

## Using a Specialized Foster Care Community Treatment Model for Children and Adolescents Leaving the State Mental Hospital

Patricia Chamberlain

and

John B. Reid

Oregon Social Learning Center  
Eugene, Oregon

This study assessed the effects of providing treatment in a Specialized Foster Care (SFC) program for children and adolescents who had been previously hospitalized. Cases were randomly assigned for placement in SFC or other extrahospital settings, including residential treatment centers and family/relative homes. The SFC program used carefully selected foster parents who were trained and supervised in the implementation of the child's treatment plan. One child or adolescent was placed in each home. SFC placements were augmented by individual therapy for the child or adolescent and by case management services, including coordination with schools and employers, weekly clinical staffings, and crisis intervention. Results showed that the SFC model is a viable treatment option for severely emotionally disturbed children and adolescents, that cases in the SFC group were placed outside of the hospital more frequently and quickly than cases in the control group, and that once placed outside of the hospital, SFC cases were slightly more successful at maintaining in their communities than were control cases.

During the past decade, an increasing number of Specialized Foster Care (SFC) programs have been implemented throughout the United States for children and adolescents with a variety of presenting problems, including emotional disturbance (Hawkins, Meadowcroft, Trout, & Luster, 1985), medical complications (Yost, Hochstadt, & Charles, 1988), and delinquency (Chamberlain, 1990). The SFC model appeals to both clinicians and policy makers because it provides the opportunity for intensive, individualized treatment in a nonrestrictive (i.e., family) setting.

The primary distinction between SFC and regular foster care is in the role played by the foster parent. In SFC the foster parent is the central or key agent in the implementation of the child's treatment plan. Accordingly, specialized foster parents are carefully selected and initially trained. This is followed by ongoing supervision and support similar to that given to therapist trainees. The notion that parents who apply systematic interventions can have positive effects on children's problems is supported by the literature on parent training treatments (Bank, Marlowe, Reid, Patterson, & Weinrott, in press; Patterson, 1982).

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Reprints of this article may be obtained from Patricia Chamberlain, Oregon Social Learning Center, 207 E. 5th Avenue, Suite 202, Eugene, OR 97401.

Although single case, group, and comparison studies on SFC have been reported in the literature (e.g., Almeida, Hawkins, Meadowcroft, & Luster, 1989; Webb, 1988), no studies have been reported that use random assignment to compare systematically the efficacy of SFC to commonly used alternatives. This is probably due to the difficulties, both practical and political, associated with conducting community-based, randomized trials with children and adolescents who require radical and intensive interventions (e.g., removal from the parental home, institutionalization, hospitalization).

This report compares SFC to "treatment as usual" for a population of psychiatrically hospitalized 9- to 18-year-olds. Participants were referred from the state mental hospital and then randomly assigned to the SFC program or to existing alternatives available in their communities. For experimental group participants, a seven-component SFC model was used including: (1) recruitment and screening of foster parents, (2) preservice training, (3) daily management of the child in the home and community, (4) ongoing supervision and support for foster parents, (5) individual child treatment, (6) family treatment, and (7) case management and community liaison services. Control group respondents were placed in residential treatment centers, parents' or relatives' homes, or received further hospitalization. All cases were assessed initially and then followed up 3 and 7 months later. The proportion of time participants spent in a community versus a hospital setting and measures of social functioning were examined.

### Methods

#### *Participants*

Participants were 8 males and 12 females who were referred to the study by outreach teams at the Oregon State Hospital. These teams were multidisciplinary and consisted of staff who had worked with each case (i.e., psychiatrists, psychologists, social workers, group workers, occupational therapists, and educators). Referred cases were all judged to be ready for a community placement. After referral, study participants were randomly assigned to the experimental (i.e., SFC) or control condition. One 18-year-old female refused to participate.

Descriptive data were collected on participants and are shown in Table 1. There were no reliable differences between the two groups on family makeup, risk variables, or the special clinical concerns listed in Table 1. Table 2 shows individual data on age, sex, full-scale IQ scores, and psychiatric diagnosis made at the hospital. All but 6 of the 20 participants (2 experimental and 4 control) had dual diagnoses. The average number of days during the year the respondents had been hospitalized prior to referral to the study was 245.1 ( $SD = 105$ ) days for the experimental group and 236 ( $SD = 125$ ) for the control group.

#### *Measures*

Following referral, all participants were assessed at baseline on their severity of emotional disturbance, level of social competency, self-reported symptoms, and the occurrence of problem behaviors.

1. Severity of emotional disturbance was rated using the Child Global Assessment Scale (CGAS) (Shaffer et al., 1983), which measures the respondent's level of functioning during the past month. Using expert raters, the scale has been shown to have good psychometric properties including test-retest stability (e.g.,  $r_s = .69-.95$ ) and concurrent and discriminant validity. The scale was completed at baseline by a senior psychiatric resident at the Oregon Medical Health Sciences University who was blind to group assignment.

Table 1

*OSLC Transitions Program, Characteristics of Participating Youth, January, 1987-August, 1988*

	Treatment group		Control group	
Youth admitted to date	10 (5 male; 5 female)		10 (3 male; 7 female)	
Average age	13.9 (range 9-18)		15.1 (range 12-17)	
Average number of out-of-home placements	5.1 (range 1-10)		5.0 (range 1-12)	
Family makeup				
Divorced	7/9	(77%)	8/9	(88%)
Failed adoptions	3/10	(30%)		
Siblings institutionalized	2/10	(20%)	3/10	(30%)
Siblings in foster care	5/10	(50%)	4/10	(40%)
History of family mental illness or in institutions	8/10	(80%)	9/10	(90%)
Family as aftercare resource	0/10	(0%)	2/10	(20%)
Risk variables				
Family at poverty level	5/10	(50%)	6/10	(60%)
Family violence	8/10	(80%)	9/10	(90%)
Three or more siblings	5/10	(50%)	4/10	(40%)
Youth with record of felonies (documented)	3/10	(30%)	3/10	(30%)
Youth with physical attacks on others (documented)	6/10	(60%)	5/10	(50%)
Sexually abusive	4/10	(40%)	2/10	(20%)
Fire setting	1/10	(10%)	1/10	(10%)
History of law violations (adjudicated)	5/10	(50%)	4/10	(40%)
Special clinical concerns				
Suicide attempts	6/10	(60%)	2/10	(20%)
Drug/alcohol dependency	3/10	(30%)	5/10	(50%)
Multiple runaways	6/10	(60%)	8/10	(80%)
Chronic truancy	4/10	(40%)	7/10	(70%)
Sexually abused	8/10	(80%)	7/10	(70%)

The following measures were administered at baseline, and again at 3 and 7 months later:

2. The Parent Daily Report Checklist (PDR) (Chamberlain & Reid, 1987) measures the occurrence of problem symptoms during the prior 24-hour period. PDR was administered by telephone on 10 separate days to ward staff at baseline and then to foster parents, ward staff, or other primary caretaker 3 and 7 months later. The PDR problem behavior score has been used in numerous treatment outcome studies (e.g., Patterson, 1974; Patterson, Chamberlain, & Reid, 1982) and has been shown to have acceptable reliability (e.g., inter-interviewer  $r = .98$ ; test-retest  $r = .6-.82$ ) and validity characteristics (Weinrott, Bauske, & Patterson, 1979).

3. The Behavior Symptom Inventory (BSI) (Derogatis & Spencer, 1982) is a 53-item self-report inventory in which children were asked to rate their level of symptoms and distress. The Global Severity Index score, which has been shown to have good test-retest stability ( $r = .90$ ), was used.

4. The Social Interaction Task that was used depended on the child's age. For youth 12 years and older, the Adolescent Problem Inventory (API) (Gaffney & McFall, 1981) was administered. For youth under 12, the Taxonomy of Problematic Social Situations (TPOS) (Dodge, McClaskey, & Feldman, 1985)<sup>1</sup> was used. Both use the same

<sup>1</sup>Both systems have reported interrater reliabilities of over .90 and test-retest reliabilities of over .70.

Table 2  
Sex, Age, IQ, and Diagnosis, Treatment and Control Groups

	Sex	Age	IQ	Diagnosis
<b>Treatment</b>				
1)*	M	15	80	Conduct Disorder; Enuresis
2)	F	18	100	Conduct Disorder; Borderline Personality
3)	F	9	76	Posttraumatic Stress; Oppositional Disorder
4)	M	11	96	Conduct Disorder
5)	M	12	76	Attention Deficit; Conduct Disorder
6)*	F	18	69	Borderline Personality; Alcohol Dependency
7)	M	14	96	Schizophrenia
8)	M	10	110	Conduct Disorder; Attention Deficit
9)*	F	13	89	Borderline Personality; Conduct Disorder
10)	F	18	97	Posttraumatic Stress; Conduct Disorder; Dysthymic Disorder
5M-5F $M = 13.8$ $M = 88.9$				
<b>Control</b>				
1)	F	15	110	Conduct Disorder; Alcohol Abuse
2)	M	18	87	Schizophrenia
3)	F	17	90	Conduct Disorder; Marijuana Dependence
4)	F	16	100	Schizotypal
5)	F	17	100	Borderline Personality; Polysubstance Abuse
6)	M	13	100	Dysthymic Disorder, Oppositional Disorder
7)	F	17	90	Schizophrenia, Marijuana/Alcohol Abuse
8)	M	12	82	Schizophrenia
9)	F	12	82	Posttraumatic Stress; Conduct Disorder
10)	F	15	100	Adjustment Disorder with Mixed Emotional Features
3M-7F $M = 15.5$ $M = 94.1$				

\*Rehospitalized.

format; the child is presented with a problem vignette and is asked to role-play a response. These tasks are designed to assess the child's level of social skills and problem solving.

5. Institutionalization rates were tabulated for all respondents during three time periods: (1) for the year prior to referral, (2) for the time from referral to initial placement out of the hospital, and (3) for the time from initial placement through the subsequent 365 days. This rate of days institutionalized was considered to be the primary or "bottom-line" indicator of success or failure of the case.

#### *Clinical Procedures for the Experimental Group*

*Foster parent recruitment and screening.* There were no preconceived structural or demographic characteristics of acceptable families. Two-parent and one-parent families of both sexes were selected, as well as families with a wide range of social, ethnic, and economic backgrounds. We attempted to recruit and select strong families both in terms of stability and skills.<sup>2</sup> In addition to evaluating the general suitability of the family and the specific match between the child and the family, another key focus was the parents' ability to function effectively in the program. It was necessary that the family

<sup>2</sup>Details on recruitment, selection, and training of foster parents are available from the authors.

provide more than acceptance, affection, and security for the youngster placed with them. Because of the magnitude of the problems presented by the children, families were selected who were willing to work actively, consistently, and cooperatively toward specific behavioral goals for the child placed with them.

Many excellent foster parents were not suitable for this program. Some of these were inexperienced in dealing with severe child problems; some had a great deal of love to give and felt that was sufficient; others had many strengths, but disagreed substantially with important elements of the program; and some wanted to work independently. This application of SFC was a team approach. Problems were dealt with as they came up through the interactive efforts of the foster family, the case manager, and the therapists. A decision was made about whether a family could function well within this team approach.

*Preservice training.* The training course consisted of four 2-hour sessions on teaching foster parents to use behavior management strategies, including specific methods of encouragement and limit setting, learning to identify and track positive and negative behaviors and to respond to them in a systematic way. The composition and functioning of the treatment team approach was also emphasized. Role-playing exercises were used to illustrate and help the foster parents practice behavior management strategies.

*Daily management of the child in the home and community.* A daily point system was implemented by the foster parents for each child. The child was given points for participating in expected activities throughout the day. School attendance and performance were tracked using an index card that the child's teachers signed. School points were awarded in the foster home. The goal was to use points to create a rich schedule of reinforcement for the child. Foster parents took a few points for targeted problem behaviors, such as noncompliance, unsupervised time, arguing, or destructiveness. Points were used to buy privileges and extra rewards.

Each child's point program was individually tailored to be responsive to his or her treatment needs and to the circumstances in the foster home. Throughout the placement, the point system was revised to address the child's progress and emerging problems.

*Ongoing supervision and support for foster parents.* After a child was placed, the foster parents were contacted daily and Parent Daily Report Checklist (PDR) (Chamberlain & Reid, 1987) data were collected. During this call, a case manager provided support to the foster parents to help them trouble-shoot problems and use the point and level system. Supervision and support were also the focus in a weekly group foster parent meeting that was led by the case manager. Each child's progress during the prior week was reviewed, treatment goals were revised, and appropriate adjustments in the child's daily program were made. Input from the child's individual therapy (described below) was integrated. The group interaction appeared to be a vital part of the continuing training for the foster parents. By reviewing issues and problems brought to the meeting by other foster parents and the case manager, they continued to learn how to deal with an increasing variety of situations.

*Individual child treatment.* Weekly individual sessions for each child were conducted. Therapists were experienced (range 3–14 years) in using a Social Learning treatment model. The first goal of the individual therapy was for the therapist to establish a positive, collaborative relationship with the child. The child was told that the therapist would act as "someone who was on their side" within the program. For this reason, the duties of case manager and therapist were performed by separate individuals. The



case managers frequently set limits for the child, so were restricted in their ability to advocate for them. In individual sessions, the child was encouraged to bring up any difficulties he or she was experiencing, including problems with the individual point program, foster home, school, or peers. The therapist would help the child negotiate changes with the case manager and the foster parents. Discussion of the past was also encouraged. Common themes included abuse, feelings of rejection and abandonment, and feelings of being insecure or out of control outside of the hospital setting. Typically, participants had difficulties with authority figures at home and at school. Ways of dealing with problem situations were discussed and role-played. Children were often given specific assignments to complete during the coming week. These included activities such as keeping track of moods or feelings and their antecedents and practicing self-control strategies or communication skills.

The therapists were available to the child in times of crisis. For every case, at least one crisis period occurred, and in 40% of the cases crises occurred at least once per month. The content of the crises varied (e.g., suicide attempts, explosive outbursts, threats of harm to others or self, inappropriate sexual conduct, animal abuse, runaways, and ingestion of nonfood substances).

*Family treatment.* None of the cases in the experimental group had parents who provided aftercare placements for them. In a sample of 60 chronically delinquent youths who had participated in another application of the SFC model (Chamberlain, 1990), parents were available for aftercare in 55% of the cases. In the current sample, it was apparent that the absence of parental support added to the severity and complex nature of the problems experienced by these children. To what extent the lack of a parental advocate interacted with the child's subsequent hospitalization in a state facility could not be directly assessed in the context of this research. Clinically, however, this situation appeared to add-in as a significant risk factor.

In three of the experimental cases, contact was established with a relative of the child. Although none of these was willing or able to provide a placement resource, regular contact was encouraged, and progress updates, visits, telephone calls, and letter writing were arranged.

*Case management and liaison services.* A case manager was assigned to each experimental case. Their role was to monitor the overall progress of the case and to coordinate the efforts of the foster parents and the individual therapists. Case managers also maintained regular contact with the child's teachers and/or employers. Cases were staffed in a weekly meeting attended by case managers, therapists, the program director, and a clinical consultant, where the overall integrity of the child's treatment plan was monitored, and the sequencing and timing of interventions was planned. Another focus of the weekly staffings was to supervise and support case managers and therapists. Support and supervision for case managers and therapists was thought to be an important factor in maintaining their enthusiasm, morale, and perspective while working with these difficult cases.

#### *Treatments for the Control Condition*

*Placement settings.* Seven of the 10 control group participants were placed in community settings (e.g., 3 in residential centers, including a juvenile corrections training school, a group home, and a secure residential treatment center; 4 went to family or relative's homes) during the course of the study. The other 3 control group participants remained in the state hospital.

*Types of treatment.* Milieu therapy was described as being part of the treatment in all residential centers and in the hospital. The types of milieu therapy ranged from highly structured programs with specific behavioral targets to a more general level of nurturing/feedback.

Some individual therapy was provided to 9 of the 10 controls. However, the amount of individual therapy was substantially less for respondents who were living at home than for others in this group. (See Table 3.) Individual therapies included general psychotherapy, behavior therapy, and issue-focused treatments (e.g., drug/alcohol, sexual abuse). Treatment was delivered by a variety of professionals, including psychiatrists, MSWs, psychologists, and hospital line staff. Years of therapist experience varied from 1 to over 10 years.

Group therapy was provided to respondents who were placed in residential settings and for two of the four respondents who were placed in their family or relative's homes. Group therapy was the most common treatment received by controls and typically focused on social relationships, management of the milieu, or specific issues.

Table 3  
*Amount of Treatment Received by Control Group by Placement Setting and Treatment Mode*

Placement setting	<i>n</i>	<i>M</i> days in milieu treatment (range)	<i>M</i> hours individual (range)	<i>M</i> hours group (hours)
State hospital	3	365 (365)	54 (52-58)	156 (149-160)
Residential centers	3	335 (191-365)	77 (27-162)	170 (0-540)
Family or relative home	4	0	15 (0-37)	12 (0-45)

## Results

### *Institutionalization Rates*

The mean length of time between referral to the study and placement outside of the hospital for the experimental group was 81 days ( $SD = 42$ ). The mean length of time to placement for control group respondents was 182 days ( $SD = 136$ ). This difference between the groups was statistically reliable ( $t = 2.15$ ,  $df = 18$ ,  $p = .05$ ). All 10 experimental group respondents were placed in a family setting. For the control group, only 4 of the 10 respondents were eventually placed in a family setting. Three were placed in residential group settings, and 3 others remained hospitalized. Excluding the 3 control cases who remained hospitalized, the average time to placement for the remaining control cases was 103 days ( $SD = 60.5$ ). A comparison of the 10 experimental cases to the 7 control cases who were eventually placed out of the hospital showed a reliable group difference (i.e.,  $t = 4.76$ ;  $df = 15$ ;  $p < .01$ ) in the time from referral to community placement.

Given that a child was placed in the community, the next step was to look at the amount of time these children were maintained in those placements. For the year following placement, experimental group participants spent an average of 288 ( $SD = 138$ ) days living in their communities. Three of them were not successfully maintained in the experimental program, and were rehospitalized during the first 6 months of community

living. One additional case was briefly hospitalized (10 days) and then returned to the foster home.

For the seven controls placed outside of the hospital, the mean number of days in the community was 261 ( $SD = 157$ ). Two of the seven were rehospitalized during the first 6 months, and one was rehospitalized briefly (i.e., for 3 days) and returned to a community placement. The mean number of days living in the community was not reliably different for the two groups. However, given the smaller number of control group respondents who were placed outside of the hospital, the results indicate that the SFC treatment model is a viable treatment option for this population of severely disturbed children.

Looking only at those respondents who were placed in family homes (experimental,  $n = 10$ ; control,  $n = 4$ ) again, those in the SFC condition did slightly (but not reliably) better than control group children, with the mean number of days in the community being 288 ( $SD = 138$ ) and 251 ( $SD = 157$ ), respectively.

#### *Ratings of Severity of Emotional Disturbance*

The results of the pretreatment CGAS ratings showed that, on the average, respondents from both groups fell into the second lowest category—major impairment in functioning in several areas ( $M$ s: experimental = 32.4; control = 31.0; n.s.). To be included in this category, respondents must have been judged to demonstrate severely disturbed behavior across settings (i.e., home, school, and community).

#### *Level of Occurrence of Problem Behaviors, Self-Reports of Symptoms, and Social Competency*

*Occurrence of problem behaviors.* Complete PDR data were available for seven respondents in each group at all three measurement points (i.e., baseline, 3 months, and 7 months postbaseline). Complete data on the three others in each group were unavailable for various reasons: child had run away, placement had no telephone, residential staff were uncooperative. For each child at each of the three points, a mean score was calculated for the number of problem behaviors reported per day. As can be seen in Figure 1, the mean daily rates for the control and experimental groups at baseline were substantial (over 20 reported problems/day). At the third month postbaseline, the experimental group showed a reduction of over 50%, and the control group showed no decrease. At 7 months, the control group mean dropped, but not to the level of the experimental group. An ANOVA (2 groups  $\times$  3 time points) showed that although these data suggest a greater and quicker reduction of day-to-day problems for the experimental group, the overall group-by-time interaction failed to reach significance,  $F(2,11) = 2.44$ ,  $p > .13$ . A significant group-by-time interaction was found, however, by comparing the groups only at baseline and the 3-month assessment,  $F(1,12) = 5.29$ ,  $p < .05$ .

Given the small amount of data, and hence the limited power available for this analysis, these results are moderately encouraging. At the very least, they indicate that the behavior of these institutionalized and very seriously disturbed youngsters was not perceived by their caretakers to deteriorate or to be unmanageable when they were moved into the less restrictive specialized foster care environments. At best, they suggest that the youngsters may show behavioral improvements.

*Self-reports of symptoms.* Respondents in both groups completed the BSI scale, Global Symptom Index (Derogatis & Spencer, 1982) before placement and again 7 months later. Before placement, experimental group members reported twice as many problems



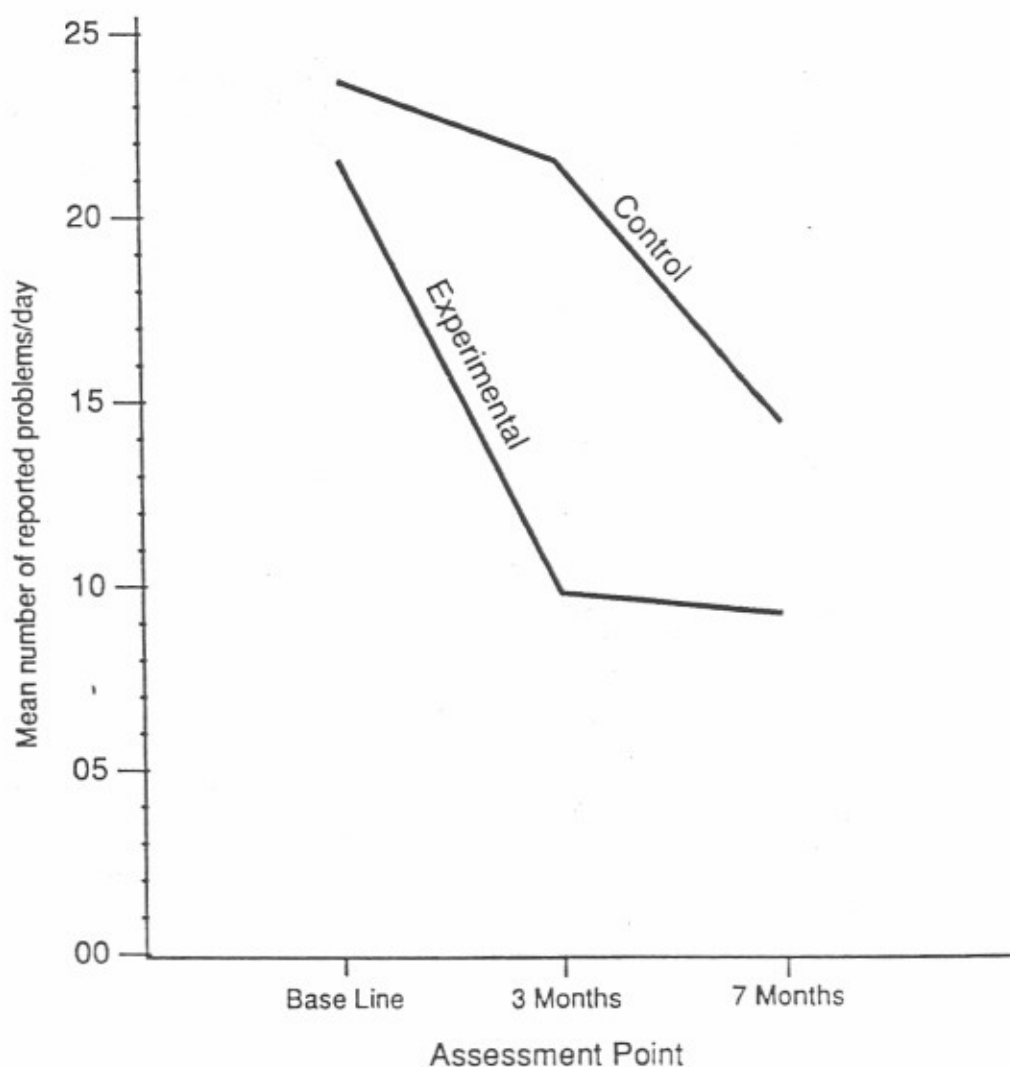


FIGURE 1. Mean Number of Problem Behaviors per Day at Three Points in Time.

as did controls ( $M = 1.3$  and  $.67$ , respectively;  $t = 1.97$ ;  $df = 15$ ;  $p = .07$ ). Seven months later, experimental group members were still reporting more distress than controls as did controls ( $M = 1.3$  and  $.67$ , respectively;  $t = 1.97$ ;  $df = 15$ ;  $p = .07$ ). Seven months later, experimental group members were still reporting more distress than controls ( $M = .92$  and  $.60$ , respectively;  $t = \text{less than } 1$ ), but this difference no longer approached statistical significance.

*Level of social competency.* The TPOS (Dodge et al., 1985) was used for the 5 children under 12 years of age. The other 15 participants were given the API (Gaffney & McFall, 1981). There was no improvement observed for either group on these measures. In fact, cases in both groups showed a slight nonsignificant decline in their scores from pre- to posttests.

Following the administration of the social interaction tasks at each phase, the interviewer was asked to rate the child on a number of dimensions, including general social competence, cooperativeness, appearance, and likelihood of the child making a normal adjustment in the future. The same ratings were later made from the videotapes of these tasks by an independent observer who was blind to group assignment and phase. The two raters' scores were then compared to assess reliability by dividing their number of agreements by the number of agreements plus disagreements at baseline ( $r = .70$ ) and at 7-month follow-up ( $r = .74$ ). Their ratings also showed no changes from pre to post on any of the dimensions assessed for respondents in either group.

### Discussion

The preliminary findings presented here support further studies and demonstrations of the SFC model with populations of severely disturbed children and teenagers. The shorter time from referral to placement found for the experimental group has obvious cost implications. At the time of the study, the hospital program cost was \$6,000 per month; the experimental program cost was \$3,000 per month. Placement in the experimental condition saved an average of \$10,280 per case in hospitalization costs. Another advantage of the SFC condition was that all of the respondents assigned to it had an opportunity to live and be treated in the context of a family setting, whereas six respondents in the control condition had no such opportunity. Key questions for future research are whether the selection and recruitment of strong homes is enough to produce positive results and, if so, to what extent.

The severity and complexity of the problems experienced by the participants in this study was evidenced by the fact that they had all been hospitalized for most of the preceding year. Seventy percent had at least dual diagnoses, and 30% had low IQs. In practice, community placements for cases such as these are difficult to find, and most community programs, if they accept these types of referrals at all, designate one or two "slots" for participants from the state hospital. The results presented here support the inclusion of the SFC model as a viable treatment alternative for this population.

In this study, the sample size restricted the conclusions that could be drawn and made it difficult to interpret if age differences and sex compositions in the two conditions might have affected the findings. Results on the child's level of self-reported problems and social competency tasks showed that, apparently, respondents felt no better outside of the hospital, and their social competency and problem-solving skills did not improve. Clinically, this was consistent with case reports from children in the experimental condition who said that they tended to feel less secure, safe, or "in control" outside of the hospital. BSI and social interaction task scores may have been restricted by a floor effect; participants never approached the normal range of functioning. In future work, measures specifically designed for this population should be developed and used. It should be remembered, however, that such self-reports probably reflect in part the context in which they are given. In the hospital, these children experienced a very predictable and structured day-to-day regimen, they interacted only with other children who were unskilled/dysfunctional, and faced few threats of failure. A less restricted, normal environment forced the children to deal with the fact that they were less competent and had more problems than virtually every other person with whom they interacted. The self-doubt, anxiety, and challenges must have been tremendous. On the other hand, the PDR data clearly indicate that at a behavioral, day-to-day level, these children were meeting the challenges of dealing with a complex and stimulating environment. The children in this sample had histories of severe disadvantage, abuse, and psychiatric

problems. It would undoubtedly take more than 6 or 12 months to provide them with feelings of comfort and self-efficacy in the complex environment outside of the hospital walls.

Further studies should be conducted on what types of children needing out-of-home placements can benefit from SFC and what the active components of the model for different clinical populations should be. For example, compared to a sample of cases referred for delinquency (Chamberlain, 1990) the respondents in this sample had lower levels of parental support, making the family therapy component relatively unimportant. Clinically, cases in the current sample had more difficulty sustaining normal-range functioning both at home and at school compared to cases referred for delinquency. A systematic examination of the number and types of crises generated by different clinical samples would add to the development of appropriate interventions. A similar strategy was used by Walker and Rankin (1983) to examine the teacher-rated potency of problem classroom behaviors.

This study represents a first step in demonstrating that the use of trained and supported foster parents as professional members of a treatment team has potential both for providing severely disturbed children with a normalized life-style and creating substantial savings for the care system.

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