3).

• Children reported much higher levels of satisfaction with their quality of life and overall well-being in kinship family foster care and non-relative family foster care than children in group care (4).

• Adolescents in family foster care were significantly more prepared to make the transition into adulthood than those in residential group care (5).

• As adults, those discharged from family foster care function better in multiple life domains than adults who spent all or part of their time in group settings (6).

Results for Question Two

No well-designed studies were located in the literature that identify certain types of children who do better in group home care; however, reasonable inferences from the above studies can be made. In addition to having the highest risk factors, violent, chronic juvenile offenders demonstrate characteristics that typically predispose youth to residential group placement such as presenting clear and imminent threat to themselves and others, self-perpetuating cycles of dysfunctional behavior, and severe emotional and physical problems. A considerable body of research indicates youthful juvenile offenders experience more life challenges than other youth. These challenges include head injuries (Chretien & Persinger, 2000), substance abuse and psychiatric problems (Lewinsohn, Gotlib, & Seeley, 1995; and Weinberg, Rahdert, Colliver, & Glantz, 1998), and severe emotional disorders and learning disabilities (Randall, Henggeler, Pickrel, & Brondino, 1999). A large proportion of juvenile offenders have histories of psychological abuse and neglect, as well as criminal and alcoholic parents (Haapasalo, 2000). Shelton (2001) found 53% of offenders were classified with diagnosable mental disorders and 46% met criteria for a diagnosis of low functioning. Twenty-six percent had functional impairments severe enough to need highly restrictive environments. Many studies indicate a strong correlation between youthful offenders and substance abuse (Pliszka, Sherman & Barrow, 2000; Julie Yum Soo Kim, 2000; and Randall, et al, 1999).

Although chronic juvenile offenders have strengths to endure against seemingly insurmountable odds in environmental conditions with predisposing risk factors, in reality, they do comprise the toughest group of youths to serve. Two articles (1 & 2), summarizing an extraordinarily well - designed, comprehensive study reported in this analysis, indicate that violent, severe, chronic offenders experienced significantly better outcomes in family foster care than those placed in group care. These youths also spent more time with their biological families, which is consistently indicated as vital to successful outcomes (Green, et al, 2001; Kiser, et al, 1996; and Pfeiffer, et al, 1990). Therefore, perhaps the question of what groups of kids may be best served in group care can be answered with these findings. If violent, chronic offenders can be better served in family foster care than in group care, it stands to reason that the same is true of other high-risk children with similar problems.

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Results for Question Three

In 1994 the U.S. General Accounting Office's examination of programs, which was extensive and exemplary, indicated:

> Not enough is known about residential group care programs to provide a clear picture of which kinds of treatment approaches work best or about the effectiveness of the programs over the long term. Further, no consensus exists of which youths are best served by residential care... or how residential care should be combined with community-based care to best serve at-risk youths over time. (p. 4).

Through the course of this investigation, it became clear that few outcome studies used rigorous research methods to test the efficacy of group home programs, which is congruent with the literature that calls for more rigorous methodology (Pecora, et al, 2000). To determine which types of group home programs (treatment models) have been shown to be effective for which types of children, this report summarizes six articles, one of which synthesizes outcomes of six additional studies. One study is a longitudinal pretest/post-test design, with an experimental group and a comparison, treatment-as-usual group (7). One is an analysis of findings, which summarizes six additional outcomes studies (8). One is a longitudinal study with two comparison groups, no random sampling or random assignment (9). One is a pretest/post-test comparison of two models, no random sampling or random assignment (10). One is a qualitative follow-up study (11). One is a pilot test of a promising program (12). Of these six studies, five had followups.

The body of outcome research on Question "3" is severely limited by:

- Lack of experimental or even quasi-experimental designs.
- Limited number of outcomes and subgroups studied.

Three models, The Teaching Family Model (TFM), Father Flanagan's Boys Home Model (BHM), and REPARE have empirical support. In general, TFM is effective in the short-term, as indicated by various studies, two of which are reported here (7 & 8). Other studies of TFM with similar conclusions have been conducted over the years by Wolf, Kirigin, Fixen, & Blase (1995); Weinrott, Jones, & Howard (1982); and Wolf, Fixsen, Braukman, Kirigin, Willner, & Shumaker (1976). Effects of TFM diminished at one-year follow-up (8). The BHM was more effective than treatment as usual (9). Follow-up outcomes of the BHM were mixed, perhaps due to uncontrolled study designs and a high dropout rate (8 & 9). The REPARE Model, a family-centered approach, was more effective than a standard treatment program in increasing family visits and family involvement during placement and achieving permanency and stability in children's living arrangements overtime (10).

Positive Peer Culture (PPC) has been studied with mixed findings, thought to be related to methodological implementation (See Gold & Osgood, 1992 and Brendtro & Wasman, 1989). Because PPC has been examined but not found to constitute "best practices" additional studies

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were not delineated in this analysis. However, in keeping with recent research trends to ascertain consumer feedback, one qualitative study, which gives voice to young men who were in residential care as youths was outlined (11). When asked about their experiences in residential care, without prompting with regard to any model, young men unanimously spoke about their negative experiences with PPC. The pilot study of a promising program, "Schema," show potential for advancing family-centered practice in group settings (12).

The findings of this report are congruent with an earlier, brief report by the University of Kansas School of Social Welfare entitled *Results of Group Home and Other Treatments for Youth with Conduct Disorder* (Walter, 2000). That report cited seven sources and concluded:

> While research does not indicate any one treatment that is certain to work for youth with conduct disorders, there are clear indications that placing conduct disordered youth with peers who have similar problems is NOT an effective treatment modality.

Conclusions for Question Three

- The Teaching Family Model (TFM) was more effective than treatment as usual in providing satisfaction with adults, reducing isolation from family, and increasing personal controls among youth who did not have histories of sexual offense, felony, or drug addiction (7).
- TFM is a durable, replicable model (8).
- Effects of TFM diminished at one-year follow up with the possible exception of social skills (8).
- Father Flanagan's Boys Home Model (BHM) was more effective than treatment as usual on measures of education, behavior, and educational attitudes during placement and at follow-up for youth who stayed in the program (9).
- Follow-up studies of BHM showed no difference in outcomes for those staying six months, 20 months, or 50 months (9).
- Lasting effects of the BHM on educational measures were found at follow-up in uncontrolled study. The attrition rate for treatment group was 27% at one year and 77%, after 36 months, suggesting youth who stayed may have been more motivated or a better fit with the program (9).
- Follow-up studies of long-term effects of BHM and TFM were disappointing (8).
- The REPARE Model was more successful in increasing family visits and achieving permanency and stability in post-discharge placement than a comparison group (10).
- With the REPARE Model, shorter lengths of stay were significantly related to achieving permanency and stability for children. Longer lengths of stay were significantly related to not achieving permanency and stability for children (10).

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D Positive Peer Culture (PPC) was described as problematic, placing youth "at odds" with each other and promoting deceit, with staff who held information obtained from groups against residents (11).

"Schema," a family-centered, strength-based model for residential settings, is promising (12).

Overall Summary and Discussion

In relation to question one, findings strongly support the "best practices" idea that family foster care is better for children than group home care.

The answer to question two, "Is there empirical literature that says some certain types of children do better in group homes than in family foster homes?," was not found definitively in published literature; but, perhaps an answer to question two lies in the answer to question one of this report. The idea that multi-problem youth can be better served in residential group care has been convincingly refuted in the companion works of Chamberlain, et al (1 & 2).

The answer to question three, "If group homes might be better for some children, or if we are always going to have group homes due to 'nowhere else to go,' which types of group home programs have been shown to be effective for which types of children?," is that three programs have some empirical support. These programs include the Teaching Family Model, the Boys Home Model, and the REPARE Model. One new model, "Schema," shows promise.

The picture of which kinds of programs work best over the long term is not clear. No consensus exists about which, if any, types of youth can best be served in residential group care. However, empirically-based findings indicate that a broad array of groups of children and adolescents enjoy significantly better outcomes in family foster care than residential group care including the toughest group of youths to serve: multi-problem, chronic, violent, criminal offenders. Outcomes also illustrate the positive influence of consistent adults found in family foster care, which is often lacking in group care facilities, due to staff turnover. Findings show that negative peer interactions, more likely to exist in group care, influence negative outcomes.

In 1983, Festinger concluded that if amelioration of children's problems is a goal of out-of-home care, more effort must be made to develop family foster homes that can accommodate the special needs of those children (6). The Multidimensional Treatment Family Model (1 & 2) provides for the development and maintenance of such homes with its emphasis on a continuum of supportive services in the home and community for foster families and youth. With this approach to "best practices," hopefully children can live with parental caregivers in foster family homes where they enjoy a good quality of life and feel loved by adults and safe in family homes more than 90% of the time (4), and be prepared to make the transition to the adult community (5) where they can enjoy meaningful, fulfilling lives as productive adults (6).

Investing resources into reintegrating children back into school and community rather than in lengthy periods of residential care enhances the likelihood of successful outcomes for children and families. Residential group care should not be thought of as "Pariah care" (Mayer, 1971); but rather as part of a continuum of care for short, interim periods of time until suitable foster family placements can be made.

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References

Braukman, C. J., Kirigin, K. A., & Wolf, M. M. (1985). Follow-up of group home youths into young adult. *Progress Report, Grant MH20030, to the National Institute of Mental Health.* Lawrence, KS: University of Kansas, Achievement Place Research Project.

Brendtro, L., & Wasmund, W. (1989). The peer culture model. In Lyman, R. D. & PrenticeDunn, S. (Eds.), *Residential and inpatient treatment of children & adolescents* (pp. 81-95). New York: Plenum.

Chretien, R. D. & Persinger, M. A. (2000). Prefrontal deficits discriminate young offenders from age-matched cohorts: Juvenile delinquency as an expected feature of the normal distribution of prefrontal cerebral development. *Psychological Reports, 87,* 1196-1211.

Gershenson, C. P. (1990). *Preparing for the future backwards: Characteristics of ecology for children and youth in long term out of home* care. Prepared for the Casey Family Programs Symposium on Long Term Care, Seattle, WA.

Gold, M. & Osgood, D. W. (1992). *Personality and peer influence in juvenile corrections.* Westport, CN: Greenwood Press.

Green, J., Kroll, L., Imrie, D., Frances, F. M., Begum, K., Harrison, L., & Anson, R. (2001). Health gain and outcome predictors during inpatient and related day treatment in child and adolescent psychiatry. *Journal of the American Academy of Child and Adolescent Psychiatry,* 40, 325-336.

Haapasalo, J. (2000). Young offenders' experiences of child protection services. *Journal of Youth and Adolescence, 29,* 355-370.

Kim, J. Y. S. (2000). The validity of juvenile arrestees' drug use reporting: A gender comparison. *Journal of Research in Crime and Delinquency,* 37, 419-433.

Kirigin, K. A., Braukmann, C. J., Atwater, J. D. & Wolf, M. M. (1982). An evaluation of Teaching-Family (Achievement. Place) group homes for juvenile offenders. *Journal of Applied Behavior Analysis,* 15, 1-16.

Kiser, L. J., Millsap, P. A., Hickerson, S., Heston, J. D., Nunn, W., Pruitt, D. B., and Rohr, M. (1996). Results of one year later; Child and adolescent partial hospitalization. *Journal of American Academy of Child and Adolescent Psychiatry,* 35, 81-91.

Larzelere, R. E., Daly, D. L., & Criste, T. R. (1998). *The follow-up evaluation of children after out-of home placement.* Paper presented at the American Association of Children's Residential Centers, Sanibel Island, FL.

Levine, C., Brandt, A. M., & Whittaker, J. K. (1998). *Staying together, living apart: The AIDS epidemic and new perspectives on group living for youth and families.* Final report of the Orphan Project. [Available from Carol Levine, United Hospital Fund, 350 Fifth Ave., 23`d floor, New York, NY 10118.]

Lewinsohn, P. M., Gotlib, I. H., & Seeley, J. R. (1995). Adolescent psychopathology IV: specificity of psychosocial risk factors for depression and substance abuse in older adolescents. *Journal of American Academy of Child and Adolescent Psychiatry, 34,* 1229.

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Mayer, M. F & Blum, A. (Eds). (1971). *Healing through living: A symposium on residential treatment.* Cambridge, MA: Harvard University Press.

Melton, G. B., Lyons, P. M., & Spaulding, W. J. (1998). *No place to go: The civil commitment of minors.* Lincoln: University of Nebraska Press.

Pecora, P., Whittaker, J. K., Maluccio, A. N., and Barth, R. P. with Plotnick, R. D. (2000). *The child welfare challenge: Policy, practice, and research* (2nd ed.) New York: Child Welfare League Press.

Pfeiffer, S. I. & Strzelecki, S. (1990). Inpatient psychiatric treatment of children and adolescents: A review of outcomes studies. *Journal of American Academy of Child and Adolescent Psychiatry,* 29, 847-853.

Phillips, E. L., Phillips, E. A., Fixsen, D. L., & Wolf, M. M. (1974). *The teaching-family handbook* (2"d ed.). Lawrence, KS: University of Kansas Printing Service.

Pliszka, S. R., Sherman, J. O. & Barrow, M. M. (2000). Affective disorder in juvenile offenders: A preliminary study. *American Journal of Psychiatry,* 157, 130-132.

Ramp, K. K., Gibson, D. M. & Wolf, M. M. (1990). *The long-term effects of Teaching-Family model group home treatment.* Paper presented at the annual meeting of the National Teaching-Family Association, Snowbird, UT.

Randall, J., Henggler, S. W., Pickrel, S. G., & Brondino, M. M. (1999). Psychiatric comorbidity and the 16-month trajectory of substance abusing and substance-dependent juvenile offenders. *Journal of the American Academy of Child and Adolescent Psychiatry,* 38, 1118-1125.

Shelton, D. (2001). Emotional disorders in youth offenders. *Journal of Nursing Scholarship,* 33, 259-267.

U.S. Department of Health and Human Services. (1994). *National study of protective, preventive and reunification services delivered to children and their families.* Washington, DC: U.S. Government Printing Office.

Weinberg, N. Z., Rahdert, E., Colliver, J. D., Glantz, M. D. (1998). Adolescent substance abuse: a review of the past 10 years. *Journal of American Academy of Child and Adolescent Psychiatry,* 37, 252-261.

Weinrott, M. R., Jones, R. R., & Howard, J. R. (1982). Cost-effectiveness of Teaching Family programs for delinquents. *Education Review, 6,* 173-201.

Wolf, M. M., Braukmann, C. J. & Kirigin, K. A. (1987). Serious delinquent behavior as a part of a significantly handicapping condition: Cures and supportive environments. *Journal of Applied Behavioral Analysis, 20,* 347-359.

Wolf, M. M., Kirigin, K. A., Fixsen, D. L., Blase, K. A. & Braukmann, C. J. (1995). The Teaching-Family Model: A case study in data-based program development and refinement (and dragon wrestling). *Journal of Organizational Behavior Management,* 15(1/2), 11-68.

Wolins, M. (1974). *Group care: Explorations in the powerful environment.* Hawthorne, NY: Aldine de Gruyter.

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Best Practices in Children's Mental Health: Report #3
Results of Group Care for Children and Adolescents

QUESTION 1: Is there empirical literature that supports the "best practices" idea that family foster care is better than group home care?

Citation	Type of Study	Type of Program/Model	Pertinent Findings
1) Chamberlain, P. and Reid, J. (1998). Comparison of two community alternatives to incarceration for chronic juvenile offenders. *Journal of Consulting and Clinical Psychology*, 66, 4, 624-633.	Pretest and Post-test comparison with random assignment to two groups. Boys referred for community placement from the juvenile justice system were randomly assigned to two groups in order to study the relative effectiveness of group care (GC) and multidimensional treatment foster care (MTFC). Groups were compared in terms of their impact on criminal offending, incarceration rates, and program outcomes. The 79 male adolescents were violent offenders who had histories of chronic and serious juvenile delinquency over a four-year period of time referred for community placement by the juvenile court. All 79 participants had been detained the year before entering the study; the average number of days spent in detention was 76. All boys had predisposing risk factors such as being perpetrators of sexual abuse, coming from single-parent family, psychiatric hospitalization of family member, parent convicted of crime, drug and alcohol abuse, chronic	The MTFC program uses a comprehensive treatment model, including: (a) foster parent recruitment and screening, (b) intensive pre-service training, (c) ongoing foster parent consultation from professional staff, (d) school consultation, individual youth treatment, and family therapy, and (e) aftercare services using a "wraparound" or customized service delivery for youths and their families. Group Care (GC) was based on Positive Peer Culture (PPC) that attempts to help youth develop pro-social skills. In PPC the assumption is that the peer group has	All differences between the two groups from pretest to post-test were statistically significant. Fewer boys in MTFC than in GC ran away from placements (30.5% vs. 57.8% respectively). A greater proportion of MTFC boys than GC boys completed programs (73% vs. 36% respectively). During the year after referral, boys in MTFC spent significantly fewer days in lockup than did GC boys (MTFC, mean = 32 days; GC, mean = 70 days). Overall, MTFC boys spent 60% fewer days in lockup than GC boys. At one year pretreatment, the mean number of criminal referrals for boys in MTFC was 8.5; at one-year follow-up, the mean number of referrals was reduced to 2.6. For the GC group, the mean number of referrals was 6.7 one year pretreatment and 5.4 at one-year follow-up. Compared with boys in GC, boys in MTFC spent nearly twice as much time living with parents or relatives during the 12 months after program enrollment.

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	truancy, fire setting, and running away from placement. There were no significant differences between groups. The youth ranged in age from 12-17, with a mean age of 14.9. On average, they were 12.3 years old when arrested for the first time, had 13 previous arrests, and 4.6 felonies. Individual records were examined, including a one-year baseline prior to placement in study. Pretests were given and follow-up measures were taken at one year post-discharge. Tests of proven reliability and validity were administered. n = 79, GC (n = 42), MTFC (n = 37).	the strongest influence over the values, attitudes, and behavior of most youth. Staff attempt to develop a peer culture where peers watch out and care for each other by giving feedback and reporting inappropriate behavior and thoughts. Youth are encouraged to help each other adopt pro-social attitudes and behaviors. Programs attempt to help youths identify "thinking errors." Daily group sessions include problem solving. A criticism of PPC is that helpfulness varies widely according to how protocol is implemented. In this study treatment integrity for both models was maintained.	MTFC was significantly more effective than GC programs in reducing officially recorded delinquent activity.
2) Chamberlain, P. & Moore, K. (1998). A clinical model for parenting juvenile offenders: A comparison of group care versus family	This study is a companion study of study "1" above with same group of boys and same study design, but a different secondary researcher. A separate question was studied over a longer period of time, with outcomes measured by instruments valid to the variables considered. The study was undertaken to test the premise that adults have little impact on	Same models described in study "1."	All outcomes on juvenile offending and time spent with families were statistically significant (SS) from pretest to post-text and favored those boys who participated in the MTFC program as indicated on study "1." These findings, when correlated with variables of the study "2" question, rendered the following: The extent that participants felt liked and understood by adults during their placement was significantly (SS) related to positive outcomes. Conversely, increased affiliation

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care. *Clinical Child Psychology and Psychiatry*, 3, 375-386.	adolescents and that peers are the only powerful influence. To knowledge of researchers, no previous studies using randomized assignment for these comparisons with this subgroup have been made. Assessments were made at baseline and after three months in placement. Outcomes were then assessed at 6-month intervals for two years post-baseline. Boys and their primary caretakers participated in the assessments to determine extent to which the boys were supervised by adults, the level of consistent discipline received, the quality of the relationship with adult caretakers, and the amount of time youth spent associating with peers who also had problems with delinquency.		with delinquent peers was significantly (SS) correlated with negative outcomes. Results dispute the premise that by the time youngsters reach their teen years, adults have little impact on them; that peers are the only powerful influence.
3) Roy, P., Rutter, M., & Pickles, A. (2000). Institutional care: Risk from family background or pattern of rearing? *Journal of Child Psychology and Psychiatry*, 139-150. (British study)	Comparison of two matched groups in two placement settings: Group Care (GC) and Family Foster Care (FFC), with stratified sampling. The key question of the study was whether rate of disturbance was a function of the children's biological backgrounds and/or experiences before being taken into substitute care, or rather rearing differences while in placement care. In order to examine the effects of group care rearing, two groups of primary school children reared in substitute care from before the age of 12 months were compared: 19 children in residential group care and 19 in continuous stable foster family care. The two groups were matched	Family foster care includes single or multiple parent households, licensed to take care of children who cannot continue to live with their birth parents. Objectives include prevention of child maltreatment; maintenance of family and school; and providing stability in placement, while providing social services to the children and families to help resolve the problems that led to	*Teacher scores*: The children in group care showed levels of disruptive behavior and hyperactivity on the teacher ratings that were substantially greater than foster family. 58% of GC, but only 27% of FFC group had hyperactivity scores of 3 or more on an interval scale from 1 to 5. The rate of hyperactivity was statistically significantly elevated in GC group ($p = .002$), but not in the FFC group ($p = .18$). The same applied to total scores on the teacher questionnaire including conduct, emotional, hyperactivity, and unsociability, with a proportion of 53% for group care and 32% for FFC. *Behavioral Observation:* Based on 300 direct observation periods made by researchers, outcomes were similar to those of teachers. The mean scores were significantly higher in the GC group than in the FFC group.

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	in coming from biological families with high rates of psychopathology and social problems, but differed with respect to pattern of rearing in placement settings. Groups were also matched for age, gender, ethnicity, and IQ. At the time outcomes were measured and comparisons were assessed, the children were between ages six and seven. The mean age for GC was 79.8 and 81.3 months for FFC. Standardized instruments of proven reliability and validity were used to measure conduct, emotions, hyperactivity, and unsociability. Three methods of inquiry were used to assure inter-rater reliability: teacher scores, classroom observation, and caregiver ratings. Individual interviews of both caregivers and teachers were conducted as an internal validity check. n = 76, GC (n = 19), FFC (n = 19). [Findings for a control group of 38 were not considered in this review because group characteristics were not comparable to experimental groups.]	the placement. Family foster care can be provided by a relative or non-relative. Group care provides 24-hour care for children who cannot be cared for in their home or with a substitute family. Residential group care facilities offer group living with educational and therapeutic services provided by a staff of adult caregivers.	*Caregiver ratings*: Scores were similar to teacher ratings in showing emotional/behavioral problems as much higher in the GC group than in the FFC group. Differences between groups were most evident with respect to emotional difficulties and unsociability, which showed a statistically significantly difference. Conduct problems and hyperactivity were greater in GC than FFC, but short of statistically significant differences. Eight out of the 19 children in GC (42%) had scores above the cutoff on both parent and teacher questionnaires on all variables, compared with only 1 (5%) in the FFC group. Findings consistently showed that children in GC had much higher levels of problems in all categories, particularly hyperactivity/inattention. Researchers conclude that group care predisposes children to hyperactivity/inattention. The two substitute care groups were comparable in background but markedly different in patterns of rearing. Therefore, differences are likely to be a function of environmental influences, patterns of rearing, rather than biological background or experiences in early infancy.
4) Wilson, L. & Conroy, J. (1999). Satisfaction of children in out-of-home care.	Pretest/post-test design with random and stratified sampling to compare three placement settings: non-relative family foster care, kinship family foster care, and group care. Post-test measures were taken at one-year	Descriptions given in study "3" above. Foster family care can be provided either by a relative or non-relative.	Quality of Life dimension included: health, how you look, school, playmates/friends, things you do for fun, clothes, comfort, food, place of residence, your bedroom or private space, sleep, family relationships, and happiness. There were significant increases in the children's satisfaction after placement. Group care

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Child Welfare, 78, 53-69.	intervals for four years for children ages 5-18, with an average length of time in system between 38.7 to 46.3 months. Instruments were used to interview children in person to determine their overall well-being and quality of life. A strength of this study is that the individuals who know best about their quality of life, the children, were interviewed over a period of four years. n = 1,100.	Kinship family foster care indicates that care is provided by a relative.	gave significantly lower satisfaction ratings than kinship care and non-relative family foster care, with statistically significant difference at p = <.0001. Few differences were found in children's satisfaction among those in family foster care (kinship and non-relative care); large and significant differences were found in the comparison of family foster care to group care. Overall well-being was determined by asking questions such as "Do you feel loved?" and "Do you feel safe?" on an interval scale. Percentage of time felt: Always loved / Always safe Kinship care 94% / 92% Non-relative family care 82% / 92% Group care 46% / 64% The data indicate children in kinship care are more likely to "always" feel loved. Children in both kinship and non-relative care felt safe 92% of the time. The most dramatic differences related to comparison of children in family foster care with those in group care. The percentage of children in group care feeling loved and safe was significantly lower and differed significantly from the other two groups with p = < .0001.
5) Mech, E., Ludy-Dobson, C., and Hulseman, F. S. (1994). Life-skills knowledge: A survey of foster adolescents in three placement settings. *Children and*	Survey of life-knowledge among foster adolescents in three placement settings: Foster Family Care (FFC), Group Homes (GC), and Apartments (A). A life-skills inventory was administered as part of a battery of instruments designed to assess readiness of adolescents for independent living. A 50-item multiple-choice inventory was used to assess life skills knowledge. Two-hour interviews were also conducted.	Descriptions for FFC and GC given in "3." In apartment placements youth live in an apartment where a staff person resides and serves monitoring/super-visory functions.	Adolescents in apartment placements scored highest, followed by youth in foster family placements. Youth in group home placements scored lowest. The relationship between life-skills and living arrangements was reflected by youth who scored below 50%, or less than 100 points on the life-skills inventory. Scores were as follows: Group homes - 29 of 185, or 15.7 % scored below 50%.

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Youth Services Review, 16, 3, 181-200.	Mean age of participants = 17.60. Characteristics of study group: FFC GC A White male 28% 38% 34% (n = 119) Non-white 16% 51% 33% male (n = 96) White female 38% 30% 32% (n = 194) Non-white 29% 25% 46% Female (n = 125) n = 534. FFC (n = 156), GC (n = 185), A (n = 193). Differentials between characteristics within sample and groups sizes were controlled for in covariate analyses.		Foster family homes - 16 of 156, or 10.3% scored below 50%. Apartments – 4 of 193 (2%) scored below 50%. The results indicate life skills preparation is better in all settings studied than in group care. Adolescents in FFC were more prepared to make transition into adulthood than those in GC. Adolescents in GC were least equipped to make transition to independent living likely due to limits of trial and error learning.
6) Festinger, T. (1983). *No one ever asked us...A postscript to foster care.* New York: Columbia University Press.	Follow-up survey of all people discharged from foster care in the New York metropolitan area in 1975, who could be located. Sample was nonrandom. Respondents had been in care continuously for at least the preceding five years, and who were 18-21 years of age at time of discharge. A standard measuring instrument of proven validity and reliability was used. Some adults responded by mail; some were interviewed by phone. Data were collected for two years. n = 277.	Program descriptions not given beyond those in study "3."	Subjects who had been in family foster care functioned better as adult than those who had spent all or part of their time in group settings: they completed more education; they were less likely to have been arrested or convicted of a crime; they were less likely to be dissatisfied with the amount of contact they had with their biological siblings at the time of the study; they were less likely to be living alone, and to be single-parent heads of households; they were less likely to report alcohol or drug problems; they had a higher level of satisfaction with their financial situation; and they assessed themselves and their lives more positively. Positive findings for family foster care over group

			homes regarding drug and alcohol use and marriage were stronger for women. Women who had been placed in family homes were also less likely to have become pregnant for the first time while still in their teens. Positive outcomes appear to be more likely for children who have been placed in family foster care than in group care. Overall, it appears that children who spend their time in care in family foster homes function better as adults than those who spent a part of their time in care in residential settings. This phenomenon may be due, in part, to the nature of the problems the children have when they enter care; children with more severe emotional, physical or mental problems may be more likely to be placed in group settings than in foster homes. Study findings suggest that group placements do not ameliorate existing difficulties. If such amelioration is a goal of out-of-home care, more effort must be made to develop family foster homes that can accommodate the special needs of these children.

QUESTION 3: If group homes might be better for some children, or if we are always going to have group home care for some children due to "nowhere else to go," which types of group models (programs) have been shown to be effective for which types of children?

Citation	Type of Study	Type of Program/Model	Pertinent Findings
7) Friman, P. C., Oswood, D. W., Smith, G., Shanahan, D., Thompson, R. W., Larzelere, & Daly, D. (1996). A longitudinal	Longitudinal, pretest/post-test design, with a comparison comprised of youth who were referred but did not attend. Interviews were taken on five scales, reflecting youths' views on aspects of their placement: 1) Delivery of helpful treatment, 2) Satisfaction with supervising	Teaching Family Model (TFM), previously called Achievement place Model. In the TFM a married couple lives in a large domestic home with six to eight adolescents. Some of the major features of the program are (a) a token economy-type motivational system wherein youths earn points and exchange them for privileges, (b) a self-government system that allows youths to participate in development of the rules and	Differences between groups on all measures were negligible at pretest. 1) *Delivery of helpful treatment:* Post-test differences were statistically significant (SS). After leaving placement, treatment group reported a decline, but difference was still SS.

evaluation of prevalent negative beliefs about residential placement for troubled adolescents. *Journal of Abnormal Child Psychology,* 24, 299-326.	adult, 3) Isolation from family, 4) Isolation from friends, and 5) Sense of personal control. Measures were taken on all scale at 3-month intervals for six years and six month intervals for two additional years. Youth, 10-17 years of age, had to meet the following criteria: IQ of 80 or above, no history of sexual offense, not regarded as habitual felon, not addicted to drugs, and not suicidal. n = 581 Treatment group (n = 497), Comparison group (n = 84).	structure of their daily lives, (c) a focus on teaching social skills from a standardized social skills curriculum, (d) an emphasis on normalization, and (e) a continuous evaluation system, part of which involves the youths evaluation of the teaching family couple. Treatment arrangements for comparison group not described. Length of stay varied widely with a mean of 702 days. Youth with negative, previous experiences in group care were less likely to complete the program.	2) *Satisfaction with supervising adults:* The pattern of change was the same as for delivery of treatment. The level of satisfaction generalized to adults in subsequent settings and the treatment group remained more satisfied. 3) *Isolation from family:* Feelings of isolation decreased in both groups. However, change was gradual and slight for the comparison group and decreased significantly more for the treatment group. A significant post-residential difference was seen between the two groups, but was lower for treatment group. 4) *Isolation from friends:* Three months after pretest, the sense of isolation from friends decreased significantly for the treatment group. Isolation decreased slightly and gradually for both groups. The comparison group continued to feel significantly less isolation from friends than comparison group. 5) *Sense of personal control:* Placement tended to bring an increased sense of control for treatment group, but improvement was not SS. The treatment group reported little reduction after leaving placement, post-residential comparison group loss was considerably greater. Positive findings were not correlated with length of stay.

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			"Findings suggest that negative beliefs about residential placement for adolescents may not apply to all programs."
8) Kirigin, K. (2001). The teaching family model: A replicable system of care. *Residential Treatment for Children & Youth,* 18, 99-110.	Analysis of findings covering 30 years of history, program evaluations, and outcomes related to the Teaching-Family Model.	Teaching Family Model (TFM) Described in "1."	Studies on TFM show consistent effects during treatment. There have been published comparison outcome studies of program effectiveness of TFM (Braukman, Kirigin, & Wolfe, 1985; Kirigin et al., 1982, Phillips, Phillips, Fixsen, & Wolf, 1974) and one uncontrolled comparative follow-up study of the Boys Home Model (BHM) based on TFM (Larzelere, Daly, & Criste, 1998). These studies have shown consistent during-treatment effects favoring youths in TFM compared to youths in other residential care. However, the major differences between the groups, with the possible exception of social skill performance (Ramp, Gibson, & Wolf, 1990) dissipate during the first year following release from the program (Kirigin et al., 1982, Braukmann et al., 1985). A later follow-up of a sample of TFM group home participants as young adults (average age 21), showed no difference in the percent arrested for non-traffic offense. Despite the lack of measured differences in types or rates of offending as adults, the TFM participants were likely to receive probation, which suggests a possible enduring effect of the social skill training (Ramp, et al, 1990).

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			"Though disappointing, follow-up results were consistent with findings from nearly every group-care intervention program that has been subjected to evaluation to date, that there are no 'easy cures' or 'quick fixes' for serious problems." What TFM has achieved, however, is to establish a replicable program. Training administrators, staff, consultants, evaluators, and teaching-parent staff is a labor-intensive exercise that may take three to five years to achieve. Once adopted and certified, the Teaching Family site appears to be durable.
9) Thompson, R. W., Smith G., Oswood, D. W., Dowd, T. P., Friman, P. C., and Daly, D. L. (1996). Residential care: A study of short and long-term educational effects. *Children and Youth Services,* 18, 221-241.	Longitudinal study with two comparison groups, no random sampling, no random assignment. The two groups were the Boys Home Model (BHM) and a treatment-as-usual group, which was comprised of youth who did not enter the program because they did not meet admissions criteria, did not come, or were not admitted due to space limitations. Variables measured: 1) Grade point average, 2) years of school completed, 3) high school diploma/GED, 4) importance/chance of college, 5) help with homework, and (6) attitudes about education. Participants were interviewed upon entry to program and every three months thereafter, for six	Father Flanagan's Boys' Home Model (BHM), a combination of the Teaching Family Model (TFM) and Project-Ed (PE), an early attempt to provide residential care with a strong academic component. The experimental group in this study differed from TFM and PE because youth attended school on campus. The school program is designed to meet needs of students with academic and behavior problems including a comprehensive behavior management system with a social skills curriculum that is integrated into the classroom and extracurricular activities.	There were negligible differences between groups on all measures at pretest. 1) *Grade point average:* There was a small grade point average increase at initial interview for treatment group, but not for comparison group. This difference grew by over half a grade point. The treatment group experienced higher grade point averages in residence than after leaving the program. 2) *Years of school completed:* Treatment group completed at a statistically significant rate of difference. There was significant decrease in the rate of years of school completed for youth after leaving placement. 3) *High school diploma/GED:*

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	years. Thereafter, for two years, respondents were interviewed every six months. Considerable attrition was experienced during the course of the study, with average number of interviews per respondent of 11.39. Groups were comparable with regard to demographics: Caucasian (71%), Black (20%), Hispanic (6%), Other (3%), Male (92%), Female (8%). n = 587. Treatment Group (n = 503), Comparison Group (n = 84).		Eighty-three percent of the treatment and 69% of comparison group graduated from high school or completed a GED. Differences between groups were not statistically significant. 4) *Importance/chance of college:* This variable increased for the treatment but decreased for the comparison group at a significant level. After departure, the level still remained significantly higher for the treatment group than for the comparison group. 5) *Help with homework from responsible adults:* The treatment group had an immediate increase. Children received less help with homework after leaving the program, but the treatment group still had more help than comparison group. 6) *Measure of academic attitude*: The treatment group showed significant improvement. At follow-up there was no difference in outcomes for youth staying six months, 20 months, or 50 months. There was faster regression for the shortest staying group after departure. Authors conclude that programs can alter long-term academic performance and attitudes and that troubled children and adolescents may need a treatment environment over an extended period of time (unspecified) to have

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			a lasting impact on their lives. Considerable attrition occurred in both groups. By one year 27% of treatment group were gone; at 36 months 77% were gone, with 23% remaining.
10) Landsman, M., Groza, V., Tyler, M., and Malone, K. (2001). Outcomes of family-centered residential treatment. *Child Welfare League of America,* 50, 351-378.	Pretest and Post-test comparison of two groups: Reasonable Efforts to Permanency through Adoption and Reunification Endeavors (REPARE) and the agency's standard treatment program as a comparison group. No random selection or assignment. The basis of group assignment was by county of residence. The study was conducted over a period of 18 months. Groups were comparable on pretest behavioral and social measures taken from parents. Difference reported on one measure by residential staff, were controlled for in analysis. Due to the restrictive and expensive nature of residential group care placements with residential care as a last resort, a key question of the study was whether the two treatment models would have a differential effect on the achievement of stable outcomes for children over time. Stability was defined as continuous, uninterrupted	The REPARE Model seeks to reduce the length of time children spend in residential care, improve family functioning and achieve placement permanency. Objectives include a continuum of services, using families as partners from placement through aftercare in the home and community-based support services. REPARE is a family-centered approach that emphasizes optimal level of connection for each child and family. REPARE also emphasizes skills training and structured learning opportunities for children, and teaching skills necessary for parents to actively participate in problem-solving; determining concrete goals necessary for permanency planning; and includes parents in shaping a plan for the child's outcome. Interventions: Schedule all appointments at family's convenience; family is a team member; increase family presence at residential unit; provide supports for family to facilitate participation; focus on social environment that maintains problems rather than cause of problems; work at multiple system levels (school and community), parent skill education; services in the home for behavior management; case management; family advocacy; community support. Both caregivers and children are served. Comparison group: Agency's standard high quality residential program that provides individual and group therapy, behavior management, educational, and recreational services with a focus on the child	Groups were comparable on pretest measures. Post-test outcomes were based the following variables: *Length of Stay:* Differences between groups were statistically significant (SS) (< 05). Assignment to the REPARE group, with fewer day in care, had a significant positive relationship with achieving stability, while more days in care was negatively related to stability in comparison group. *Family Visits During Placement:* REPARE group children had more family visits, SS (<.001). Comparison group had more contact with family by mail, SS (<.005). Controlling for geographic distance, differences between groups remained significant on same variables. *Achievement of permanency and stability in children's living arrangements over time:* At discharge, REPARE group children were significantly more likely to be discharged home directly (< .001) whereas comparison group

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	placement with a parent, relative or legal guardian, or in a planned long-term foster family home. The study consisted of 139 children, ages 4.7 to 14 years, with a mean of 10 years. The REPARE group was 84% male, and comparison group was 70% male, a difference that was not statistically significant. Groups were similar in age and ethnicity. Stability was measured at six months post-discharge for both groups, and again at 12 months post-discharge for the REPARE group and comparisons made to determine if REPARE participants were more likely than comparison participants to have achieved stability at six months after leaving residential treatment. Additionally, stability was measured at 12 months post-discharge for the REPARE group so that outcomes essentially followed both groups for equal periods of time (18 months from admission for residential treatment) could be compared. n = 139 REPARE group (n = 82) Comparison group (n = 57).	as primary recipient of services. REPARE (LOS mean = 242.25 days), Comparison (LOS mean = 443.97).	children were more likely to be discharged to another group facility (< .0005) or long-term family foster care, not SS (<.10). Stability at six months post-discharge: 59.1 % of REPARE group vs 37.8% of comparison group had attained stability, a SS difference (< .05). Group differences were greater when outcomes were compared at 18 months from admission. Children in the REPARE group were more likely than those in comparison group to have achieved stability at SS difference of < .001. Care effectively provided in a family-centered fashion, maintaining a dual focus on the child and family was positively related to placements after discharge. Residential placement need not be long in duration to achieve stabilization for the child and family, despite the traditionally long lengths of stay associated with these services.
11) Kapp, S. (2000). Positive peer	A qualitative study undertaken in light of a shortage of evaluation research assessing the impacts	A particular model was not identified for study. Rather, open-ended, neutral language questions were asked such as, "What did you think of___?"	From open-ended, neutral question about general experiences in child welfare residential group care,

culture: The viewpoint of former clients. *Journal of Adolescent Group Therapy,* 10, 175-189.	of residential treatment models from the perspective of the client. In-depth interviews were conducted with eight young men initially identified from a group of individuals formerly placed at a juvenile facility and currently in prison who had been in residential care as youths, to provide a unique look at common practices in residential group care and juvenile justice settings. The data were documented in writing and findings were shared with participants as a "member check" to assure accuracy. The researcher did not seek to compare models, but to understand the meaning of the participants' experiences as previous recipients of residential care in the child welfare system who are presently imprisoned, to get the impression of services received as children. n = 8, 7 white males, 1 black male.	and "What was it like at _ _ _?" This relatively unstructured format allowed the young men to give their impressions of any and all residential group services they received as children.	without prompting, participants consistently described the model of Positive peer Culture (PPC) [Described in study #1]. The PPC experience was consistently discussed critically in descriptions from participants. The PPC environment was described as negative and problematic, particularly being forced to work with negative influence of other delinquent youth. Participants consistently described being placed "at odds" with peers as harmful, especially when the model invited intense personal evaluation from all group members. In most cases, individuals did not perceive the staff as monitoring or influencing a constructive nature of peer interactions. Participants commented: "If a juvenile had a conflict, they got to hurt you." "If a member did not like you, they took advantage." So you have to be cut-throat with other people. To be honest, if they tried to run PPC in here (prison), do you know how many people would get hurt?" Respondents felt the staff was adversarial and aggressive. Comments offered included: "Info is used by staff against kids. While we are pointing fingers, Mr. _ _ _ is sitting back remembering what happened for discussion about the

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			next level or home visits." "[G]uys in the group... would set individuals up against one another. Staff would use us...against one another." Another strong sentiment expressed concern about the deception encouraged in the program. Many of the young men discussed the idea of PPC promoting "frontin." Being deceitful was described as a necessary skill, promoted and developed in order to survive the group experience. A participant said, "PPC...teaches you how to front." The sample size was small; however, "The stories of these individuals illustrate the value of client, in this case former client, feedback. Their portrayals of group treatment are grounded in experience. When attempting to judge the merit of the information in this study the reader should remember that each participant offered their opinions about PPC with no prompting. There was consistency in feedback around PPC" to a saturation point. "All respondents raised the issue and provided similar viewpoints" without prompting. The former service recipients in this study offer a negative portrayal of PPC and its impact. The issues raised in the findings are very consistent with the

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			caveats offered by Brendtro and Wasman (1989) regarding the struggle to implement the model effectively."
12) Bass, L., Dosser, D., Powerll, J. (2000). Celebrating change: A schema for family-centered practice in residential settings. *Residential Treatment for Children & Youth,* 17, 123-137.	Pilot study testing "Schema" (a family-centered, strength-based helping process model) in two children's residential settings. No comparison group. One specialized in longer placements, and the other in shorter but more intense placements. During the one-year test of the "schema" model, researchers made field visits to each agency at three month intervals to collect both qualitative and quantitative data. Data were also collected at end of pilot of program to measure family-centered progress.	There are six continuous and cumulative steps or phases in "schema." 1) Joining: Engaging families/agency staff. Encouraging families and agency staff to become partners in process or journey together to meet the goals of the family, 2) Discovery: Beyond diagnosis. Looking for strengths in families and communities as well as recognizing the reality of struggles and concerns, 3) Change: More than treatment. Working together to promote positive change for children, families, agency staff, and agencies, 4) Celebration: Recognizing and appreciating strength and potential. Attending to and amplifying change, however small, and affirming growth, potential, competence, confidence and hope, 5) Separation: Sharing belief in families' capacity to cope. Ending the journey together so that families and agency staff separate; both better for having been on the journey together and with each carrying with them new ways of coping, new possibilities, new life, and new meanings, and 6) Reflection: Opportunity to grow. Thinking through what has happened for both families and agencies and beginning again. Staff are challenged to think critically, to re-examine and select the most promising approaches.	Both quantitative and qualitative data were collected, but there were insufficient quantitative data for statistical analysis. However, extensive qualitative interviews conducted with family members and staff yielded data that supported the use of "schema" as a guide to help promote family-centered practice. Participants indicated satisfaction with the model on 1) helping clients achieve a greater level of involvement, ownership, voice and access, 2) assisting clients and helpers maintain focus and intensity, 3) greater level of satisfaction with services, 4) helping family members develop greater appreciation of family heritage, ethnicity, and culture. Researchers felt the research project demonstrated that a schema-like helping process model has potential to advance family-centered practice in children's residential care settings.

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