

Growing the Tri-CAS Treatment Foster Care Program¹: A Fifteen Year Retrospective

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Tom came to the Tri-CAS Treatment Foster Care Program (TFC) as a 4-year-old boy who had suffered multiple losses and separations, and had been exposed to undisclosed trauma. He was full of rage, fueled by his underlying sadness. Tom's mother, herself a former Crown ward who had been rejected by both her biological and adoptive families, could not meet Tom's needs as an infant and toddler; her own unresolved grief manifested in substance abuse and ongoing mental health issues. Tom came into Children's Aid Society (CAS) care, and was placed with an adoptive family. However, this placement failed and Tom was placed into another adoptive home. Again, Tom's very difficult behaviour led to the family's "failure to bond" with him, to the point of emotional rejection, and a second adoption breakdown. The CAS was determined to prevent a further placement breakdown, so Tom was moved into the home of parent therapists in our TFC. At this point, he had no selective attachment figure.*

Throughout his first five years in care, Tom's behaviour was characterized by an insatiable neediness and intense negative interactions with his female parent therapist. His challenging behaviours included poor impulse control, rage, biting, kicking, name-calling, and property destruction. He feared being left alone and often fought off sleep. His parent therapists assessed Tom as being in a constant state of anxiety, with almost no capacity to regulate his emotions. In

conversation with his parent therapists, he would say that if he were a girl he would have been "picked" by a family. Tom's parent therapists, while up to the challenge, began to wonder about Tom's capacity to form a selective attachment and move beyond his intense rage. Due to Tom's extreme behaviours, the Society considered replacing him to a group home but because of his age, and the likelihood that another move would be permanently damaging, Tom remained in the parent therapists' home. He is still living there at age ten. While he is still impacted by past trauma and emerging mental health issues, he enjoys the security of long term placement, attends community school and is involved in community activities.

Overview of the Program

The Tri-CAS TFC Program has been operating out of Cobourg, Ontario since 1989. It provides residential treatment for 38 children in 24 foster treatment homes. The TFC serves three CASs: Durham, Kawartha-Haliburton, and Northumberland, with the latter handling administration. The three Societies have a combined budget of over \$80 million, and a combined staff of over 500. Most of the children in TFC are Crown wards; their average age is 9.6 years; and they have experienced an average of four placements prior to TFC.

TFC began to operate the Clinical

Service Support Program (CSSP) on April 1, 2004. This Program serves 64 foster families/children annually and aims to support permanency and prevent placement breakdown for children in all levels of the foster care system. Learning developed through the existing TFC Program is being applied with a great measure of success.

In general, treatment foster care is a growing response to the needs of children in residential care who have experienced trauma, neglect, abandonment, and whose consequent behaviour has led to multiple placements. The TFC program provides a safe and lasting placement in a family home, where the child's treatment needs can be met by well-trained and supported parent therapists. From the beginning, TFC was based on well established goals and methodologies and the Program Standards developed by the Foster Family-based Treatment Association (revised 2004). The essence of TFC is that the focus of treatment resides primarily within the daily life-space of the child. It consults with outside therapists, but the treatment is delivered within the child's home. As well as being less expensive than a group home, this allows children to live in a family environment, attend local schools, and participate in

¹ The Program is sponsored by the Children's Aid Societies (CASs) of Durham, Kawartha-Haliburton, and Northumberland
*Not his given name but he is a real person, which is the same for other children referred to in this paper.

community-based activities. Placements are usually long term and children have the benefit of establishing stable and enduring relationships.

Where possible, the children's biological families are included in the treatment process. In this paper, the terms "parent" and "family" will be used to refer to biological families, while "parent therapists" will be used for therapists providing family care. Our program gives special attention to children's families because we believe that children's loyalty binds and unresolved issues from their early experience often interfere with their progress in care. We have worked to improve relationships between children and their biological parents by the use of clinically managed access (Osmond, Durham, & Palmer, 2002), as described later in the paper. Family work is not a common theme in treatment foster care programs: in searching the literature, we found that most published articles on foster care and treatment foster care programs give little attention to the children's families.

Beginnings

In the mid-1980s, the three Societies and the Ontario Ministry of Community and Social Services participated in the CAS Services Coordination Project. Among many other issues, this Project identified general concern about the escalating cost of residential care and the scarcity of quality local placements (Nutter & Sullivan, 1989). The study also found that children's needs were not being consistently met by their

existing programs: 68% of the children placed in group homes were identified as needing treatment, but placement decisions often seemed to be based on behaviour management issues rather than meeting children's treatment needs. Furthermore, 40% of group home placements were outside the area served by the child's own CAS. Coming out of this study was the resolve by the three Societies to develop a cost-effective, residential treatment foster care program which would allow children to stay in their own communities; the TFC Program began operation in October 1989.

Early Evaluation of the Program

After 2½ years in operation, the TFC was evaluated in a Pilot Project Evaluation Study (Osmond, 1992). This study compared 32 children in TFC with 72 children who had been placed in group homes operated outside the CASs, in Outside Paid Institutions (OPIs). The children were compared on four variables: caregivers' ability to cope with children presenting problems; child outcomes; caregiver satisfaction, and; cost. In determining ability to cope with presenting problems, the children's behaviour was measured using a standardized behaviour checklist: the 72 children in OPIs were measured in 1989, while the 32 TFC children were measured as they entered the program. Program effectiveness was measured by a pre and post test of the children, using a questionnaire developed for the Ontario Child Health Study. This portion of research was conducted through a Ministry commissioned

study operated out of Queen's University. A softer measure of program effectiveness was obtained through a referring worker questionnaire, with a number of questions directed at service comparison. Often the workers had the same child in both an OPI and TFC setting. A similar questionnaire was developed for staff directly employed by the Program. Similarly, parent therapist satisfaction and functioning was also studied through a satisfaction questionnaire, and a pre and post-test for family functioning.

Cost effectiveness was studied in two ways: (1) comparing the cost of TFC (including the treatment parent per diem) to the average costs of OPI care over a five year period, and (2) analyzing the costs of identified alternative care for the first thirteen children admitted to the program. The findings of this research were generally positive on all measures used: caregivers' ability to cope; service outcomes; caregiver satisfaction, and; cost.

Development Through the 1990's

Through the 1990's, TFC did not increase in size, but it continued to develop and refine its treatment approach and day-to-day practices, as will be described later.

Clinical input was sought from a number of external consultants including: Psychiatrists, Dr. Paul Steinhauer and Dr. Jim Wilkes; Psychologist Dr. Nitzza Perlman and Behaviourist Jim Reaume; our staff Psychologist Dr. Anita Halpern, and;

Art Therapist, Ed Hagedorn. TFC began to integrate and apply trauma and attachment theory in developing child-specific milieu-based treatment plans. Over its 15 years, TFC has enjoyed stability with staff and parent therapists. Two of the present staff and five parent therapists have been with the program since it began.

In 2002, the TFC conducted a detailed review. It sought the views of all stakeholders, including CAS staff, parent therapists, outside consultants, and children in the program. The purpose of the review was to set future direction. The main strengths of the program were identified as:

- team work and inter-professional collaboration
- timely, quality support to parent therapists
- high quality, long tenure professionalism and personal suitability of TFC staff
- quality assessments and treatment plans
- advocacy and good relations with schools
- relevant and high quality training
- persistence with children resulting in longevity of placement
- quality of care provided to children
- work with children's families.

The main problems facing TFC were identified as:

- the instability of funding
- competition for parent therapists from the private sector
- the need to firm up the overall clinical direction of the program.

The review confirmed the important role of treatment foster care in our spectrum of services. We established a comprehensive work plan, setting out future directions in the areas of:

- program philosophy and direction
- work priorities of staff
- funding stability
- recruitment, and development and retention of parent therapists and consultants
- development of mobile "wraparound" responses to all levels of foster care
- clinically-managed access
- development of mixed-modality beds for children in limbo
- incorporating more family work into the child's treatment.

The results of the review reinforced our belief that TFC had a unique position in the heart of child welfare, and confirmed the usefulness and advantages of the three CASs pooling their time and resources in this way. At TFC's request, the Centre of Excellence for Research in Child Welfare, based in the faculty of Social Work, University of Toronto, is currently evaluating the Program.

Presently the average age of children in the Program is 9.6 years with a fairly equal distribution of boys and girls. Early on in the life of TFC the average age of children was around 12 years of age with boys outnumbering girls three to one. Prior to coming to TFC, children have experienced an average of four placement breakdowns. Each of the previous placements have been an average of

10 months in duration. Now, over 80% of the children grow up in the home where they were first placed after coming to TFC with no subsequent moves.

Team Approach

Parent therapists have continual access to support in providing treatment for the children in their homes from other TFC staff members: a Clinical Case Consultant (CCC), an Art Therapist, and a Psychologist. As well, parent therapists are also part of the core TFC Team. The core team consists of parent therapists, CCC's and CAS workers. Many team members contribute to formulating the assessment and treatment plan for each child and to supporting parent therapists in developing a therapeutic milieu. We have worked to make the team a respectful, safe, and supportive structure to help parent therapists meet the challenges of placement.

Role of Clinical Case Consultant

Following the Foster Family Treatment Association (FFTA) Standards and Practices, Clinical Case Consultants (CCCs) provide intensive weekly support to our parent therapists. The CCCs have a Child and Youth Worker diploma or a Social Work degree, plus residential experience caring for emotionally disturbed children in a treatment center or group home. Their role is to provide the clinical leadership to the child's individual treatment team by developing the assessment and treatment plan and implementing the

treatment plan, in collaboration with the parent therapists.

The CCCs have assigned caseloads, with each supervising four to five homes involving a total of 9-10 children. This allows for close collaboration, with the CCCs and parent therapists learning together to understand a particular child and how best to respond to their internalizing and externalizing problems. Over time, our CCCs have gained an in-depth understanding of child welfare, especially fostering.

Role of Parent Therapists

During the early stages, TFC attempted to identify some of the differences between parent therapists and regular foster parents.

At that time we defined the word foster as “to love and cherish as is.” As a system, we were asking foster parents to incorporate children into their family, with the expectation that a healthy family environment would meet most of the child’s needs; yet many of our children have had their development seriously compromised and required professional treatment. In establishing the role of parent therapist, we wanted to take the best of fostering and add a more in-depth treatment component that would be part of the child’s daily life, i.e. the therapeutic milieu would be the parent therapists’ home. While this is the case for most foster homes, treatment is often not developed to the child’s maximum advantage.

Some children would receive additional treatment from psychologists or psychiatrists, but the parent therapist would be the “central

agent of change.” We also trained the parent therapists to expect and understand the spillover effects when children had individual therapy with a consultant; we wanted to ensure that the placement could withstand the behavioural manifestations of the “stirring up” caused by therapy.

Moving a child’s therapy into the home requires a good deal of communication and teamwork. As the program has matured, and the parent therapists have participated in training, they have moved into the role of the child’s primary therapists. They have become more independent in knowing how to seize “the therapeutic moment” and use it as a learning opportunity for the child. Moreover, they have become effective advocates for the children in their homes.

The health of the parent therapists’ family is an important core value in TFC; thus the CCCs also monitor the pressures on a parent therapist family, and help parent therapists to recognize their own familial stress. Parent therapists accrue the right to two days respite per month for each placed child, a benefit provided by the sponsoring Societies. We encourage parent therapists to take this time off to rejuvenate their families. We also hold groups, as needed, for the parent therapists’ own children, recognizing that their acceptance of a child in their home is crucial to the success of the placement.

Role of Art Therapist

A key person in the TFC from the beginning is Art Therapist, Ed

Hagedorn, who provided art therapy assessments for all children in the program. The main purpose was to provide the parent therapists with an assessment of the children’s adaptation to the therapeutic milieu in the new home, as well as the children’s view of their own family relationships. Thus, the art therapy modality has acted as a “barometer” for the work being done in the therapeutic milieu. Now, art therapy assessments are conducted annually for all children in the program.

The Placement Process: Selection of home and initial assessment

From the beginning, we have involved parent therapists in the selection of children for their homes. After a CCC completes an initial intake and determines the child’s appropriateness for TFC, the CCC reviews the file with a potential parent therapist. If the parent therapist accepts the idea of placement, an initial child and family screening is arranged at the TFC office in the presence of the parent therapists, CAS workers, and TFC staff. The CCC interviews the child and family in an attempt to understand their “story” better for the purpose of making a placement decision. Parent therapists also ask questions and participate fully in the decision-making process. After the placement decision is made, a pre-placement process is initiated, and children usually move into their new placement within a couple of weeks.

With the support of the CCCs, the

parent therapists are expected to record the child's baseline behaviour, generate daily logs, institute routines and structure to support behavioural change, and contribute to the assessment of the child. The CCC undertakes a comprehensive milieu-based assessment, in conjunction with the parent therapist, and including the findings from an art therapy assessment. Often the child's treatment team recommends a psychological assessment, which may be conducted by the staff psychologist or a community-based psychologist. A comprehensive assessment may also be done of the child's family by the CCC or CAS worker, who reviews the file and sets up meetings with family members. The results of these assessments are discussed at a special conference to which all members of the TFC clinical team are invited. The findings of the initial assessment are then used to formulate a plan for the child's treatment.

Inter-Agency Relations

An important part of our teamwork has been strengthening relations between the Program and the sponsoring Societies. We have spent time defining our roles and responsibilities in order to function as an effective team. Child protection and the treatment of children are highly integrated processes that can and do reinforce each other. The TFC Program shows that good clinical work can be done within CASs. This point is reflected in the fact that Society staff and parent therapists participate in joint training sessions with our external consultants.

Training for Team Members

Ongoing training has been an important part of our team building. The CCCs work individually with parent therapists to help them develop their own professional goals and fill the gaps in their learning. Along with other team members, parent therapists have developed their clinical knowledge base through training programs in which we have made liberal use of external consultants. Gradually, our own staff have taken leadership in our training and in recent years we have been able to provide training opportunities to staff and foster parents in all three Societies.

External Consultants

Early in TFC development, Dr. Marshall Dorosh, a psychologist with experience as supervisor of a TFC program at Thistleton Regional Centre, was brought in for weekly clinical consultations with staff. This helped TFC to develop clinical thinking, as well as the structure of the program. Gradually, TFC began to bring in other clinical consultants in the areas of trauma, attachment, developmental delays, family work, and mental health. Depending on their primary presenting problem, each of the children in TFC is discussed in a "Grand Rounds" format, i.e. the child's history and progress is reviewed in sessions that are open to all parent therapists, CAS workers and our own staff, with external consultants being brought in depending on the child's needs. The parent therapists reported that they all benefited from the experience and

were able to put the new learning into practice with the children in their homes.

Staff-led Training

Monthly group sessions – "Parent Therapist Training Groups." A regular training program for parent therapists has been critical to the development of the program, in helping team members to develop a common knowledge base of clinical understanding and expertise. TFC provides this through a monthly training and support group that brings together the parent therapists from all three Societies, as well as all TFC staff. While some external trainers are used, TFC staff develops and delivers most of the training, which maximizes the integration of learning across the team.

Shared background

experiences. The effectiveness of the training led by staff is partly attributable to the backgrounds of our TFC team staff members, in residential treatment programs and other relevant settings, such as children's mental health centres and schools. These earlier experiences allow them to make the training 'come alive,' to identify with the parent therapists, and contribute to a climate of mutual respect. Parent therapists have now developed to the point where they are delivering their own training directly or in concert with TFC staff.

Compared with their earlier work in group care, staff has found the family

milieu a new and exciting way to work with emotionally-disturbed children. They experience parent therapists as eager to learn, and having a mature sense of normal family development beyond what most workers have attained through their education and work experience. The staff also values the advantages of family-based care in terms of more caregivers per child, more individual attention, and less contagion from other disturbed children.

Layers of training. Staff-led training is delivered as a “layering in” process—laying a foundation of basic skills and understanding, and then adding more complex subjects to this foundation. The consecutive layers are: milieu therapy, behaviour modification, mentoring the child’s family, and clinically-managed access.

Milieu therapy. This form of treatment uses ordinary life events as corrective teaching opportunities. Included in this training is a primer that includes ego psychology, a systems approach to treatment, nature and purpose of milieu therapy, components of a milieu, assessment in the milieu, and opportunities for growth in the milieu. This training has been well received by the parent therapists, as they have easily grasped the theory and practical suggestions, from their previous fostering experiences. As a staff member noted, “We were just helping them look at what they did in a more planned and meaningful way.”

Behaviour modification. The next cornerstone of training focuses

on behaviour. Initially, we adhered strictly to behaviour modification principles, aimed at changing a child’s external behaviour. After a few years, we began to move beyond this approach to think about what ‘the child’s message behind the behaviour’ was and how we could respond in a manner that felt safe and supportive of the child. Our training is now focused on behaviour formation, assessment, normal vs. abnormal behaviour, and options for changing behaviours. Other aspects of training have expanded over time to become part of our basic approach to helping children, thus they will be discussed in more detail.

Key Components of the TFC Model of Treatment:

Mentoring the Child’s Family

Historically, relationships between a child’s parents and foster parents have been difficult and often fraught with tension. We needed to develop our parent therapists’ willingness and ability to work with the children’s parents. Our work with children is based on the assumption that parents are usually victims of adverse experiences and unmet needs in their own developmental history, which limits their ability to function as parents to their own children. We have taken an inclusive approach to foster care, encouraging parent therapists to become mentors to the child’s family. Parent mentoring can be defined as a form of direct service to client families, in which the foster parent approaches the biological parents of a child in care with guidance, teaching, and coaching in

the techniques and tasks required to care for their children. The relationship is informal and requires the treatment foster parent to develop a positive relationship with the child’s parents over time.

Parent therapists were enthusiastic about the mentoring approach. Once they accepted the view of children’s parents as victims, they slowly but surely developed a passion for working with them. Now, often the strongest bond in the system is the bond between the parent therapist and the child’s parents. As one parent said about her parent therapist, “No one else shares in the daily living with our child.” Even in some of our most contentious cases, where a child’s parents are very angry at the CAS, they may remain allied with, and supported by, the parent therapist. Our training has focused on the importance of children’s relationships with their families, the debunking of myths and attitudes about parents, and the introduction of family reconnections within foster care.

Clinically Managed Access

Concern about managing child-parent access has developed over the years, as experience in Ontario’s child protective services has shown that Court orders for child-parent access can be difficult to implement, and may create difficulties for caregivers. In the process of reaching an agreement during a Court proceeding, the CAS may agree to conditions that are not compatible with the child’s treatment needs. This sets the stage for problematic child-parent contact over the long term, which may be

further aggravated by a lack of agency resources to manage access. Thus the children's actual experience of visiting may diverge significantly from the treatment plans. (Osmond et al., 2002).

Managing ongoing family connections for children in out-of-home care can be a challenging task. Often a child's important early relationships have been troubled and disrupted, damaging their capacity for attachment. If they then experience a period when parental responsibility is not clear, while decisions are being made, their development may be seriously compromised. Under these conditions managing access effectively becomes increasingly important. The case of Tyler and Lorraine illustrates how clinically managed access can contribute to treatment.

Tyler, four, was placed in foster care following a police investigation of physical abuse by his mother, Lorraine. His behaviour was intensely and continuously anti-social. He bit, spat, ran, urinated, and defecated in all the wrong places, refused to eat, and damaged property. He was hurtful to animals, people, and himself. He was quickly rejected by his first two foster placements and referred to TFC.

Lorraine had experiences early in life that made her distrustful, especially toward people in authority. The person Lorraine chose to trust first was Pam, the parent therapist. Rather than instructing Lorraine about parenting Tyler, Pam modeled for her, using a variety of innovative parenting methods. Pam taught

Lorraine a simple technique for managing non-compliance and reinforcing compliance. Lorraine began to share with Pam her own childhood experiences that led to her difficulties in putting limits on Tyler. By sharing these feelings with Pam, Lorraine entered into a therapeutic relationship. For the next year Pam mothered Lorraine while Lorraine learned to meet Tyler's need for structure.

Well-managed access can be an important clinical vehicle for ensuring that family relationships contribute as much as possible to a child's well being. Well-managed access does not always lead to a reunion; sometimes it contributes to permanency by assisting children to come to terms with the past, so they can move on with their lives in out-of-home placement. In foster care, there are often too few resources for managing access in a way that improves the parent-child relationships. Staff training in this area can influence workers to undertake clinically managed access, using family visits as an opportunity for teaching parents how to interact constructively with their children.

Trauma from Abuse

Another cornerstone of our training has been learning to work with traumatized children, particularly children who are dealing with the aftermath of sexual abuse. Our training and support to parent therapists focused on helping children to tell their 'story'. When children come into TFC, they may be unable to talk about their abusive experiences, but may cue us with behaviours that hint at what has

happened. The caregivers become careful, thoughtful listeners and interpreters, so that children may come to know their own stories and find a path to healing. This treatment is carried out in the child's day-to-day living environment by sensitive and well-trained parent therapists who offer comfort and guidance to the child. Other forms of treatment may be used as well, but these are viewed as supplemental, not central, to the child's progress. Our experience in using this model in the TFC environment suggests that parent therapists can reliably assist severely traumatized children, sometimes with remarkable results. The following is an example of a real life conversation between a foster child and a parent therapist helping her to heal from the aftermath of sexual abuse.

At six years of age, Angie had a question she could not answer: "Why did my mommy marry Ivan when she knew Ivan was hurting me? Why did she pick him instead of me?" Joan, her parent therapist, waited for the right moment: "Boy, Angie, you just think and think about that question. It is very important for you to have an answer." Angie: "I want to know. Why did my mommy do that?" Joan: "Yes, you want to know. Have you thought of any answers?" Angie: "Me?" Joan: "Yes. Why do you think mommy did that?" Angie: "Maybe she didn't know Ivan was hurting me?" Joan: "Oh, I'm confused, I thought she did know?" Angie: "Yeah. I told her. I'm mad, mad, mad! Mom should have picked me". Joan: "You sure are mad. If I were a little girl in care whose Mom had married the man who hurt me, I think I would feel mad

too." Angie: "She cried you know." Joan: "She cried?" Angie: "When I told her. She called the Children's Aid, and then she cried." Joan: "Why was she crying, do you think?" Angie: "I don't know. I can't get inside my mother's head! Can I go now?" Joan let her go. For today, Angie had taken a big step. There were many steps to go, but the first one had been taken.

Joan did not answer Angie's questions directly, but encouraged Angie to express her own feelings. Joan did point out reality, by reminding Angie of what she had told Joan earlier—that her mother knew about the abuse. Joan could have used Angie's statement about her mother crying to reassure Angie that her mother did feel pain about the abuse, although she apparently was not strong enough to leave Ivan. Joan might also try to find out more about the mother's own possible victimization, to help Angie understand why her mother was limited in her capacity to protect her.

Attachment-Related Difficulties

Another important part of training was the development, management, and treatment of children and families with attachment-related difficulties. Children in foster care may be expected to struggle with feelings of separation and disrupted attachments. Some have limited ability to form attachments, because of insecurity experienced in their formative years. Moving into an unknown home tends to exacerbate difficulties related to attachment: children may withdraw, or act out their frustration, leaving

caregivers feeling rejected, exhausted, and impotent. In under-supported placements, there is a high risk of placement breakdown. Through training and support, our parent therapists become attuned to the needs of the child, learn to identify their attachment styles, predict their behavioural and emotional responses, and develop appropriate strategies for handling these. The approach taken with the child should be realistic, but should also provide hope to both the child and the parent therapist family. Melanie is an example:

Melanie appears to be guarded and wary of her caregivers. She often seems aloof, resistant to their direction, and inner directed. She seems somewhat emotionally detached in general from human relationships. She appears mainly interested in what she can get from people or what they give her, rather than engaging in a mutually satisfying relationship. The parent therapists feel that she treats them exactly as she does people who are peripheral in her life (e.g. volunteer driver, crossing guard, or swimming instructor). The parent therapists have become quite adept in avoiding power struggles, and they give Melanie the time, space, and support in managing her episodes of upset and anger. The parent therapists work hard to recognize that Melanie's lack of emotional response to them is part of her inability to attach, and not to interpret this as a sign of their failure as parents. With this attitude, they are able to give her messages of safety, acceptance, and support, and to experience a minimum of frustration.

In addition to teaching parent therapists about attachment, TFC has developed a "Remembering Book," a workbook similar to the life story books often used with children in foster care. The Remembering Book is designed to help children with the impact of poor initial attachments followed by multiple separations, by providing information about their personal histories. Reviewing the past, and filling in gaps in the child's information can help them to accept living apart from their families. Parent therapists can learn about, and interpret to children, the role of events and conditions over which neither the child or their parents had much control, such as family poverty, and the parents' limitations arising from their own childhood experiences. Without this understanding, children tend to blame themselves for being rejected, and to build defenses against forming attachments with new caregivers. An example is Sheila, age ten, who felt compelled to write, after working on her Remembering Book, to her mother who had died of a drug overdose.

Dear Mom,
I want to know why you did drugs. It was a bad thing to do. I loved you so much, and you died, because you took drugs. I really loved you but you did the wrong thing. You probably know it was the wrong thing but you couldn't stop. I am so sad that you died because I loved you and I will always love you. You were so pretty like I am. Remember, that was wrong, but I will forgive you because you were my Mom.
Love, Sheila

The TFC program has been able to successfully provide long term care for many children with severe attachment issues through the informed and sensitive work of our parent therapists.

Future Directions

The Tri-CAS TFC Program remains strong and vital 15 years after its tentative beginning. We have managed to grow and develop as we have learned from our experience, and from the work of others, as documented in the treatment foster care literature. We are able to provide for high needs children and help them through their treatment journeys, through our trained and dedicated parent therapists, who continue to be supported by all team members, including external consultants as needed.

TFC is now receiving referrals for younger children, some as young as three. This means that adoption may be the preferred option for permanency as opposed to long-term foster care. Thus, we are beginning to train prospective adoptive parents in the same way as parent therapists. Bringing on foster and adoptive parents as full members of the TFC team is seen as the single most important ingredient to the success of our Program.

Areas of clinically managed access, mixed modality staffing response for children in limbo, and increased family work with families of origin remain exciting objectives for the future.

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November is Adoption Awareness Month

To experience healthy development, and create a sense of their own self-worth, children need to have roots and feel they belong to a family that cares for them.

In Ontario, adoption can be arranged through **Children's Aid Societies** (CASs), private adoption agencies, or directly through the courts if you are a relative or stepparent.

Each CAS is responsible for adoption in the area it serves, and the children waiting for adoptions are in that agency's care.

If you decide you'd like to adopt, the CAS will conduct a home study that involves several visits to your home. By working together through this process, a decision can be made about whether adoption is right for you, and what kind of child or children you could parent.

**For more information on
Adoption in Ontario, contact
your local Children's Aid
Society.**