Foundations
What Works Centre for Children & Families

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Intervention website: https://www.tfcoregon.com/

GUIDEBOOK INTERVENTION INFORMATION SHEET

Treatment Foster Care Oregon Prevention (TFCO-P)

Please note that in the 'Intervention Summary' table below 'child age', 'level of need', and 'race and ethnicities information is **as evaluated in studies**. Information in other fields describes the intervention as **offered/supported by the intervention provider**.

Intervention summary	
Description	Treatment Foster Care Oregon Prevention (TFCO-P) is a wrap-around, therapeutic intervention for families with a looked-after child between the ages of 3 and 6 years old with a history of placement disruptions due to behavioural or emotional issues. Children are placed with a 'treatment foster family' for approximately 9 to 12 months. During this time, a clinical team works intensively with the foster carers and birth family to increase placement stability and support family reunification.
Evidence rating	2+
Cost rating	5
Child outcomes	• Supporting children's mental health and wellbeing - Increased attachment security - Reduced child maltreatment - Increased placement stability.
Child age (population characteristic)	2 to 5 years old
Level of need (population characteristic)	Targeted Indicated

Intervention summary	
Race and ethnicities (population characteristic)	• African American • Latino • Native American • White.
Type (model characteristic)	Individual
Setting (model characteristic)	Home
Workforce (model characteristic)	TFCO-P is delivered by a clinical team, consisting of: • a Team Leader (typically a psychologist or social worker) • TFCO-P Foster Carers • a Foster Carer Recruiter/Consultant • a Birth Family Coach • a Skills Coach • an Individual Therapist • Administrator • the Programme Manager.
UK available?	No
UK tested?	No

Model description

Treatment Foster Care Oregon Prevention (TFCO-P, formerly Multidimensional Treatment Foster Care Preschool) is for families with a looked-after child between the ages of 3 and 6 receiving foster care or in a residential placement. Eligible children typically have a history of placement disruptions due to behavioural difficulties that negatively impact their ability to form a positive relationship with their carer or attend school.

TFCO-P is delivered by a clinical team, consisting of a Team Leader (typically a psychologist or social worker), TFCO-P Foster Carers, a Foster Carer Recruiter/Consultant, a Birth Family Coach, a Skills Coach, an Individual Therapist, Administrator, and the Programme Manager.

Children are placed with a 'treatment foster family' trained in the TFCO-P model for nine months to a year. TFCO carers are highly trained and supported to offer a nurturing and consistent home

environment to the child. Within these warm and structured family environments, children receive positive and consistent reinforcement for appropriate behaviour and age-appropriate consequences for challenging and disruptive behaviour.

While the child is with the TFCO-P parents, family therapy is provided to the biological (or adoptive) family, with the goal of reuniting the child with their parents. During this time, parents are taught the same parenting strategies that are enforced in the TFCO-P foster home. The child also attends a therapeutic playgroup and receives individual therapy and skills training from a member of the TFCO-P team.

The Team Leader coordinates and guides the TFCO intervention for each child, within the foster home, at school, with the biological family and in the move-on family's home for three months following TFCO.

A primary aim of TFCO-P is family reunification. However, placement stability within a new 'move-on' family is also a goal if reunification with the birth family is not possible.

Target population

Age of child	3 to 6 years old
Target population	Families with a looked-after child between the ages of 3 and 6 years old who are at risk of placement instability due to emotional and behavioural difficulties

Please note that the information in this section on target population is as **offered/supported by the intervention provider**.

Theory of change

Why		Who	How	What		
Science-based assumption	**Science-based assumption**	**Science-based assumption**	**Intervention**	**Short-term outcomes**	**Medium-term outcomes**	**Long-term outcomes**
Experiences of abuse and neglect and exposure to trauma substantially increase the risk of children having emotional and behavioural difficulties as they develop.	Serious and chronic behavioural problems negatively impact looked after children's placement stability and ability to successfully attend school.	Looked after children with problematic behaviour often require more support than some foster carers can provide.	• Specially trained and supported foster carers provide a nurturing home for looked after children • Individual therapy is provided to the child • Individual therapy is provided to the biological parents or move on family.	• The child is better able to form a positive relationship with the foster carer • The child is better able to regulate their behaviour.	• The child's behaviour improves • The child successfully attends school.	• The child remains in a stable placement • The child is less at risk for behavioural and emotional problems in later childhood • Family reunification is achieved when possible.

Implementation requirements

Who is eligible?	Families with a looked-after child between the ages of 3 and 6 years old who are in foster placements or residential placements Targeted children have complex needs and may have already experienced a number of placement disruptions. Children may present with a wide range of behavioural difficulties, which are likely to be impacting on a number of areas of life such as their relationships with adults and peers and their capacity to manage preschool or school environments.
How is it delivered?	The main components of TFCO-P are: **Component 1:** TFCO Foster Carers deliver the TFCO model directly to the children in their everyday interactions, under the guidance of the TFCO Team Leader. They have two days of TFCO training prior to the first placement. While they have a child in their care, they attend weekly foster carer meeting and complete a daily Parent Daily Report that monitors children's behaviours and carer stress. The Foster Carers have access to 24/7 support and are provided with regular respite. **Component 2:** All children follow a behavioural incentive intervention within the foster placement, developed and overseen by the Team Leader. All children receive weekly Skills Coaching sessions for 1 to 1.5 hours, for the duration of their placement, and for up to three months post-TFCO. Some children attend a weekly Therapeutic Playgroup for 1.5 hours, which focuses on skills for school-readiness. **Component 3:** The Birth Family Coach works weekly with the birth family and/or extended family for one hour. They make use of a TFCO parenting intervention to help shape up strengths and skills and improve the quality of contact, and to increase the chances of children being returned home. This work can continue once a child returns home or will be offered to the follow-on placement. **Component 4:** The TFCO team work closely with schools to develop interventions for teachers to deliver. Alternatively, an intervention will be delivered directly to the child from the TFCO team, within the school.

Implementation requirements (cont.)

What happens during the intervention?	Timely information sharing with the Team Leader is key to the effective delivery of TFCO and there are a number of mechanisms within the TFCO model that facilitate this: • Weekly clinical team meeting • Weekly foster carer meeting • 24/7 on-call to help carers navigate stresses and difficulties • Daily completion of a Parent Daily Report with foster carers, which tracks carer stress and child behaviours • Team Leader providing TFCO supervision to all clinical staff. Children's skill development is targeted in a number of ways throughout the TFCO intervention: • Modelling, coaching, and practise of specific skills in the community or in social situations with a Skills Coach • Modelling and reinforcement of targeted skills within the foster home and the biological family home • Weekly attendance at the Therapeutic Playgroup where TFCO children come together with Skills Coaches to learn and practise school-based skills, in a structured environment • Children already in school may have support from Skills Coaches who work closely with staff to help them implement TFCO interventions that target specific skill development.
Who can deliver it?	TFCO-P is delivered by a clinical team. The team consists of a Team Leader, TFCO-A Foster, Foster Carer Recruiter/Consultant, Birth Family Coach, Skills Coach, Individual Therapist, Administrator, and the Programme Manager.
What are the training requirements?	Practitioners have three to four days of intervention training depending on their role. Booster training of practitioners is recommended. The TFCO-P clinical team and Foster Carers are required to be trained by the National Implementation Service when they initially set up. Following this, new Foster Carers can be trained by the Team Leader.

Implementation requirements (cont.)

How are practitioners supervised?	It is a requirement that Team Leaders are supervised by one external supervisor at the National Implementation Service, through weekly one-hour consultations via the telephone. The National Implementation Service provides consultation to the Team Leader on all aspects of the TFCO-P model, to ensure fidelity to the model. This is not clinical supervision, and the NIS does not hold clinical responsibility for TFCO-P children. TFCO-P skills-based supervision is provided by the Team Leader (to the rest of the clinical team. This is done via weekly face-to-face meetings. TFCO-P team members would still be expected to meet the supervision requirements of the agency they are employed by, that is appropriate for the team member's professional qualification (e.g. Social Worker or Mental Health Practitioner). This includes, clinical, skills, and case management.
What are the systems for maintaining fidelity?	Intervention fidelity is maintained through the following processes: • Training manual • Other printed material • Other online material • Fidelity monitoring.
Is there a licensing requirement?	Yes
*__Contact details__	Contact person: John Aarons Email address: johna@tfcoregon.com Website: https://www.tfcoregon.com/ *Please note that this information may not be up to date. In this case, please visit the listed intervention website for up to date contact details.

Evidence summary

TFCO-P's most rigorous evidence comes from single RCT conducted in the United States consistent with Foundations 'Level 2+ evidence strength criteria.

This study observed statistically significant improvements in TFCO-P parents' reports of their children's attachment security, as well as stable cortisol levels in comparison to children not exposed to the intervention. Additionally, TFCO-P caregivers reported significantly less stress in comparison to carers not supported by the intervention.

Treatment Foster Care Oregon Prevention has preliminary evidence of improving a child outcome, but we cannot be confident that the intervention caused the improvement.

Search and review

	Number of studies
Identified in search	11
Studies reviewed	1
Meeting the L2+ threshold	1
Meeting the L3 threshold	0
Contributing to the L4 threshold	0
Ineligible	10

Individual study summary: Study 1

Study 1	
Study design	RCT
Country	United States
Sample characteristics	137 children aged 2 to 5 years in foster care
Race, ethnicities, and nationalities	• 89% European American • 5% Latino • 5% Native American • 1% African American.
Population risk factors	On average, children had spent 171 days in foster care prior to the study
Timing	Baseline, and 3-monthly

Study 1	
Child outcomes	• Increased secure attachment (Physiological measure) • Reduced avoidant behaviour (Physiological measure) • Maintenance of cortisol levels (Physiological measure).
Other outcomes	Reductions in caregiver stress (caregiver report)
Study Rating	2+
Citations	**Study 1a:** Fisher, P. A. & Kim, H. K. (2007) Intervention effects on foster preschoolers' attachment-related behaviors from a randomized trial. *Prevention Science*. 8, 161–170. **Study 1b:** Fisher, P. A., Stoolmiller, M., Gunnar, M. R. & Burraston, B. O. (2007) Effects of a therapeutic intervention for foster preschoolers on diurnal cortisol activity. *Psychoneuroendocrinology*. 32 (8), 892–905. **Study 1c:** Fisher, P. A. & Stoolmiller, M. (2008) Intervention effects on foster parent stress: Associations with child cortisol levels. *Development and Psychopathology*. 20 (3), 1003–1021.

Brief summary

Population characteristics

This study involved 137 children aged 2 to 5 years old entering a new foster care placement in the US state of Oregon. To be eligible for the study, the current placement had to be expected to last for three or more months.

The mean age in years at baseline was 4.54 in the treatment group and 4.34 in the comparison group. Boys made up of roughly half of the study population in both groups. The ethnic breakdown across groups was 89% European American, 1% African American, 5% Latino, and 5% Native American.

On average, children had spent 171 days in foster care prior to baseline. The foster placements at study entry included first-time foster placements, moves between foster homes, or re-entries into foster care following failed permanent placements.

Study design

64 eligible children were randomly allocated to Treatment Foster Care-Prevention (TFCO-P), and 73 to a regular foster care comparison group (RFC). Of these children, consent to participate was obtained for 57 in the treatment group and 60 in the comparison group, resulting in a sample of 117 children. Randomisation occurred prior to recruitment into the study to reduce uncertainty among eligible foster parents regarding the conditions of their participation and to reduce the number of

caseworker contacts needed to complete recruitment. Once randomisation was completed, a staff member contacted the child's caseworker and requests consent for the child to participate in the project.

There were no significant differences between the groups on age, gender, ethnicity, time in foster care, attachment-related behaviours or foster placement, and case history at baseline.

The study recruited an additional comparison group (CC) of 60 same-aged, low-income, non-maltreated community children and their families.

Measurement

Assessments were completed at baseline (pre-intervention) and information was collected from the families on a monthly or quarterly basis (i.e. every three months) during the first 12 months following the foster care placement.

- **Caregiver report** measures included Parent Attachment Diary (PAD) to assess children's attachment-related behaviour. This was collected from the foster parents every three months.
- **Physiological** measures included monthly salivary cortisol samples. The samples were gathered on 2 consecutive days in early mornings and evenings every month for 12 months.
- **Researcher assessments** included the Parent Daily Report, which was completed via a telephone interview at monthly intervals on the same day the children's cortisol was collected.

Study retention

Complete data sets were available for 85% (117) at study completion, including 89% (57) in the treatment group and 82% (60) in the control group.

Results

Data-analytic plan

Separate analyses were conducted for the data involving the attachment diaries, the child's diurnal cortisol activity and the PDI.

- **Attachment diaries:** A latent growth analysis to examine changes in attachment-related behaviour from baseline to 12 months post-baseline was employed. An intent-to-treat design was used, and missing data was handled using full information maximum likelihood (FIML) estimation in Mplus.
- **Cortisol activity:** A latent growth analysis to analyse cortisol activity over the course of the study was employed. A diurnal cortisol activity index was created by subtracting the daily PM cortisol level from the daily AM cortisol level. The plan was to examine group differences over time in AM-PM cortisol change and, if significant group differences were obtained, AM and PM cortisol levels were examined separately. This strategy allowed a more detailed analysis of whether variations in AM cortisol levels, PM cortisol levels, or both contributed to group differences in this index of diurnal cortisol activity. An intent to treat approach was used and missing data was handled by including all available data for all

participants at all time points, even when only partial data were available, and the model was estimated under the assumption of ignorable missingness.

- **Parental stress levels:** A three-level linear growth model to analyse intervention effects on caregiver stress was employed: level one consisted of repeated assessments on two consecutive days within a month, level two consisted of repeated assessments over 12 months within a family, and level three consisted of the family. Child problem behaviour was included as a time-varying covariate of caregiver stress. The study examined whether diurnal cortisol activity was associated with caregiver self-reported stress in response to child problem behaviour. An intent to treat approach was used and missing data was handled using linear growth modelling under the ignorable missingness assumption, with all available data included.

Findings

The study found that TFCO-P children showed significant increases in secure behaviour and significant decreases in avoidant behaviour relative to children assigned to a regular foster care (RFC) condition.

Additionally, the study observed that TFCO-P children maintained stable morning-to-evening cortisol change, whereas children in the RFC condition showed a significant decline, leading to a flattened diurnal cortisol curve associated with poorer stress regulation. Additionally, morning cortisol levels remained stable in TFCO-P children, whereas children in the RFC condition exhibited a significant decline, indicating HPA axis dysregulation and chronic stress adaptation. Finally, TFCO-P children showed increases in evening cortisol levels, reflecting a more typical evening cortisol pattern, whereas children in the RFC condition exhibited no significant change, suggesting stress dysregulation.

The TFCO-P caregivers also reported significantly less caregiver stress, which was sustained through 12 months post-baseline, in comparison to the regular foster care condition.

Limitations

The conclusions that can be drawn from this study are limited by methodological issues pertaining to overall attrition being over 10% and no analyses being conducted to demonstrate that overall attrition did not undermine the equivalence of the two groups, hence why a higher rating is not achieved.

Study 1: Outcomes table

Outcome	Measure	Effect size	Statistical significance	Number of participants	Measurement time point
Child outcomes					
Secure attachment	Parent Attachment Diary (PAD)	β = 0.18	Yes	117	12 months post-baseline
Avoidant behaviour	Parent Attachment Diary (PAD)	β = -0.13	Yes	117	12 months post-baseline
Resistant behaviour	Parent Attachment Diary (PAD)	Not reported	No	117	12 months post-baseline
AM to PM Cortisol change	Salivary cortisol samples	d=-0.65	Yes*	117	12 months post-baseline
AM Cortisol change	Salivary cortisol samples	d=-0.66	Yes**	117	12 months post-baseline
PM Cortisol change	Salivary cortisol samples	d=-0.68	Yes***	117	12 months post-baseline
Parent outcomes					
Caregiver stress	Parent Daily Report (PDR)	Not reported	Yes	117	1 to 2 months post-baseline

Outcome	Measure	Effect size	Statistical significance	Number of participants	Measurement time point
Caregiver stress	Parent Daily Report (PDR)	Not reported	Yes	117	3 to 12 months post-baseline

* The TFCO-P group maintained stable morning-to-evening cortisol change while the regular foster care (RFC) showed a significant decline in morning-to-evening cortisol change over time, indicating increased flattening of the diurnal cortisol curve, which is associated with poorer stress regulation.

** Morning cortisol levels remained stable in the TFCOC-P group, while the RFC group showed a decline, indicating HPA axis dysregulation and chronic stress adaptation.

*** Evening cortisol levels increased in the TFCO-P groups, indicating a more typical evening cortisol pattern, while it remained unchanged in the RFC group.

Other studies

The following studies were identified for this intervention but did not count towards the intervention's overall evidence rating. An intervention receives the same rating as its most robust study or studies.

Bruce, J., McDermott, J. M., Fisher, P. A. & Fox, N. A. (2009) Using behavioral and electrophysiological measures to assess the effects of a preventive intervention: A preliminary study with preschool-aged foster children. *Prevention Science*. 10 (2), 129–140.

Fisher, P. (2015) Review: Adoption, fostering, and the needs of looked after and adopted children. *Child and Adolescent Mental Health*. 20 (1), 5–12.

Fisher, P. A., Burraston, B. & Pears, K. (2005) The early intervention Foster Care Program: Permanent placement outcomes from a randomized trial. *Child Maltreatment*. 10, 61–71.

Fisher, P. A., Kim, H. K. & Pears, K. C. (2009) Effects of Multidimensional Treatment Foster Care for Preschoolers (MTFC-P) on reducing permanent placement failures among children with placement instability. *Children and Youth Services Review*. 31 (5), 541–546.

Fisher, P. A., Stoolmiller, M., Mannering, A. M., Takahashi, A. & Chamberlain, P. (2011) Foster placement disruptions associated with problem behavior: Mitigating a threshold effect. *Journal of Consulting and Clinical Psychology*. 79 (4), 481 .

Fisher, P. A., Van Ryzin, M. J. & Gunnar, M. R. (2011) Mitigating HPA axis dysregulation associated with placement changes in foster care. *Psychoneuroendocrinology*. 36 (4), 531–539.

Jonkman, C. S., Bolle, E. A., Lindeboom, R., Schuengel, C., Oosterman, M., Boer, F. & Lindauer, R. J. (2012) Multidimensional treatment foster care for preschoolers: Early findings of an implementation in the Netherlands. *Child and Adolescent Psychiatry and Mental Health*. 6 (1), 38.

Jonkman, C. S., Schuengel, C., Lindeboom, R., Oosterman, M., Boer, F. & Lindauer, R. J. (2013) The effectiveness of Multidimensional Treatment Foster Care for Preschoolers (MTFC-P) for young children with severe behavioral disturbances: Study protocol for a randomized controlled trial. *Trials*. 14 (1), 197.

Leve, L., Harold, G. T., Chamberlain, P., Landsverk, J. A., Fisher, P. A. & Vostanis, P. (2012) Practitioner review: Children in foster care – vulnerabilities and evidence-based interventions that promote resilience processes. *Journal of Child Psychology and Psychiatry*. 53 (12), 1197–1211.

Luke, N., Sinclair, I., Woolgar, M. & Sebba, J. (2014) *What works in preventing and treating poor mental health in looked after children?* NSPCC.

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Note on provider involvement: This provider has agreed to Foundations' terms of reference (or the Early Intervention Foundation's terms of reference), and the assessment has been conducted and published with the full cooperation of the intervention provider.