

Illinois Therapeutic Foster Care (TFC)

# PILOT EVALUATION



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Submitted to the Illinois Department of Children and Family  
Services in partial fulfillment of Contract 3012009023

**APR**  
**2023**



## Recommended Citation

Chor, K. H. B., Kakuyama-Villaber, R., Burkhardt, T., Morsch, M. S., Oltmans, C., & Jacobsen, H. (2023). *Illinois Therapeutic Foster Care (TFC) Pilot evaluation*. Chapin Hall at the University of Chicago.

## Acknowledgements

This evaluation is funded by the Illinois Department of Children and Family Services. We would like to acknowledge the invaluable contributions of Richard A. Epstein, Ph.D., M.P.H., Shannon Kugley, M.L.I.S., and Zhidi Luo, M.S., during their time at Chapin Hall.

## Disclaimer

The points of view, analyses, interpretations, and opinions expressed here are solely those of the authors and do not necessarily reflect the position of the Illinois Department of Children and Family Services.

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# INTRODUCTION

## Illinois State Legislation

Illinois Public Act 099-0350, enacted on January 1, 2016, required that the Illinois Department of Children and Family Services (DCFS) arrange for an independent evaluation of a 5-year pilot program of multi-dimensional treatment foster care (MTFC) or a similar evidence-based program of professional foster care. It says, in relevant part:

Sec. 5.40. Multi-dimensional treatment foster care.

Subject to appropriations, beginning June 1, 2016, the Department shall implement a 5-year pilot program of multi-dimensional treatment foster care, or a substantially similar evidence-based program of professional foster care, for (i) children entering care with severe trauma histories, with the goal of returning the child home or maintaining the child in foster care instead of placing the child in congregate care or a more restrictive setting or placement, (ii) children who require placement in foster care when they are ready for discharge from a residential treatment facility, and (iii) children who are identified for residential or group home care and who, based on a determination made by the Department, could be placed in a foster home if higher level interventions are provided.

The Department shall arrange for an independent evaluation of the pilot program to determine whether it is meeting the goal of maintaining children in the least restrictive, most appropriate family-like setting, near the child's home community, while they are in the Department's care and to determine whether there is a long-term cost benefit to continuing the pilot program.

At the end of the 5-year pilot program, the Department shall submit a report to the General Assembly with its findings of the evaluation. The report shall state whether the Department intends to continue the pilot program and the rationale for its decision.

## DCFS Therapeutic Foster Care (TFC) Pilot

In response to this state legislative requirement, DCFS implemented the 5-year Therapeutic Foster Care (TFC) Pilot between July 1, 2016, and June 30, 2021. The TFC Pilot aimed to provide a home-based setting to serve youth with a history of trauma or severe behavioral challenges who would otherwise enter or remain in

residential care or be discharged from residential care to other non-TFC community-based settings such as home of relative, fictive kin, or specialized foster care..

DCFS contracted with four community partner agencies to implement the TFC Pilot—Children’s Home and Aid (CH+A), Jewish Children and Family Services (JCFS), Lutheran Social Services of Illinois (LSSI), and Youth Outreach Services (YOS)—to serve eligible children ages 6 to 17 in the Cook County, Aurora, and Rockford subregions. TFC was defined by the specific model implemented by each community partner agency. CH+A used the Therapeutic Crisis Intervention-Family (TCI-F) Model (Nunno et al., 2003), JCFS used the Together Facing the Challenge Model (Farmer et al., 2010), and both LSSI and YOS used the Therapeutic Foster Care Oregon (TFCO) Model (Chamberlain et al., 2007), the current name of MTFC (Blueprints for Healthy Youth Development, 2022).

Staffing, training, and foster parent recruitment occurred in the first seven months of the TFC Pilot from July 1, 2016, to January 31, 2017. TFC referrals officially began on February 1, 2017. However, JCFS and YOS ended their participation in the TFC Pilot in April 2018 and May 2018, respectively. At that point, LSSI and CH+A were the remaining active providers in the TFC Pilot. Beyond June 30, 2021, LSSI continues to implement TFCO outside the purview of the Pilot evaluation. For these reasons, LSSI comprised most of the youth served in the five-year TFC Pilot.

## Independent Evaluation of the DCFS TFC Pilot

Chapin Hall at the University of Chicago (Chapin Hall) was the independent evaluator contracted by DCFS to evaluate the five-year TFC Pilot. To address the distinct components of the independent evaluation requirement described in Illinois Public Act 099-0350, Chapin Hall conducted the following evaluation studies: (1) benefit-cost study, (2) distance-from-home study, and (3) outcome study. In addition, Chapin Hall completed a (4) process study consisting of focus groups about program implementation and the feasibility of the TFC model as a community-based alternative to residential treatment in the Illinois child welfare system.

Collectively these four evaluation studies sought to provide comprehensive information to DCFS as required by the state legislation. Findings from the evaluation studies will inform DCFS’ decision about continuing TFC in Illinois.

## Benefit-Cost Study

To address the legislation requirement about determining the long-term benefit-cost to continuing the DCFS TFC Pilot, Chapin Hall conducted a benefit-cost study that: (1) focuses on youth who received the LSSI TFC intervention compared to youth in the comparison group who entered or remained in residential care instead; (2) leverages the long-term benefit-cost evidence of TFC established in the literature; and (3) applies benefit-cost methods from existing studies on evidence-based interventions in other states for adaptation to the Illinois child welfare context.

## Distance-from-home Study

To address the state legislation requirement about maintaining children in the least restrictive setting near the child's home community, Chapin Hall conducted a distance-from-home study on youth who received the LSSI TFC intervention, by examining TFC and post-TFC placement types, and the distance from these placements to the youth's home community.

## Outcome Study

The outcome study addressed the state legislation requirement that the TFC Pilot provide a home-based setting to serve youth with a history of trauma and/or severe behavioral challenges who would otherwise enter or remain in residential care, or be discharged from residential care to other non-TFC community-based settings.

Specifically, the outcome study combined program data provided by the TFC community partner agencies (e.g., TFC referrals, youth placed in TFC) and DCFS administrative data, as of June 30, 2021, to examine 13 outcomes on safety, well-being, and permanency.

## Process Study

To provide the implementation context for the five-year TFC Pilot evaluation components required by state legislation, Chapin Hall completed a process study. This study focused on LSSI's implementation of the TFCO Model to provide a home-based setting, TFC, to serve youth with a history of trauma and/or severe behavioral challenges who would otherwise enter or remain in residential care or be discharged from residential care to other non-TFC community-based settings. Chapin Hall conducted focus groups with LSSI and DCFS to better understand the context and processes of the TFC Pilot implementation and to explore the feasibility of the TFC Model as a community-based alternative to residential treatment in Illinois' child welfare system.



# A BENEFIT-COST STUDY OF THE THERAPEUTIC FOSTER CARE (TFC) PILOT

Ka Ho Brian Chor, Ph.D., Cody Oltmans, M.P.A., Mary Sue Morsch, A.M.

## EXECUTIVE SUMMARY

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The Illinois Children and Family Services Act (Illinois Public Act 099-0350) requires that the Illinois Department of Children and Family Services (DCFS) arrange for an independent evaluation of a 5-year pilot program of multidimensional treatment foster care (MTFC) “to determine whether there is a long-term cost benefit to continuing the pilot program.” Chapin Hall at the University of Chicago (Chapin Hall) is the independent evaluator of the DCFS 5-year Therapeutic Foster Care (TFC) Pilot. Lutheran Social Services of Illinois (LSSI) was the primary provider that fully implemented Therapeutic Foster Care Oregon (TFCO), the current name of MTFC (Blueprints for Healthy Youth Development, 2022), to serve youth ages 6–14 in the Cook County, Aurora, and Rockford subregions.

This benefit-cost study of the 5-year DCFS TFC Pilot: (1) focuses on youth who received the LSSI TFCO model ( $n=74$ ), as compared to youth who were referred to the LSSI TFCO model (hereafter referred to as TFC) but entered or remained in residential care instead ( $n=87$ ); (2) leverages the long-term benefit-cost evidence of TFC established in the literature; and (3) applies benefit-cost methods from existing studies on evidence-based interventions in other states for adaptation to the Illinois child welfare context.

### Overall Pilot Study Placement and Cost in TFC and Residential Care in February 2017 – June 2021 (Pilot Period)

Regarding placement duration, number of placements, and costs in TFC and residential care between the TFC Pilot group ( $n=74$ ) and the comparison group ( $n=87$ ) for placements occurring in February 2017-June 2021:

- Youth in the TFC Pilot group stayed, on average, for 5 months per TFC placement and had up to two TFC placements during the study period.
- Based on youth’s length of stay in TFC and in residential care during the study period, as well as the corresponding TFC and residential DCFS per diem rates adjusted to FY21 dollars, the overall mean cost per Pilot youth for the duration of the study period was \$94,438 in TFC placement costs.
- The comparison group stayed, on average, for 13 months per residential placement during the study period, resulting in an average cost per youth in residential care of \$212,649. The 25 Pilot youth who also spent time post-TFC in residential care incurred, on average, \$174,207 in residential placement costs.

## Cohort of Youth with 2 Years of Living Arrangement Data Post-TFC Start/TFC Referral: Placement Distribution and Cost Estimates

To estimate the impact of TFC on the Pilot youth's placement trajectories after leaving TFC, Chapin Hall identified a subset of Pilot youth ( $n=52$ ) and comparison youth ( $n=67$ ) who had at least 2 years of DCFS living arrangement data available between their TFC start date (Pilot) or TFC referral date (comparison) and May 2022. Per diem rates from FY21 were used to project the costs associated with the average placement distribution for a single Pilot and comparison youth. During the 2-year period:

- TFC Pilot youth spent nearly 50% of their days, or 355 days, on average, in TFC. In Year One, 75% of days (on average, 274 days) were in TFC, which aligned with the expected length of TFC treatment of up to 9 months. In Year Two, however, TFC Pilot youth spent 27% of days in specialized foster care and 23% in residential care.

After TFC youth exited their TFC placements after Year One, over time the **majority of their placement days were in less restrictive, less costly settings**. In contrast, the comparison group continued to **spend more days in more costly residential care**.

- Youth in the comparison group spent 77% of their days, or 563 days, on average, in residential care. This was consistent between Year One (78%) and Year Two (76%).
  - The daily distribution of placement types showed that the TFC Pilot group saw lower rates of TFC placement over time (as expected due to the short-term treatment model). Youth were equally placed in specialized foster care, traditional foster care/relative, and residential care (20–25% each) by the end of the 2-year period.
  - The daily distribution of placement types showed that the comparison group saw a consistently large and static percentage (80–90%) of youth placed in residential care, with minimal filtering out into less restrictive and less expensive placement types such as specialized foster care and traditional foster care/relative over time.
- The longitudinal changes in the mean daily cost of DCFS care for a single youth showed that the TFC Pilot group began at a substantially higher average daily rate on day 0 (\$320). However, by day 50, the mean daily cost of care for the comparison group surpassed that of the TFC Pilot group and would remain higher until the end of the 2-year period. By the end of the 2-year period, the daily cost of youth in the TFC Pilot (who likely had left TFC at that point) was approximately \$200, compared to \$300 in the comparison group.
  - After TFC youth exited their TFC placements after Year One, over time the majority of their placement days were in less restrictive, less costly settings. In contrast, the comparison group continued to spend more days in more costly residential care.

The estimated cost of care for youth in the TFC Pilot group was \$179,492 over the 2-year period. The estimated cost of care for youth in the comparison group was \$230,500, yielding 2-year estimated cost savings of \$51,058 attributable to TFC. In Year One, the estimated cost savings were \$11,868, compared to the estimated cost savings of \$39,190 in Year Two.

## Overall Net Benefit of TFC Per Youth

Washington State Institute for Public Policy (2019) derives the lifetime monetary benefit of MTFC (that is, TFCO, the TFC model subjected to this benefit-cost study) from a meta-analysis and from empirical literature on outcomes (such as depression) impacted by MTFC. Monetary benefit estimates were operationalized from the perspectives of taxpayers, MTFC participants, individuals other than taxpayers and MTFC participants, and indirect benefits. The total benefit of MTFC per participant in FY21 dollars is \$43,236. To estimate the net benefit of TFC, the lifetime monetary benefit of TFC from empirical literature (\$43,236 per youth) was added to the 2-year cost savings of TFC (\$51,068 per youth). Compared to residential care, the overall net benefit of TFC was \$94,294.26 per youth.

The overall net benefit of TFC per youth is  
**\$94,294.26 (\$43,236.00 per WSIPP + \$51,058.26  
2-year cost savings in DCFS TFC Pilot).**

## Implications

During the study period (February 2017–June 2021), the TFC Pilot group ( $n=74$ ) on average, spent less time in and incurred less cost from residential care than the comparison group ( $n=87$ ). Youth in the TFC Pilot group stayed, on average, 5 months per TFC placement, had up to two TFC placements during the study period, and, in total, had close to 10 months of TFC across TFC placements. However, 25 youth in the TFC Pilot group also spent time in residential care—more than 15 months on average. Youth in the comparison group, who either remained in or entered residential care after TFC referral, spent on average, 20 months in residential care. The overall mean cost per youth in TFC for the duration of the study period was \$94,438. The 25 Pilot youth who also spent time post-TFC in residential care, incurred, on average, \$174,207 in residential placement costs. The comparison group, with an overall longer stay in residential care during the study period, incurred an average cost per youth in residential care of \$212,649. These figures represented the overall DCFS financial investment in TFC placements and residential care placements for the duration of the Pilot.

To estimate the impact of TFC on the Pilot youth's placement trajectories after leaving TFC, Chapin Hall identified a subset of Pilot youth ( $n=52$ ) and comparison youth ( $n=67$ ) who had at least 2 years of DCFS living arrangement data available between their TFC start date (Pilot) or TFC referral date (comparison) and May 2022. Over the 2-



year period, the estimated cost of care for youth in the TFC Pilot group—made up of predominantly initial placement days in TFC and subsequent placement days in specialized foster care, traditional foster care/relative, or residential care—was \$179,492. In contrast, the estimated cost of care for youth in the comparison group—predominantly made up of placement days in residential care—was \$230,500. This means the overall 2-year cost savings of TFC, compared to residential care, was \$51,058 for a single youth. Significant cost savings were seen after youth exited their TFC placement, as they tended to move into less restrictive and less expensive settings such as traditional foster care/relative and specialized foster care. Comparison youth primarily stayed in the most expensive setting, residential care, throughout the 2-year period. To estimate the net benefit of TFC, the lifetime monetary benefit of TFC from empirical literature (\$43,236 per youth) was added to the 2-year cost savings of TFC. Compared to residential care, the overall net benefit of TFC was \$94,294.26 per youth, providing relevant evidence that there is a long-term cost-benefit to continuing the Pilot in Illinois.

This study has several limitations. Due to the conclusion of the 5-year DCFS TFC Pilot in FY21, Chapin Hall was only able to project TFC-related cost savings for 2 years from TFC placement (Pilot) or TFC referral (comparison). It is possible that further cost savings are realized beyond this period. Therefore, the cost savings figures shown in this report may be considered a conservative estimate. Second, the DCFS per diem rates for TFC in FY17–FY21 were lower than those for residential care, partially explaining the favorable cost savings findings attributable to TFC. In addition, cost data in this study only reflected DCFS fiscal investment in TFC and residential care. It did not account for non-DCFS costs associated with TFC and residential care, such as Medicaid billable services.

**Significant cost savings** were seen after youth exited their TFC placement, as they tended to move into less restrictive and less expensive settings such as traditional foster care/relative and specialized foster care.

# INTRODUCTION

The Illinois Department of Children and Family Services (DCFS) implemented a 5-year Therapeutic Foster Care (TFC) Pilot between July 1, 2016, and June 30, 2021. The pilot provided therapeutic home-based settings serving youth with a history of trauma or severe behavioral challenges who would otherwise enter or remain in residential care or be discharged from residential care to other non-TFC, community-based settings such as home of relative, fictive kin, or specialized foster care. Staffing, training, and foster parent recruitment occurred in the first 7 months. TFC referrals began on February 1, 2017.

The Illinois Children and Family Services Act (Illinois Public Act 099-0350) requires that DCFS arrange for an independent evaluation of a 5-year pilot program of multidimensional treatment foster care (MTFC) “to determine whether there is a long-term cost benefit to continuing the pilot program.” Chapin Hall at the University of Chicago (Chapin Hall) is the independent evaluator of the DCFS 5-year TFC Pilot. Lutheran Social Services of Illinois (LSSI) was the primary provider that fully implemented Therapeutic Foster Care Oregon (TFCO), the current name of MTFC (Blueprints for Healthy Youth Development, 2022), to serve youth ages 6–14 in the Cook County, Aurora, and Rockford subregions. Because LSSI’s TFCO youth comprised 80% of all youth in the TFC Pilot, this benefit-cost study focused on the LSSI TFCO model (see Table 1).

**Table 1. Summary of LSSI TFCO Model**

|  |   |
|--|---|
| <b>TFC evidence-based model</b>              | Therapeutic Foster Care Oregon (TFCO)   |
| <b>Trauma-informed intervention</b>          | Trauma-informed TFCO and therapists trained in Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)   |
| <b>Subregion (child’s legal/home county)</b> | Aurora (Kane, DuPage, Kendall, Will counties)   |
|  | Cook County   |
|  | Rockford (Boone, Ogle, Stephenson, Winnebago counties)  |
| <b>Youth’s age range</b>                     | 6–14 years old  |
| <b>TFC caregiver</b>                         | Foster parent   |
| <b>Program length</b>                        | 6–9 months  |
| <b>Target population</b>                     | <b>1. Deflection:</b> Youth who were not in residential care at the time of TFC referral, though <i>were</i> indicated to need residential care based on the Child and Adolescent Service Intensity Instrument (CASII) assessment (CASII level=5) |
|  | <b>2. Step-Down:</b> Youth who were in residential care at the time of TFC referral and <i>were</i> indicated to need residential care based on the CASII assessment (CASII level=5).   |

TFCO is “a **cost-effective alternative to group or residential treatment**” (Blueprints for Healthy Youth Development, 2022).

Since the DCFS TFC Pilot concluded in fiscal year (FY) 21, determining the current “long-term cost benefit to continuing the pilot program” would need to rely on evidence of TFCO benefit-cost in the empirical literature. According to the Blueprints for Healthy Youth Development, an independent organization that identifies, recommends, and certifies programs based on scientific evidence of effectiveness, TFCO is “a cost-effective alternative to group or residential treatment, incarceration, and hospitalization for adolescents who have problems with chronic antisocial behavior, emotional disturbance, and delinquency” (Blueprints for Healthy Youth Development, 2022). The Washington State Institute for Public Policy (WSIPP) is a leading authority on the long-term benefit-cost of major evidence-based programs that include MTFC or TFCO. For each program, WSIPP uses the same rigorous methods for synthesizing meta-analyses of high-quality research studies that have been tested and found to achieve

measurable improvement of long-term outcomes and for applying statistical modeling to calculate the benefit-cost of a program (Washington State Institute for Public Policy, 2019). WSIPP continuously updates its findings and calculations based on emerging studies in the literature that meet criteria for the meta-analyses.

Three states have drawn on WSIPP’s research to conduct their local benefit-cost analyses of interest. Arizona State University evaluated the benefit-cost of seven evidence-based early childhood programs in Arizona—Early Head Start, Family Spirit, Healthy Families Arizona, Healthy Steps, Nurse-Family Partnership, Parents as Teachers, and SafeCare Augmented (Evans & Shoemaker, 2016). The evaluation derived the monetization of benefits from WSIPP’s comprehensive meta-analyses of the corresponding programs. Monetization of program costs and participation costs were derived from Arizona-specific cost data from three state agencies—Arizona Department of Health Services, Arizona Department of Child Safety, and First Things First (Arizona’s early childhood agency)—that administered the seven evidence-based early childhood programs. In 2014, 10,971 families participated in these seven programs for estimated total costs of \$51,449,401 and estimated total benefits of \$96,425,509, yielding a total net benefit of \$44,976,107 for the 10,071 families, or \$4,100 per family (Evans & Shoemaker, 2016).

In Minnesota, the Minnesota Department of Management and Budget conducted benefit-cost analyses of five services offered in the child welfare system—Northstar Kinship Assistance, Family Assessment, Healthy Families America, Other Long-Term Home Visiting, and Nurse-Family Partnership (Kramer et al., 2018). Monetization of benefits was based on WSIPP’s model for child welfare-related outcomes and avoided victim costs. Monetization of costs was based on Minnesota-specific data for each child welfare service or practice. In 2017, the estimated net benefit per participant ranged from a net benefit loss of \$2,770 to a net benefit gain of \$1,200 (Kramer et al., 2018).

In Pennsylvania, the Pennsylvania Commission on Crime and Delinquency evaluated the benefit-cost of 12 prevention and intervention evidence-based programs—Aggression Replacement Training, Big Brothers Big Sisters, Functional Family Therapy, LifeSkills Training, Multisystemic Therapy, Positive Action, Positive Parenting Program, Project Towards No Drug Abuse, Promoting Alternative Thinking Strategies, Strengthening Families Program, Trauma-Focused Cognitive Behavioral Therapy, and Incredible Years (Pennsylvania Commission on Crime and Delinquency & Penn State’s Edna Bennett Pierce Prevention Research Center, 2019). Monetization of benefits was based on WSIPP’s meta-analyses and Pennsylvania-specific program benefits. Monetization of costs was based on Pennsylvania-specific program costs and population data. In 2017, the average cost per participant in the 12 programs ranged from \$63 to \$8,683, while the average benefit per participant ranged from -\$169 to \$19,300, with a range from a net benefit loss of \$3,051 to a net benefit gain of \$17,634 (Pennsylvania Commission on Crime and Delinquency & Penn State’s Edna Bennett Pierce Prevention Research Center, 2019).

One study examined the long-term economic benefit of TFCO for 81 adolescent females who were involved in the child welfare or juvenile justice systems in California and were referred to congregate care, as compared to 85 adolescent females in treatment as usual in congregate care (Saldana et al., 2019). Monetization of benefits was based on long-term cost differences in long-term child welfare services, legal, victimization, incarceration, and arrest outcomes associated with the study sample. Monetization of costs was based on WSIPP’s calculation of MTFC net program cost. Compared to treatment as usual in congregate care, the cost per participant in a cohort of youth placed in TFCO with at least 8 years of follow-up was \$10,776. The benefit was \$48,965, yielding a net benefit of \$38,199 (Saldana et al., 2019).

Taken together, the benefit-cost study of the 5-year DCFS TFC Pilot in this report: (1) focuses on youth who received the LSSI TFCO model, as compared to youth who were referred to the LSSI TFCO model but entered or remained in residential care instead; (2) leverages the long-term benefit-cost evidence of TFCO established by WSIPP; and (3) applies benefit-cost methods from existing studies on evidence-based interventions in other states for adaptation to the Illinois child welfare context.

# METHOD

The TFC Pilot evaluation was approved by the DCFS Institutional Review Board (IRB) and the Crown Family School of Social Work, Policy, and Practice and Chapin Hall IRB (IRB #16-1125).

## Sample

DCFS contracted with four purchase of service (POS) providers to implement the 5-year TFC Pilot—Children’s Home and Aid (CH+A), Jewish Children and Family Services (JCFS), Lutheran Social Services of Illinois (LSSI), and Youth Outreach Services (YOS). However, only LSSI fully implemented the Therapeutic Foster Care Oregon (TFCO) model, the current name of multidimensional treatment foster care (MTFC), the specific model required by the Illinois Children and Family Services Act (Illinois Public Act 099-0350) for which to conduct a benefit-cost study. TFC referrals officially began on February 1, 2017. Thus, the TFC Pilot group in this benefit-cost study focused on the 74 youth who received LSSI’s TFCO intervention between February 1, 2017, and June 30, 2021. The comparison group in this benefit-cost study was comprised of 87 youth who were referred to the TFC Pilot but were placed or remained in residential care instead (see Table 2).

**Table 2. Distribution of LSSI TFCO Youth in the Two Target Population/Intervention Groups and Their Respective Comparison**

| TFCO Target Population/Intervention Group                                    |                            | Comparison Group   |
|--|----------------------------|--|
| 1. <b>Deflection</b> (need residential care but are not in residential care) | TFCO youth ( <i>n</i> =50) | Referred to TFC Pilot but placed in residential care ( <i>n</i> =72)   |
| 2. <b>Step-Down</b> (need residential care and are in residential care)      | TFCO youth ( <i>n</i> =24) | Referred to TFC Pilot but remained in residential care ( <i>n</i> =20) |
| <b>Total</b>   | <b>74</b>                  | <b>87<sup>a</sup></b>  |

<sup>a</sup> Five youth were in both the step-down and deflection comparison groups at different points in time during the study period.

## Data Sources

Chapin Hall analyzed DCFS administrative data from the Child and Youth Centered Information System (CYCIS), Statewide Automated Child Welfare Information System (SACWIS), DCFS contract and payment data, and the Residential Treatment Outcomes System (RTOS). All analyses were conducted using R 4.1.2 (The R Foundation for Statistical Computing, 2021).

## Calculation of within Study Period (February 1, 2017 to June, 30 2021) Costs for Pilot and Comparison Groups

Chapin Hall analyzed data on all 74 Pilot and 87 comparison youth listed in Table 2. Each of these youth spent at least one day in TFC (Pilot only) or residential care (comparison) between February 1, 2017, and June 30, 2021. Youth were referred to TFC at different points in time within the study period, meaning that some youth had a greater number of overall placement days than others depending on their TFC referral and placement date. TFC and residential care costs were estimated for each youth based on the methods described below.

## **TFC Placement Cost**

DCFS provided detailed living arrangement data for the 74 youth in the TFC Pilot who received LSSI's TFCO intervention and for the 87 comparison youth. The living arrangement data included contract IDs and specific per diem rate information for placements in POS providers, including LSSI. Chapin Hall used the contract IDs with annual rates in FY17-FY21 (July 1, 2016 and June 30, 2021) to identify TFC placements that occurred between at LSSI's TFC sites. In order to exclude costs incurred after the study period ended, TFC placements that continued beyond June 30, 2021 were censored to an end date of June 30, 2021. Chapin Hall calculated the total number of days each Pilot youth spent in TFC within the study period and used the per diem rates to generate a total TFC cost per Pilot youth. All TFC placement costs are adjusted to FY21 dollars.

## **Residential Care Cost**

Chapin Hall used RTOS data to identify days spent in residential care between FY17 and FY21 for both the Pilot and comparison youth. DCFS provided per diem residential care cost data for FY17–FY21. In order to exclude costs incurred after the study period ended, residential placements that continued beyond June 30, 2021, were censored to an end date of June 30, 2021. Similarly, days youth spent in residential care prior to their TFC referral date were excluded from the cost calculations. Chapin Hall calculated the total number of days each Pilot and comparison youth spent in residential care within the study period and used the per diem rates to generate a total residential care cost per youth. All residential placement costs are adjusted to FY21 dollars.

## **Cohort of Youth with Two Years of Living Arrangement Data Post-TFC Start/TFC Referral: Placement Trajectories and Cost Estimates**

To estimate the impact of TFC on the Pilot youth's placement trajectories after leaving TFC, Chapin Hall identified a subset of Pilot youth ( $n=52$ ) and comparison youth ( $n=67$ ) who had at least 2 years of DCFS living arrangement data available between their TFC start date (Pilot) or TFC referral date (comparison) and May 2022. Having a full 2 years of living arrangement data allowed Chapin Hall to observe if youth in the Pilot group benefitted from TFC and therefore were more likely to move to and remain in nonresidential care placements after leaving TFC relative to the comparison group.

## **Two-Year Placement Trajectories**

Chapin Hall used the detailed living arrangement data provided by DCFS, as well as the RTOS data, to identify all placements and residential care spells associated with these youth. Chapin Hall excluded all placement days occurring prior to a youth's TFC start/referral date, so that the first day of placement data for each youth was either their TFC start date (Pilot) or their TFC referral date (comparison). To align with DCFS payments for pre-existing living arrangement groupings, each placement was classified under one of six categories: therapeutic foster care (TFC), transitional living program (TLP), residential care, traditional foster care/relative, specialized foster care, and unpaid placements.

With each youth having a full 2 years of placement data from the point of TFC start (Pilot) and TFC referral (comparison), Chapin Hall then created a placement profile showing, on average, the number of days a single

youth spent in each placement category over the course of the 2 years for the Pilot group (beginning from the TFC start date) and the comparison groups (beginning from the TFC referral date).

## Two-Year Cost Projection

DCFS also provided per diem rate information for FY17–FY21 for each of the six placement categories, allowing Chapin Hall to develop a projected cost associated with the 2 years after the TFC start/referral date for a single youth. To generate a total 2-year cost projection, Chapin Hall used the FY21 per diem rates for each placement category and multiplied them by the average number of days spent in each placement category. This cost projection represents an estimate of the total living arrangement-related expenses associated with a single youth over the course of 2 years, beginning from either their TFC start date (Pilot) or TFC referral date (comparison).

## Calculation of Benefit

TFC benefit estimates, adjusted to FY21 dollars, were derived from benefits accrued to taxpayers, TFC youth, and indirect benefits, based on a meta-analysis conducted by WSIPP about TFC (Washington State Institute for Public Policy, 2019). These benefits include decreased criminal justice involvement, decreased repeating a grade at school, better labor market earnings, healthcare, and reduced mortality.

## Calculation of Net Benefit

Chapin Hall defined the TFC net benefit as the sum of TFC benefit estimates accrued to taxpayers, TFC youth, and indirect benefits according to WSIPP (2019), and the projected 2-year cost savings associated with TFC placement in the DCFS Pilot (see Table 3). Specifically, Chapin Hall subtracted the Pilot group cost projection from the comparison group cost projection to obtain the estimated cost savings associated with TFC placement. The TFC net benefit represents the net benefits for a single youth participating in the TFC program.

**Table 3. Calculation of Net Benefit per Youth in TFC**

| <b>Component</b>  | <b>Calculation</b>   |
|---|--|
| <b>WSIPP (2019) estimated lifetime benefits per youth</b> (FY21 dollars) in TFC compared to residential care (treatment as usual) | Benefits to taxpayers (\$12,199)<br>Benefits to participants (\$290)<br>Benefits to others (\$29,723)<br>Indirect benefits (\$1,024) |
| <b>Cost savings estimates per youth in DCFS TFC Pilot</b> (FY21 dollars) compared to residential care (treatment as usual)        | Estimated two-year cost per comparison youth (treatment as usual)<br>–<br>Estimated two-year cost per TFC Pilot youth                |
| <b>Net benefit per youth in TFC</b> (FY21 dollars)  | <b>WSIPP estimated lifetime benefits per youth</b><br>+<br><b>Cost savings estimates per youth in DCFS TFC Pilot</b>                 |

# RESULTS

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## Overall Pilot Study Placement and Cost in TFC and Residential Care in February 2017 – June 2021

Table 4 summarizes the placement duration, number of placements, and costs in TFC and residential care between the TFC Pilot group ( $n=74$ ) and the comparison group ( $n=87$ ) for placements occurring between February 2017 and June 2021. Youth in the TFC Pilot group (step-down or deflection) stayed, on average, 5 months per TFC placement and had up to two TFC placements during the study period. In total, youth in the Pilot group had close to 10 months of TFC (298 days) across TFC placements. Notably, some Pilot youth ( $n=25$ ) also spent time in residential care post-TFC. The TFC step-down group (those coming from residential care prior to TFC) stayed, on average, nearly 13 months (389 days;  $n=10$ ) per residential placement post-TFC, compared to approximately 9 months (268 days;  $n=15$ ) per residential placement in the TFC deflection group. By study design, youth in the TFC comparison groups did not spend any days in TFC. However, the deflection comparison group stayed, on average, in each residential placement for almost 15 months (443 days), and in total close to 20 months (591 days) in residential care across residential placements.

The 25 youth in the Pilot who spent time post-TFC in residential care, incurred, on average, **\$174,207 in residential placement costs**. In contrast, because the comparison group overall had a longer stay in residential care during the study period, their average cost per youth in residential care was higher, **at \$212,649**.

Based on youth's length of stay in TFC and in residential care during the study period, as well as the corresponding TFC and residential DCFS per diem rates adjusted to FY21 dollars, Chapin Hall estimated the mean cost per youth in TFC and mean cost per youth in residential care. Of note, the per diem rates of TFC and residential care were comparable to those in FYs 17 through 19, though the per diem rates of TFC were substantially lower in FYs 20 and 21, \$51 and \$67 less, respectively (see Table 4 footnotes). The overall mean cost per youth in TFC for the duration of the study period was \$94,438. The 25 youth in the Pilot who also spent time post-TFC in residential care, incurred, on average, \$174,207 in residential placement costs. In contrast, because the comparison group overall had a longer stay in residential care during the study period, their average cost per youth in residential care was higher, at \$212,649. Of note, the 10 Pilot youth in the step-down group incurred the highest mean cost per youth in residential care, at \$253,821.40.



**Table 4. All Youth during TFC Pilot Study Period (February 2017 – June 2021): Placement and Cost in TFC and Residential Care, by TFC Pilot Groups and Comparison Groups**

| All Youth  | TFC Pilot                               |   |  | Comparison                     |                                |                                |
|--|---|---|--|--------------------------------|--------------------------------|--------------------------------|
|  | Step-Down<br>(n=24)                     | Deflection<br>(n=50)                    | Total<br>(n=74)                          | Step-Down<br>(n=20)            | Deflection<br>(n=72)           | Total<br>(n=87) <sup>a</sup>   |
| <i>Placement</i>   |   |   |  |                                |                                |                                |
| <b>Mean length of stay (days) in TFC placement (SD)</b>              | 155.09<br>(144.71)                      | 149.41<br>(165.61)                      | 151.12<br>(159.13)                       | --                             | --                             | --                             |
| <b>Mean number of TFC placements (SD)</b>                            | 1.83<br>(1.01)                          | 2.04<br>(1.40)                          | 1.97<br>(1.28)                           | --                             | --                             | --                             |
| <b>Mean total days in TFC placement (SD)</b>                         | 283.81<br>(187.07)                      | 304.80<br>(205.11)                      | 297.71<br>(198.39)                       | --                             | --                             | --                             |
| <b>Mean length of stay (days) in residential placement (SD)</b>      | 389.17<br>(234.64)<br>(n=10)            | 267.50<br>(235.83)<br>(n=15)            | 328.33<br>(239.91)<br>(n=25)             | 264.97<br>(204.33)             | 443.30<br>(321.05)             | 408.12<br>(312.94)             |
| <b>Mean number of residential placements (SD)</b>                    | 1.80 (0.79)<br>(n=10)                   | 1.20 (0.41)<br>(n=15)                   | 1.44 (0.65)<br>(n=25)                    | 1.75<br>(1.02)                 | 1.33<br>(0.77)                 | 1.46<br>(0.86)                 |
| <b>Mean total days in residential placement (SD)</b>                 | 698.40<br>(284.63)<br>(n=10)            | 319.47<br>(239.03)<br>(n=15)            | 471.04<br>(315.61)<br>(n=25)             | 463.70<br>(286.01)             | 591.07<br>(356.06)             | 595.76<br>(346.51)             |
| <i>Cost</i>  |   |   |  |                                |                                |                                |
| <b>Mean cost per youth in TFC placement<sup>b</sup> (SD)</b>         | \$90,178.15<br>(\$59,321.68)            | \$96,483.31<br>(\$64,995.32)            | \$94,438.39<br>(\$62,873.90)             | --                             | --                             | --                             |
| <b>Mean cost per youth in residential placement<sup>c</sup> (SD)</b> | \$253,821.40<br>(\$95,511.38)<br>(n=10) | \$121,131.10<br>(\$90,031.63)<br>(n=15) | \$174,207.20<br>(\$112,030.80)<br>(n=25) | \$167,014.00<br>(\$103,199.40) | \$213,524.20<br>(\$124,091.00) | \$212,649.40<br>(\$122,232.20) |

<sup>a</sup> Five youth were in both step-down and deflection comparison groups at different points in time during the study period.

<sup>b</sup> TFC per diem rates adjusted to FY21 dollars: FY17 (\$313.21), FY18 (\$319.99), FY19 (\$315.32), FY20 (\$314.30), FY21 (\$322.23).

<sup>c</sup> Residential care per diem rate adjusted to FY21 dollars: FY17 (\$311.08), FY18 (\$307.09), FY19 (\$317.61), FY20 (\$365.43), FY21 (\$388.85).

## Cohort of Youth with Two Years of Living Arrangement Data Post-TFC Start/TFC Referral: Placement Distribution and Cost Estimates

To estimate the impact of TFC on the Pilot youth’s placement trajectories after leaving TFC, Chapin Hall identified a subset of Pilot youth ( $n=52$ ) and comparison youth ( $n=67$ ) who had at least 2 years of DCFS living arrangement data available between their TFC start date (Pilot) or TFC referral date (comparison) and May 2022. Having a full 2 years of living arrangement data allowed Chapin Hall to observe if youth in the Pilot group benefitted from TFC and were more likely than members of the comparison group to move to and remain in nonresidential care placements after leaving TFC.

Chapin Hall used this data to identify the average number of days a single youth spends in each placement category in the 2-year period beginning after their TFC start/referral date. Table 5 shows how the 2-year placement distribution for a single youth differs depending on if they received TFC (Pilot) or treatment as usual

(comparison). Per diem rates from FY21 were used to project the costs associated with the average placement distribution for a single Pilot and comparison youth.

## TFC Pilot vs. Comparison

Over the 2-year period, the estimated cost of care for youth in the TFC Pilot group was **\$179,492**, which was less than the estimated cost of care for youth in the comparison group, \$230,500.

This difference yields 2-year estimated cost savings of **\$51,058** attributable to TFC.

In the TFC Pilot group during the full 2-year period, youth spent nearly 50% of their days,<sup>1</sup> or 355 days, on average, in TFC. In Year One, 75% of days (on average, 274 days) were spent in TFC, which aligned with the expected length of TFC treatment of up to 9 months. In Year Two, however, TFC Pilot youth spent 27% of days in specialized foster care and 23% in residential care. In the comparison group during the full 2-year period, as expected, residential care constituted the majority of youth's days.<sup>2</sup> On average, youth were in residential care 77% of the time, or 563 days. This was consistent with Year One (78%) and Year Two (76%). In both the TFC Pilot group and the comparison group, specialized foster care and traditional foster care/relative made up most of the remaining days, followed by unpaid placements (e.g., detention, runaway). Placement in transitional living program never occurred in the TFC Pilot group and was rare in the comparison group.

The per diem (per day) cost for a single youth at each placement type is shown in the "FY21 Daily Rate" column of Table 5. Based on FY21 rates, residential care was the most expensive placement type, at \$388.85 per day for a single youth. Therapeutic Foster Care was the second most expensive placement, although still significantly less expensive than residential care, at \$322.23 per day. Specialized Foster Care (\$136.37 per day) and Traditional Foster Care/Relative (\$44.60 per day) were the least expensive placement types.

Chapin Hall used these FY21 rates to estimate costs over the 2-year period for both the Pilot and comparison groups. Over the 2-year period, the estimated cost of care for youth in the TFC Pilot group was \$179,492, which was less than the estimated cost of care for youth in the comparison group, \$230,500. This difference yields 2-year estimated cost savings of \$51,058 attributable to TFC. In Year One, the estimated cost savings of \$11,868 were smaller, and expected. The smaller savings were due to the majority of days youth spent in TFC and the TFC per diem rate being the second highest across placement types, behind residential care. In Year Two, as Pilot youth exited TFC and filtered into less expensive placement types such as Traditional Foster Care/Relative and Specialized Foster Care, the estimated cost savings increased to \$39,190.

Figure 1 and Figure 2 show the longitudinal changes in the daily distribution of placement types of the TFC Pilot group and the comparison group, respectively, over the 2-year period. The TFC Pilot group saw a smaller percentage of TFC placement over time (as expected due to the short-term treatment model). However, by the

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<sup>1</sup> Post-TFC start date

<sup>2</sup> Post-TFC referral date

By the end of the 2-year period, the daily cost of youth in the TFC Pilot was approximately **\$200**, compared to **\$300** in the comparison group.

end of the 2-year period, youth were relatively equally placed in specialized foster care, traditional foster care/relative, and residential care (20–25% each; see Figure 1). In contrast, the comparison group over the 2 years saw a consistently large and static percentage (80–90%) of youth placed in residential care (see Figure 2), with minimal filtering out into less restrictive and less expensive placement types such as specialized foster care and traditional foster care/relative over time.

Figure 3 shows the longitudinal changes in the mean daily cost of DCFS care for a single youth between the TFC Pilot group and the comparison group over the 2-year period since TFC placement/referral. Although the TFC Pilot group began at a substantially higher average daily rate on day 0 (\$320), by day 50, the mean daily cost of care for the comparison group

surpassed that of the TFC Pilot group and would remain so until the end of the 2-year period. By the end of the 2-year period, the daily cost of youth in the TFC Pilot (who likely had left TFC at that point) was approximately \$200, compared to \$300 in the comparison group. These trends were consistent with the summative findings in Table 4 and the longitudinal changes in placement distribution shown in Figures 1 and 2. When TFC youth exited their TFC placements after Year One, the majority of their placement days were in less restrictive, less costly settings over time, whereas the comparison group continued to spend more days in more costly residential care.

**Table 5. Youth with 2 Years of Living Arrangement Data Post-TFC Start/Referral: Placement Distribution and Cost, by TFC Pilot Group and Comparison Group, and by Follow-up Period**

| All Youth with Two Years of Living Arrangement Data post TFC Start/Referral | FY21 Daily Rate | Full Two-Year Trajectory |        |                     |        | Year One            |                    |                     |                | Year Two           |                   |                     |                |      |
|---|-----------------|--------------------------|--------|---------------------|--------|---------------------|--------------------|---------------------|----------------|--------------------|-------------------|---------------------|----------------|------|
|   |                 | TFC Pilot (n=52)         |        | Comparison (n=67)   |        | TFC Pilot (n=52)    |                    | Comparison (n=67)   |                | TFC Pilot (n=52)   |                   | Comparison (n=67)   |                |      |
|   |                 | Mean Days (SD)           | % Days | Mean Days (SD)      | % Days | Mean Days (SD)      | % Days             | Mean Days (SD)      | % Days         | Mean Days (SD)     | % Days            | Mean Days (SD)      | % Days         |      |
| <b>Therapeutic Foster Care (TFC)</b>  | \$322.23        | 355.23<br>(194.57)       | 48.66  | 0.00<br>(0.00)      | 0.00   | 0.00                | 273.83<br>(114.48) | 75.02               | 0.00<br>(0.00) | 0.00               | 81.40<br>(112.66) | 22.30               | 0.00<br>(0.00) | 0.00 |
| <b>Transitional Living Program (TLP)</b>                                    | \$275.57        | 0.00<br>(0.00)           | 0.00   | 0.33<br>(2.69)      | 0.04   | 0.00<br>(0.00)      | 0.00               | 0.00                | 0.00<br>(0.00) | 0.00               | 0.00<br>(0.00)    | 0.0                 | 0.33<br>(2.69) | 0.09 |
| <b>Residential Care</b>   | \$388.85        | 117.13<br>(203.02)       | 16.05  | 562.81<br>(183.85)  | 77.10  | 33.96<br>(85.70)    | 9.30               | 286.22<br>(92.68)   | 78.42          | 83.17<br>(137.16)  | 22.79             | 276.58<br>(127.30)  | 75.78          |      |
| <b>Traditional Foster Care/Relative</b>                                     | \$44.60         | 76.83<br>(125.21)        | 10.52  | 39.18<br>(109.00)   | 5.37   | 12.06<br>(30.08)    | 3.30               | 11.96<br>(34.06)    | 3.28           | 64.77<br>(110.03)  | 17.74             | 27.22<br>(86.64)    | 7.46           |      |
| <b>Specialized Foster Care</b>  | \$136.77        | 117.37<br>(164.73)       | 16.08  | 72.13<br>(142.89)   | 9.88   | 18.15<br>(63.13)    | 4.97               | 32.90<br>(78.12)    | 9.01           | 99.21<br>(132.33)  | 27.18             | 39.24<br>(88.04)    | 10.75          |      |
| <b>Unpaid Placement</b>   | N/A             | 56.04<br>(64.68)         | 7.68   | 55.55<br>(58.39)    | 7.61   | 26.98<br>(36.59)    | 7.39               | 33.93<br>(34.12)    | 9.29           | 29.06<br>(51.64)   | 7.96              | 21.63<br>(52.30)    | 5.93           |      |
| <b>Not in DCFS Care</b>   | N/A             | 7.40<br>(32.18)          | 1.01   | 0.00<br>(0.00)      | 0.00   | 0.02<br>(0.14)      | 0.01               | 0.00<br>(0.00)      | 0.00           | 7.38<br>(32.18)    | 2.02              | 0.00<br>(0.00)      | 0.00           |      |
| <b>Total Cost (FY21 Rates)</b>  |                 | <b>\$179,491.75</b>      |        | <b>\$230,550.01</b> |        | <b>\$104,461.76</b> |                    | <b>\$116,330.10</b> |                | <b>\$75,029.99</b> |                   | <b>\$114,219.91</b> |                |      |
| <b>TFC Cost Savings</b>   |                 | <b>\$51,058.26</b>       |        |                     |        | <b>\$11,868.35</b>  |                    |                     |                | <b>\$39,189.92</b> |                   |                     |                |      |

Figure 1. Daily Distribution of Placement Types of Youth in the TFC Pilot Group ( $n=52$ ) in the 2-year Period Post-TFC Start Date

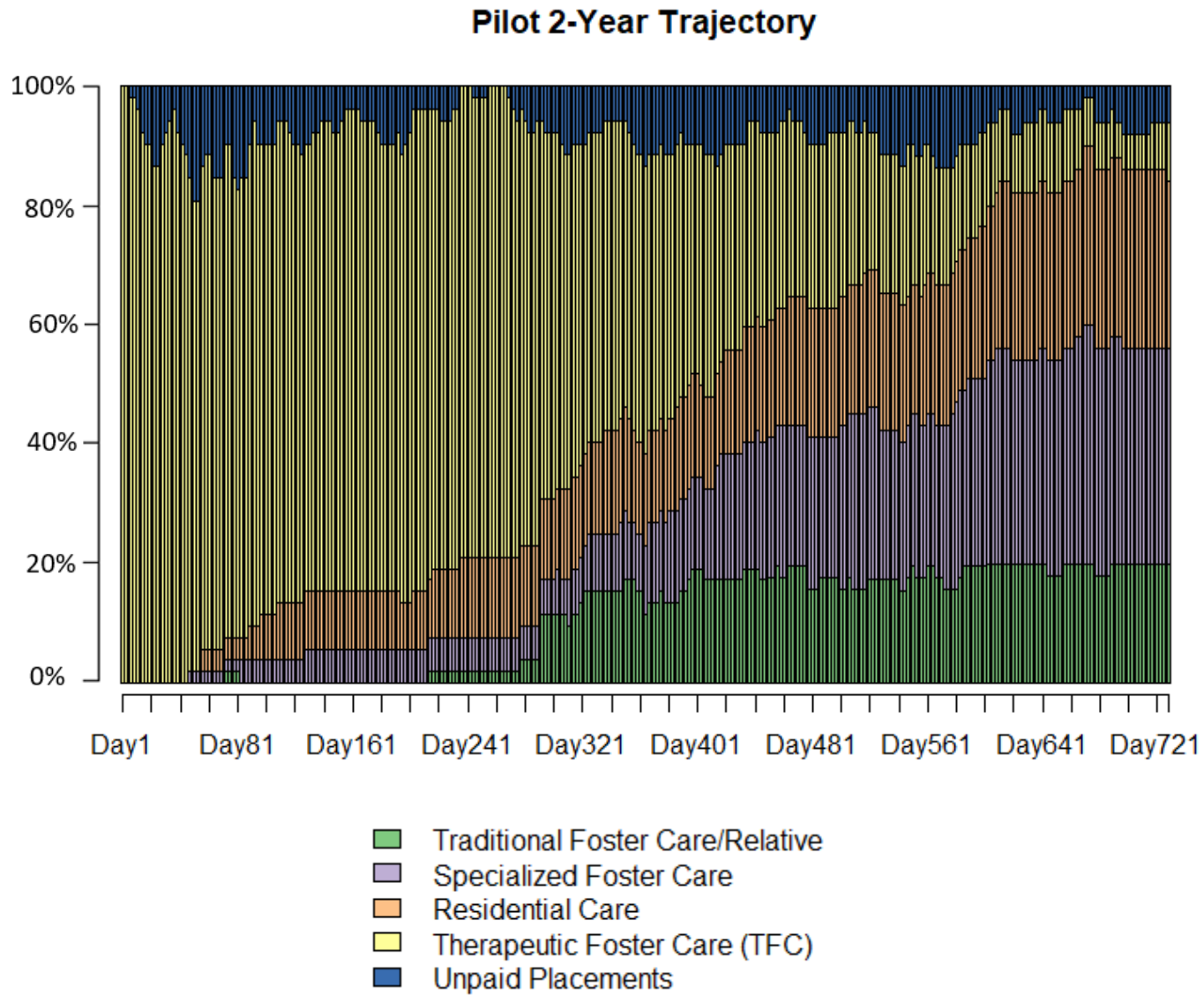
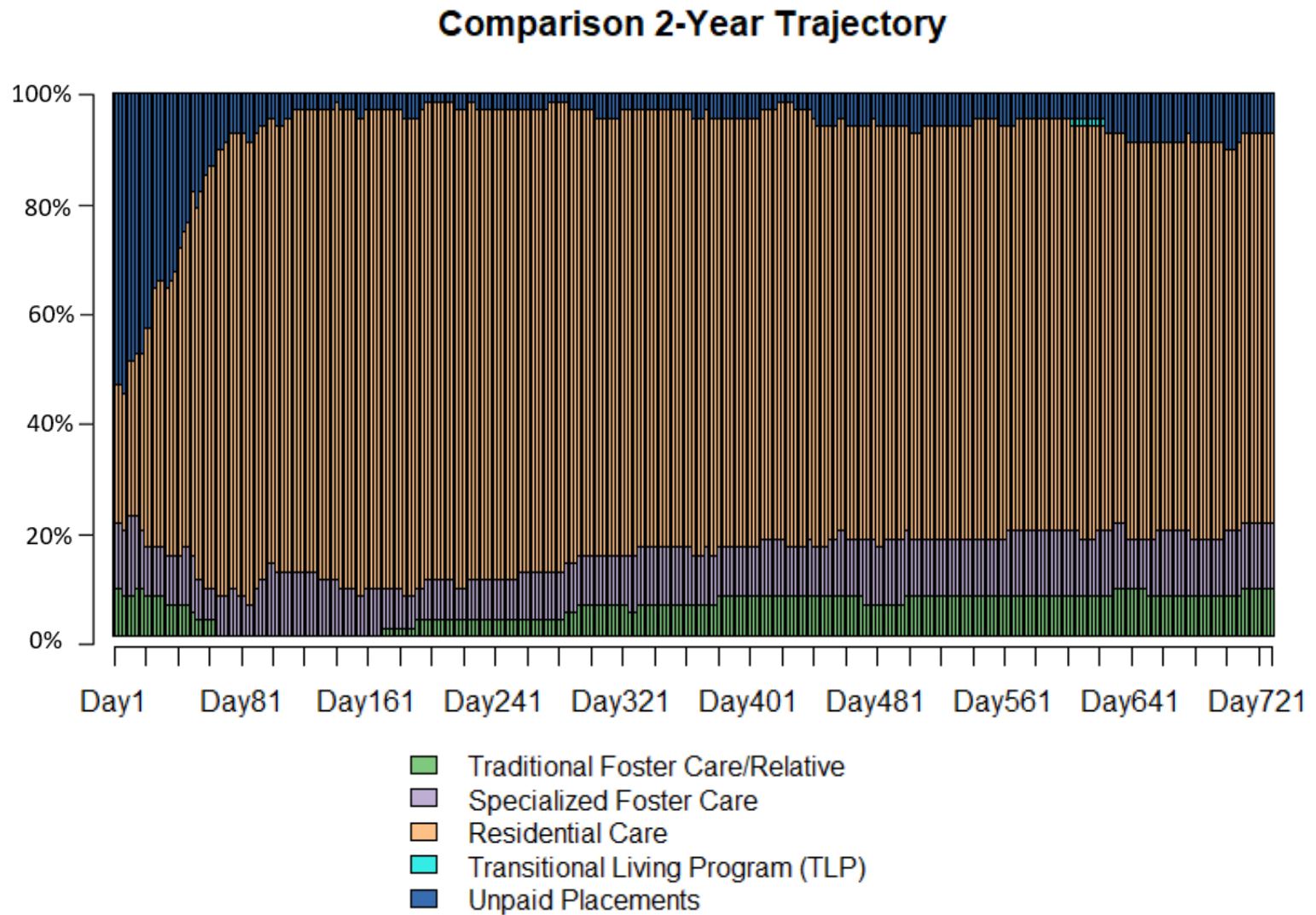


Figure 2. Daily Distribution of Placement Types of Youth in the Comparison Group ( $n=67$ ) in the 2-year Period Post-TFC Referral Date



**Figure 3. Mean Daily Cost of Care (FY21 rates) of Youth, by TFC Pilot Group (n=52) and Comparison Group (n=67), in the 2-year Period Post-TFC Start/Referral Date**



TFC Step-Down vs. Step-Down Comparison (see Table 6) shows that subgroup findings regarding the TFC step-down group ( $n=18$ ) and its comparison group ( $n=15$ ) were consistent with the overall findings (see Table 5). During the full 2-year period, Pilot youth spent nearly 50% of their days (348 days, on average) in TFC. In Year One, 75% of youth's days (on average, 274 days) were in TFC. In Year Two, however, TFC step-down youth spent 33% of days in specialized foster care and 27% in residential care. In the comparison group during the full 2-year period, time spent in residential care constituted the majority youth's days (75% or, on average, 552 days). This was consistent in both Year One (87%) and Year Two (65%). In both the TFC step-down group and comparison group, specialized foster care and traditional foster care/relative made up most of the remaining days, followed by unpaid placements that indicate disruption (such as detention or runaway).

Over the 2-year period, the estimated cost of DCFS care for youth in the TFC step-down group was \$187,201, which was less than the estimated cost of care for youth in the comparison group (\$225,227). In other words, 2-year estimated cost savings of \$38,026 could be attributed to TFC. For individual years, estimated cost savings favored TFC but were smaller in Year One (\$19,698) and in Year Two (\$18,328) when compared to the overall Pilot group.

Figure 4 and Figure 5 show the longitudinal changes in the daily distribution of placement types of the TFC step-down group and its comparison group, respectively, over the two-year period. The TFC step-down group saw a decrease in the percentage of TFC placement over time (as expected due to the short-term treatment model), as specialized foster care (45%), and residential care (40%) became the majority placement types by the end of the two-year period (see Figure 4). In contrast, the comparison group saw a consistently large and static percentage of youth placed in residential care (70-80%) over time. Nearly 20% of comparison youth were in unpaid settings at the end of the two-year period, indicating disruption (see Figure 5).

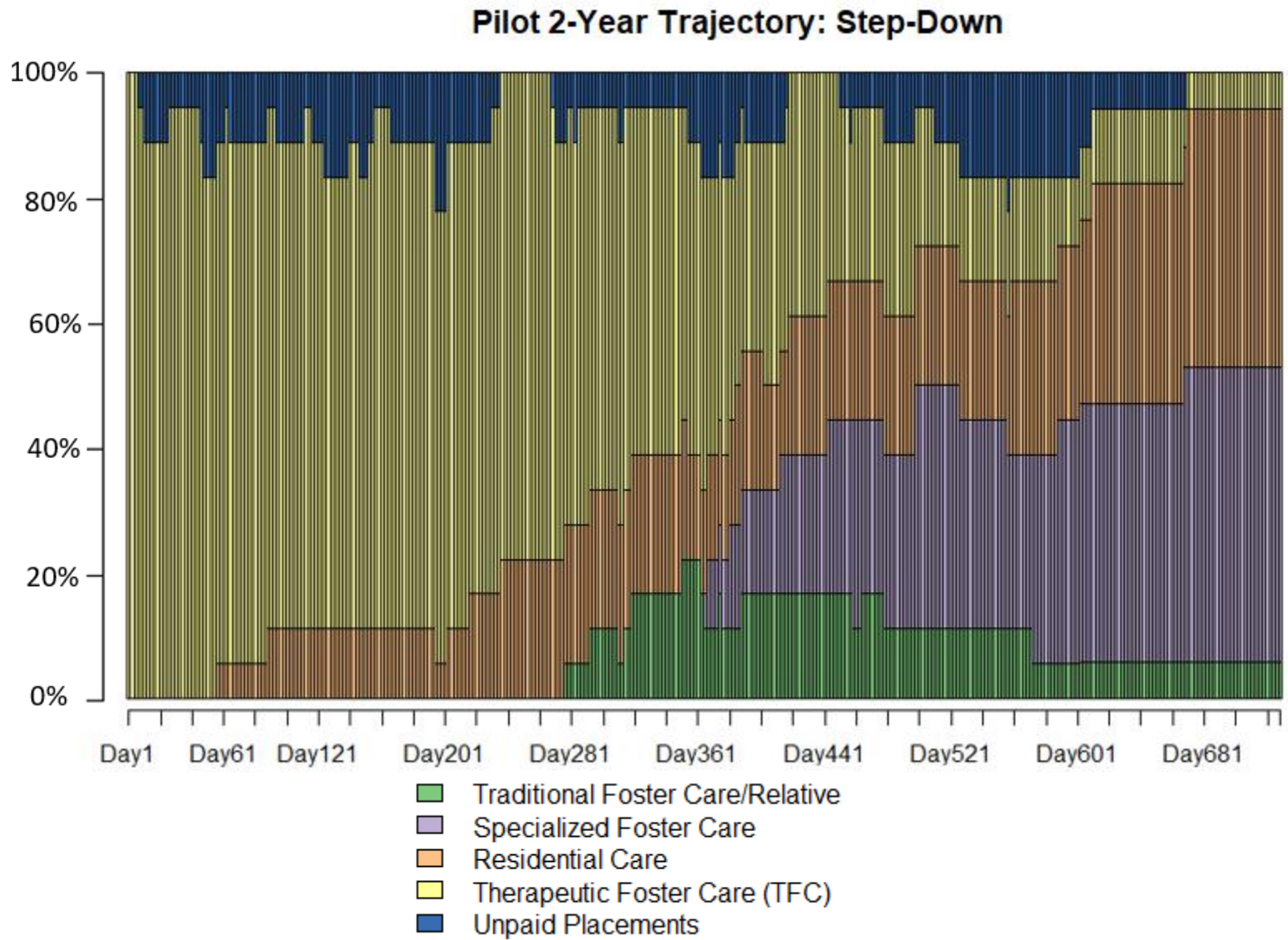
Figure 6 shows the longitudinal changes in the mean daily cost of DCFS care for a single youth between the TFC step-down group and the comparison group over the two-year period since TFC placement/referral, respectively. The comparison group, starting in residential care, began at a higher daily rate (approximately \$380) than the TFC step-down group (approximately \$325). Over the first 200 days, while the TFC step-down group's daily cost of DCFS care remained relatively the same with some fluctuations, the comparison group's daily cost of DCFS care continued to decrease until day 300. After that, the TFC step-down group had a lower daily cost but the difference narrowed towards the end of the two-year period. These trends were consistent with the summative findings in Table 6 in which over 25% of the days in the TFC step-down group in Year Two were in residential care, therefore driving up the daily cost of care.



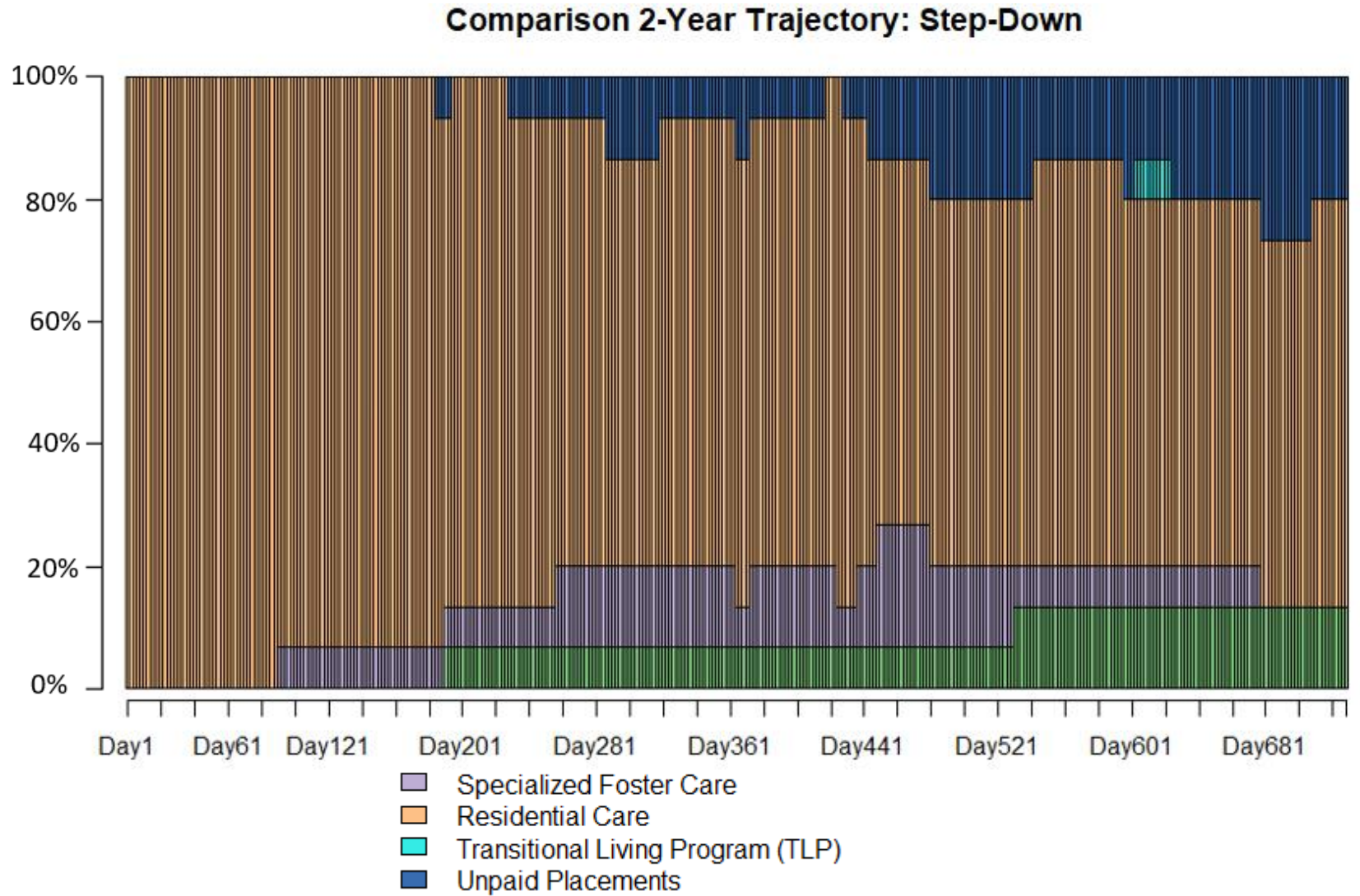
**Table 6. Youth with 2 Years of Living Arrangement Data Post-TFC Start/Referral: Placement Distribution and Cost, by TFC Step-down Group and Comparison Group, and by Follow-up Period**

| All Youth with Two Years of Living Arrangement Data post TFC Start/Referral | FY21 Daily Rate | Full Two-Year Trajectory |        |                      |        | Year One            |                    |                      |                | Year Two           |                   |                      |                |      |
|---|-----------------|--------------------------|--------|----------------------|--------|---------------------|--------------------|----------------------|----------------|--------------------|-------------------|----------------------|----------------|------|
|   |                 | TFC Step-Down            |        | Step-Down Comparison |        | TFC Step-Down       |                    | Step-Down Comparison |                | TFC Step-Down      |                   | Step-Down Comparison |                |      |
|   |                 | (n=18)                   |        | (n=15)               |        | (n=18)              |                    | (n=15)               |                | (n=18)             |                   | (n=15)               |                |      |
|   |                 | Mean Days (SD)           | % Days | Mean Days (SD)       | % Days | Mean Days (SD)      | % Days             | Mean Days (SD)       | % Days         | Mean Days (SD)     | % Days            | Mean Days (SD)       | % Days         |      |
| <b>Therapeutic Foster Care (TFC)</b>  | \$322.23        | 348.28<br>(193.87)       | 47.71  | 0.00<br>(0.00)       | 0.00   | 0.00                | 274.17<br>(116.99) | 75.11                | 0.00<br>(0.00) | 0.00               | 74.11<br>(113.26) | 20.30                | 0.00<br>(0.00) | 0.00 |
| <b>Transitional Living Program (TLP)</b>                                    | \$275.57        | 0.00<br>(0.00)           | 0.00%  | 1.47<br>(5.68)       | 0.20   | 0.00<br>(0.00)      | 0.00               | 0.00                 | 0.00<br>(0.00) | 0.00               | 0.00<br>(0.00)    | 0.00                 | 1.47<br>(5.68) | 0.40 |
| <b>Residential Care</b>   | \$388.85        | 145.5<br>(221.65)        | 19.93  | 552<br>(177.29)      | 75.62  | 46.89<br>(96.47)    | 12.85              | 315.8<br>(82.92)     | 86.52          | 98.61<br>(144.74)  | 27.02             | 236.20<br>(139.28)   | 64.71          |      |
| <b>Traditional Foster Care/Relative</b>                                     | \$44.60         | 48.44<br>(103.83)        | 6.64   | 49.33<br>(145.18)    | 6.76   | 11.83<br>(26.36)    | 3.24               | 11.67<br>(45.18)     | 3.20           | 36.61<br>(90.06)   | 10.03             | 37.67<br>(104.18)    | 10.32          |      |
| <b>Specialized Foster Care</b>  | \$136.77        | 118.72<br>(141.29)       | 16.26  | 58.33<br>(122.69)    | 7.99   | 0.06<br>(.24)       | 0.02               | 25.53<br>(74.25)     | 7.00           | 118.67<br>(141.19) | 32.51             | 32.80<br>(81.53)     | 8.99           |      |
| <b>Unpaid Placement</b>   | N/A             | 61.94<br>(66.57)         | 8.49   | 68.87<br>(87.11)     | 9.43   | 32.06<br>(42.87)    | 8.78               | 12 (29.62)           | 3.29           | 29.89<br>(56.19)   | 8.19              | 56.87<br>(85.95)     | 15.58          |      |
| <b>Not in DCFS Care</b>   | N/A             | 7.11<br>(30.17)          | 0.97   | 0.00<br>(0.00)       | 0.00   | 0.00<br>(0.00)      | 0.00               | 0.00<br>(0.00)       | 0.00           | 7.11<br>(30.17)    | 1.95              | 0.00<br>(0.00)       | 0.00           |      |
| <b>Total Cost (FY21 Rates)</b>  |                 | <b>\$187,200.85</b>      |        | <b>\$225,227.17</b>  |        | <b>\$107,112.81</b> |                    | <b>\$126,810.98</b>  |                | <b>\$80,088.05</b> |                   | <b>\$98,416.19</b>   |                |      |
| <b>TFC Cost Savings</b>   |                 | <b>\$38,026.32</b>       |        |                      |        | <b>\$19,698.17</b>  |                    |                      |                | <b>\$18,328.14</b> |                   |                      |                |      |

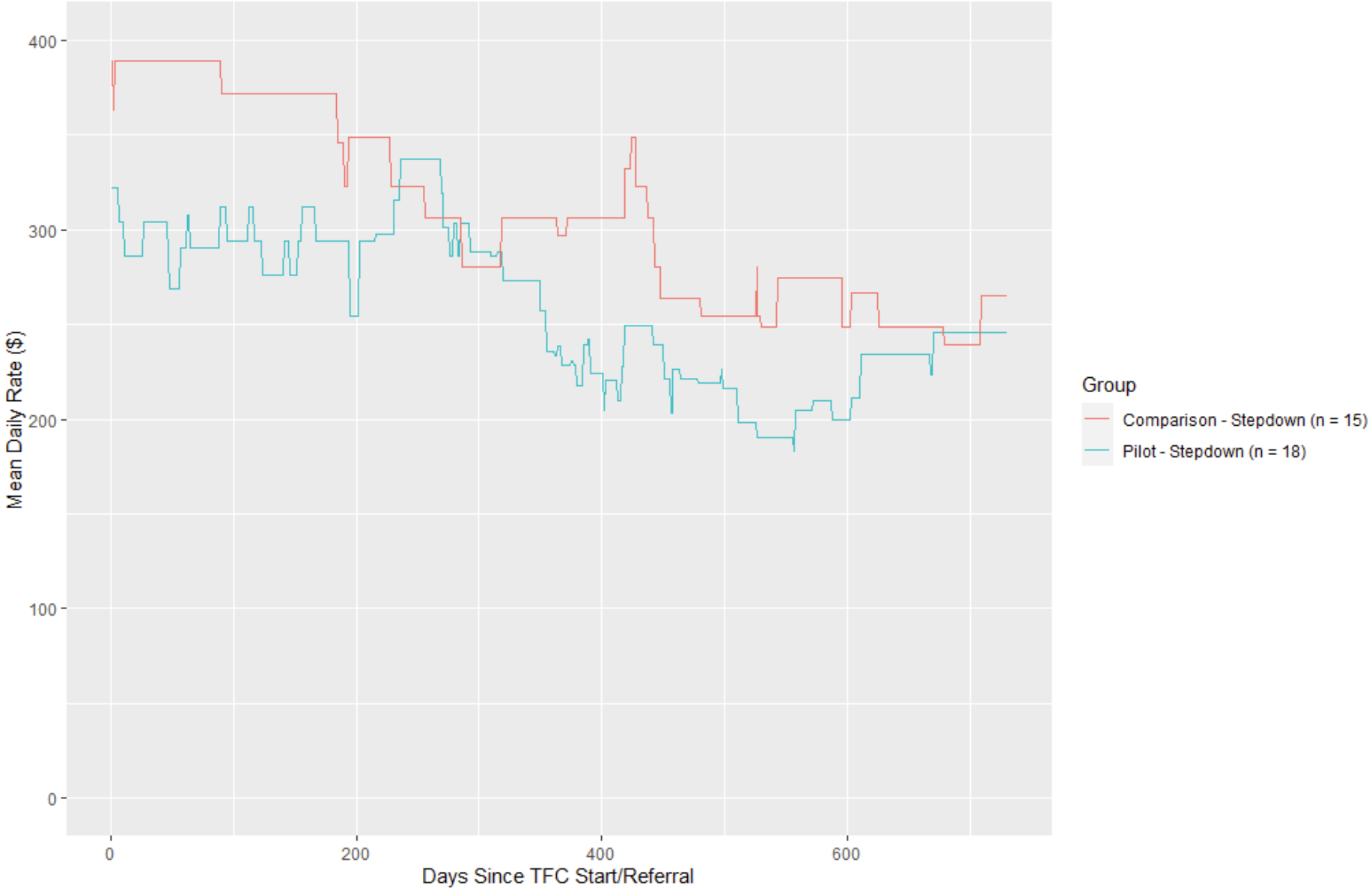
Figure 4. Daily Distribution of Placement Types of Youth in the TFC Step-down Group (n=18) in the 2-year Period Post-TFC Start Date



**Figure 5. Daily Distribution of Placement Types of Youth in the Step-down Comparison Group ( $n=15$ ) in the 2-year Period Post-TFC Referral Date**



**Figure 6. Mean Daily Cost of Care (FY21 Rates) of Youth, by TFC Step-down Group (n=18) and Comparison Group (n=15), in the 2-Year Period Post-TFC Start/Referral Date**



## TFC Deflection vs. Deflection Comparison

Table 7 shows that subgroup findings regarding the TFC deflection group ( $n=34$ ) and its comparison group ( $n=51$ ) were also consistent with the overall findings (see Table 5). During the full 2-year period, on average, youth spent nearly 50% of their days (359 days) in TFC. In Year One, 75% of youth's days (on average, 274 days), were in TFC. In Year Two, however, TFC deflection youth spent their time somewhat evenly in either specialized foster care (24%), TFC (23%), traditional foster care/relative (22%), and residential care (21%). In the comparison group during the full 2-year period, residential care constituted the majority of youth's days (78%, or, on average, 566 days). This was consistent in Year One (78%) and Year Two (77%).

Over the 2-year period, the estimated cost of DCFS care for youth in the TFC deflection group was \$175,410. This was less than the estimated cost of DCFS care for youth in the comparison group (\$232,580) and yielded 2-year estimated cost savings of \$56,169 attributable to TFC. Estimated cost savings favored TFC and were smaller in Year One (\$11,982) than in Year Two (\$44,187). This is because TFC deflection youth exited TFC in Year Two while transitioning into less expensive placement types such as Traditional Foster Care/Relative and Specialized Foster Care.

Figure 7 and Figure 8 show the longitudinal changes in the daily distribution of placement types of the TFC deflection group and its comparison group, respectively, over the 2-year period. The TFC deflection group saw a decrease in the percentage of TFC placement over time (as expected due to the short-term treatment model), while traditional foster care/relative, specialized foster care, and residential care became roughly equal-part placement types (20–30% each) by the end of the 2-year period (see Figure 7). In contrast, the comparison group saw a consistently large and static percentage of youth (70–80%) placed in residential care throughout the 2-year period (see Figure 8).

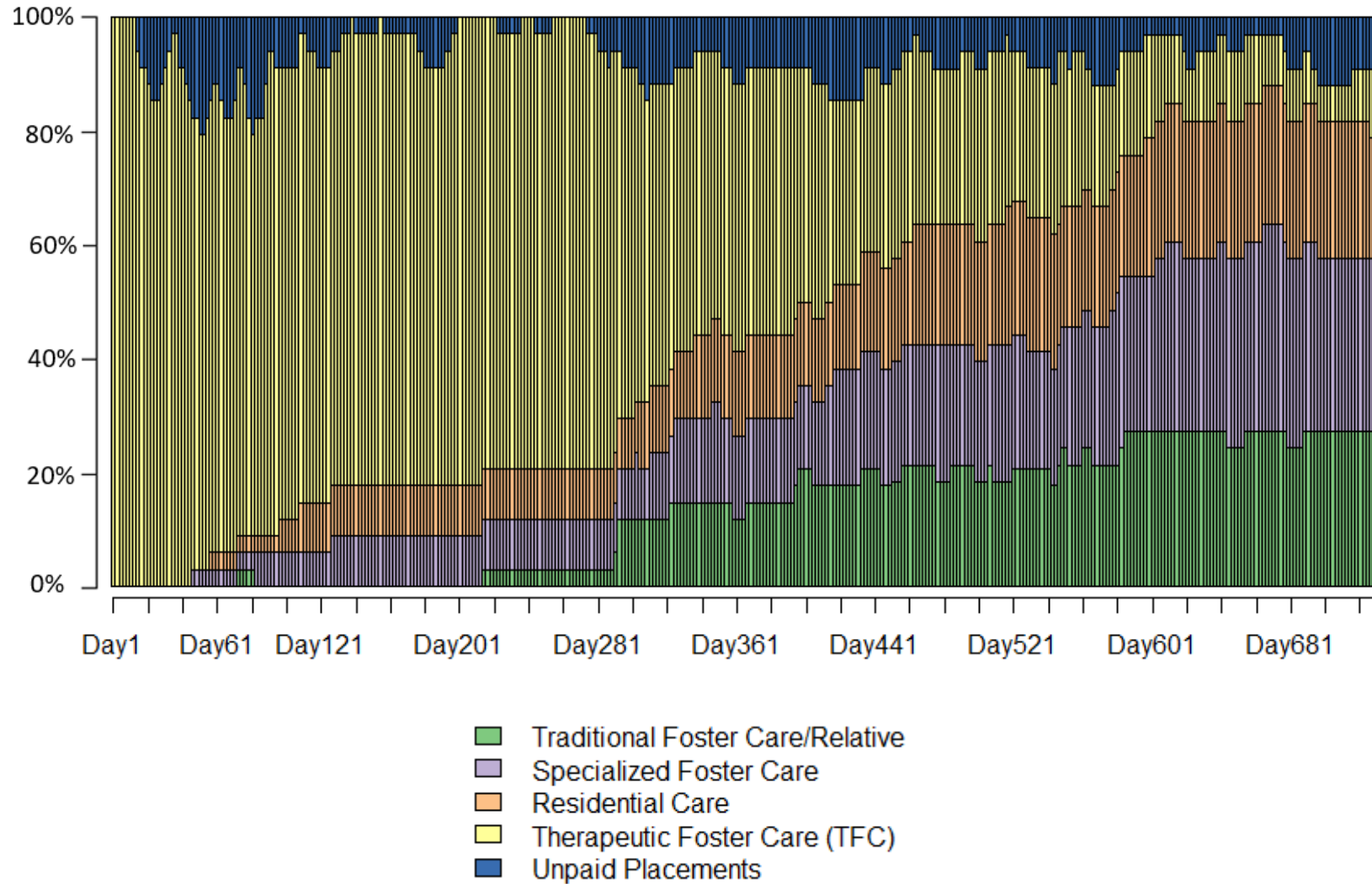
Figure 9 shows the longitudinal changes in the mean daily cost of DCFS care for a single youth between the TFC deflection group and the comparison group over the 2-year period since TFC placement/referral, respectively. The comparison group began at a substantially lower rate (\$110). This was likely because at the time of TFC referral, youth were in unpaid settings, compared to the daily rate of the TFC deflection group (\$320) that was more consistent with the TFC rate. By day 50, however, the comparison group surpassed the TFC deflection group's daily cost of DCFS care and would maintain approximately a \$100 higher rate over time until the end of the 2-year period. These trends were consistent with the summative findings in Table 5, which shows over 77% of days in the comparison group in Year One and Year Two were in the costly residential care. On the other hand, the TFC deflection group spent 45% of days in Year Two in specialized or traditional foster care/relative, and only 20% in residential care.

**Table 7. Youth with 2 Years of Living Arrangement Data Post-TFC Start/Referral: Placement Distribution and Cost, by TFC Deflection Group and Comparison Group, and by Follow-up Period**

| All Youth with Two Years of Living Arrangement Data post TFC Start/Referral | FY21 Daily Rate | Full Two-Year Trajectory |        |                       |        | Year One            |                    |                       |                | Year Two           |                   |                       |                |      |
|---|-----------------|--------------------------|--------|-----------------------|--------|---------------------|--------------------|-----------------------|----------------|--------------------|-------------------|-----------------------|----------------|------|
|   |                 | TFC Deflection           |        | Deflection Comparison |        | TFC Deflection      |                    | Deflection Comparison |                | TFC Deflection     |                   | Deflection Comparison |                |      |
|   |                 | <i>(n=34)</i>            |        | <i>(n=51)</i>         |        | <i>(n=34)</i>       |                    | <i>(n=51)</i>         |                | <i>(n=34)</i>      |                   | <i>(n=51)</i>         |                |      |
|   |                 | Mean Days (SD)           | % Days | Mean Days (SD)        | % Days | Mean Days (SD)      | % Days             | Mean Days (SD)        | % Days         | Mean Days (SD)     | % Days            | Mean Days (SD)        | % Days         |      |
| <b>Therapeutic foster care (TFC)</b>  | \$322.23        | 358.92<br>(197.76)       | 49.17  | 0.00<br>(0.00)        | 0.00   | 0.00                | 273.65<br>(114.90) | 74.97                 | 0.00<br>(0.00) | 0.00               | 85.26<br>(113.86) | 23.36                 | 0.00<br>(0.00) | 0.00 |
| <b>Transitional living program (TLP)</b>                                    | \$275.57        | 0.00<br>(0.00)           | 0.00   | 0.00<br>(0.00)        | 0.00   | 0.00                | 0.00<br>(0.00)     | 0.00                  | 0.00<br>(0.00) | 0.00               | 0.00<br>(0.00)    | 0.00                  | 0.00<br>(0.00) | 0.00 |
| <b>Residential care</b>   | \$388.85        | 102.12<br>(194.22)       | 13.99  | 566.35<br>(185.37)    | 77.58  | 27.12<br>(80.11)    | 7.43               | 284.37<br>(92.21)     | 77.91          | 75<br>(134.48)     | 20.55             | 281.98<br>(126.27)    | 77.25          |      |
| <b>Traditional foster care/relative</b>                                     | \$44.60         | 91.85<br>(134.18)        | 12.58  | 40.88<br>(101.01)     | 5.60   | 12.18<br>(32.26)    | 3.34               | 12.27<br>(30.94)      | 3.36           | 79.68<br>(117.78)  | 21.83             | 28.61<br>(86.04)      | 7.84           |      |
| <b>Specialized foster care</b>  | \$136.77        | 116.65<br>(177.91)       | 15.98  | 69.69<br>(144.67)     | 9.55   | 27.74<br>(76.71)    | 7.60               | 28.63<br>(72.57)      | 7.84           | 88.91<br>(128.37)  | 24.36             | 41.06<br>(91.25)      | 11.25          |      |
| <b>Unpaid placement</b>   | N/A             | 52.91<br>(64.45)         | 7.25   | 53.08<br>(49.58)      | 7.27   | 24.29<br>(33.19)    | 6.66               | 39.73<br>(33.64)      | 10.88          | 28.62<br>(49.95)   | 7.84              | 13.35<br>(36.44)      | 3.66           |      |
| <b>Not in DCFS care</b>   | N/A             | 7.56<br>(33.63)          | 1.04   | 0.00<br>(0.00)        | 0.00   | 0.03<br>(0.17)      | 0.01               | 0.00<br>(0.00)        | 0.00           | 7.53<br>(33.64)    | 2.06              | 0.00<br>(0.00)        | 0.00           |      |
| <b>Total Cost (FY21 Rates)</b>  |                 | <b>\$175,410.46</b>      |        | <b>\$232,579.89</b>   |        | <b>\$103,058.29</b> |                    | <b>\$115,040.70</b>   |                | <b>\$72,352.19</b> |                   | <b>\$116,539.19</b>   |                |      |
| <b>TFC Cost Savings</b>   |                 | <b>\$56,169.43</b>       |        |                       |        | <b>\$11,982.42</b>  |                    |                       |                | <b>\$44,187.00</b> |                   |                       |                |      |

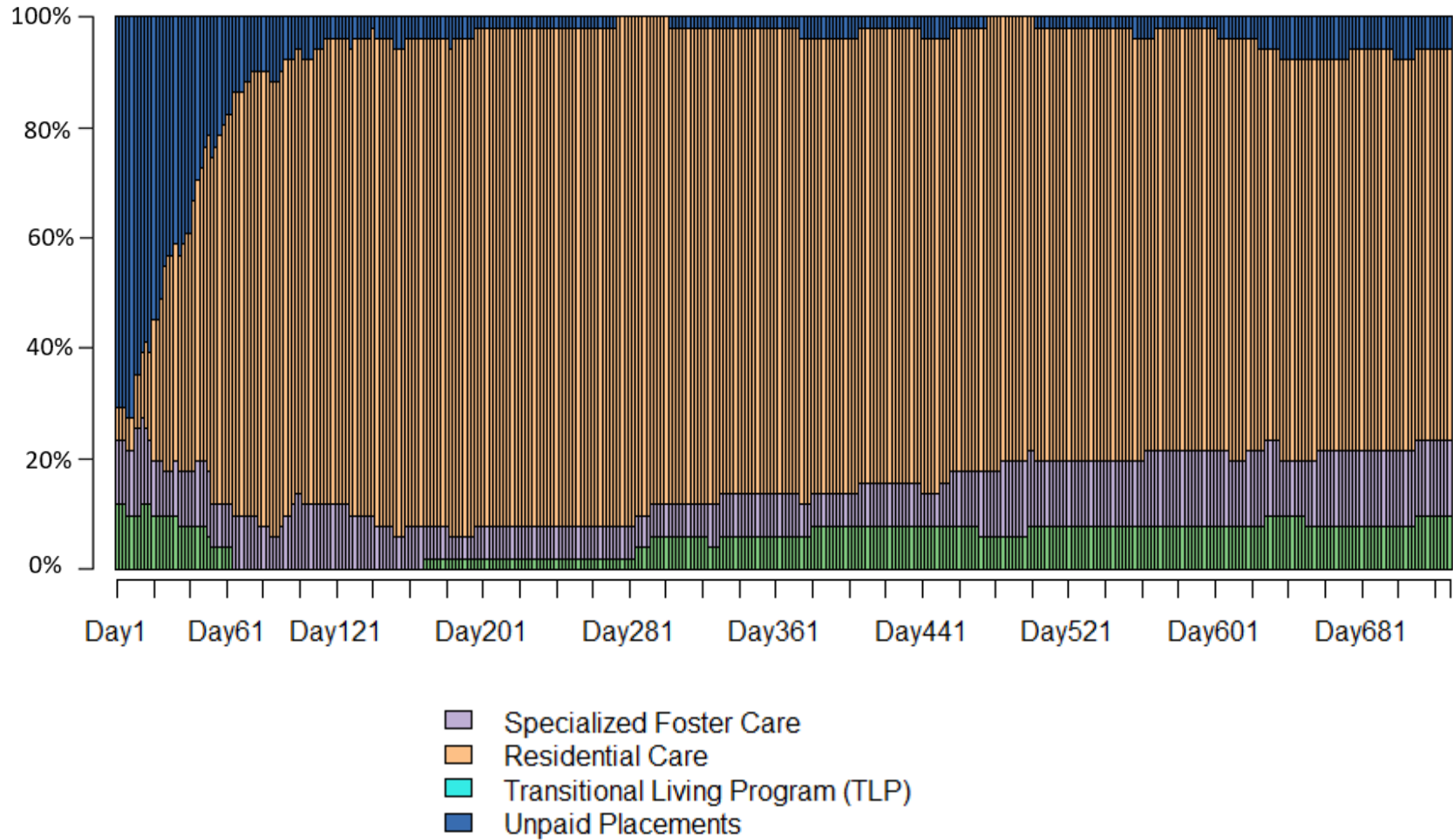
Figure 7. Daily Distribution of Placement Types of Youth in the TFC Deflection Group (n=34) in the 2-year Period Post-TFC Start Date

### Pilot 2-Year Trajectory: Deflection



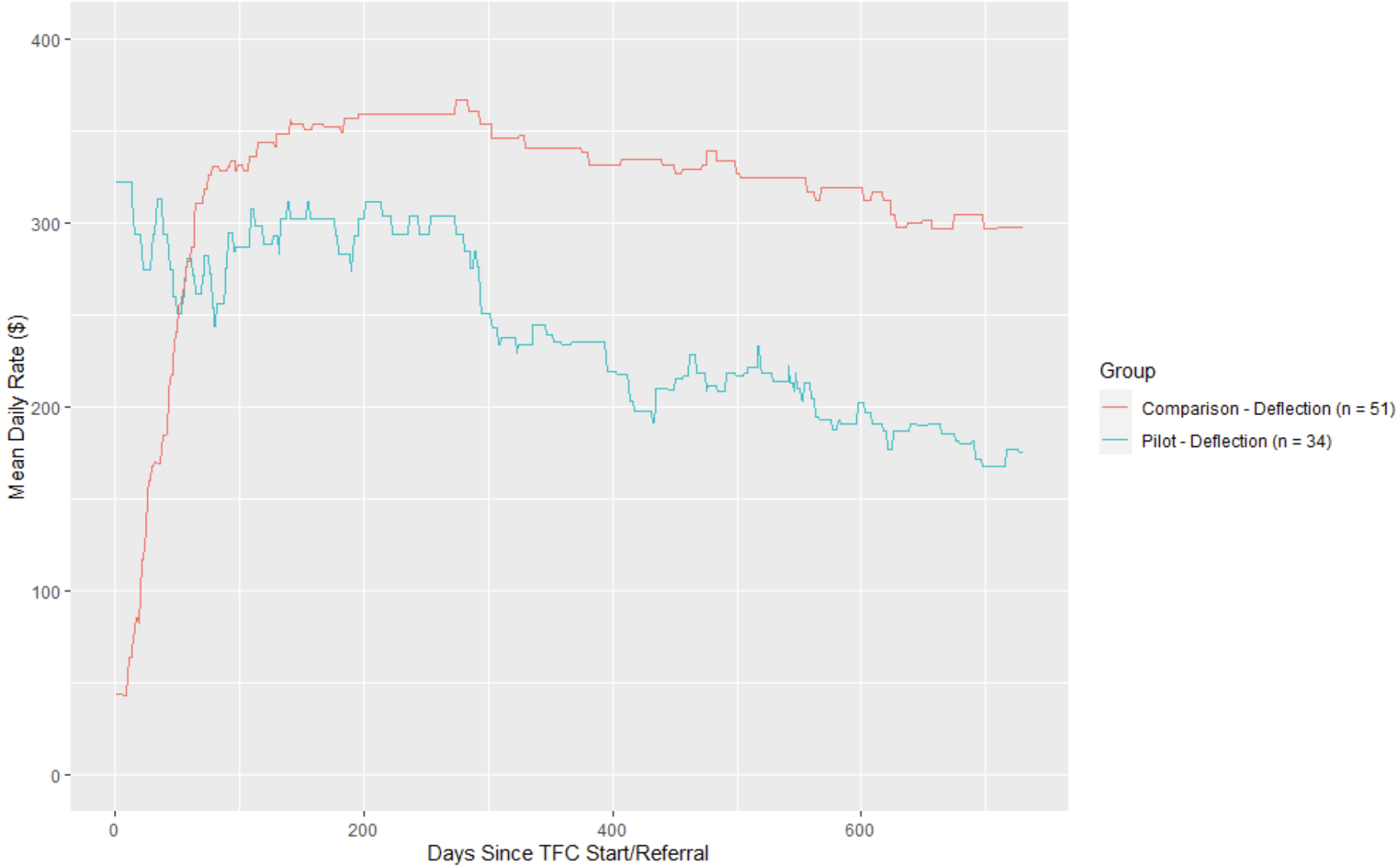
**Figure 8. Daily Distribution of Placement Types of Youth in the Deflection Comparison Group ( $n=51$ ) in the 2-year Period Post-TFC Referral Date**

### Comparison 2-Year Trajectory: Deflection





**Figure 9. Mean Daily Cost of Care (FY21 rates) of Youth, by TFC Deflection Group (n=34) and Comparison Group (n=51), in the 2-year Period Post-TFC Start/Referral Date**



## Net Benefit of TFC

Washington State Institute for Public Policy (2019) derives the lifetime monetary benefit of MTFC (specifically, TFCO, the TFC model subjected to this benefit-cost study) from a meta-analysis and empirical literature on outcomes (such as depression) impacted by MTFC. Monetary benefit estimates were operationalized from the perspectives of taxpayers, MTFC participants, individuals other than taxpayers and MTFC participants, and an analysis of indirect benefits. The total benefit of MTFC per participant in FY21 dollars is \$43,236.

The overall net benefit of TFC per youth is  
**\$94,294.26**  
(\$43,236.00 per WSIPP + \$51,058.26 2-year cost savings in DCFS TFC Pilot).

In addition, Chapin Hall derived the monetary benefit of TFC by estimating the difference in cost of care for a single TFC youth relative to a single comparison youth in a 2-year period beginning from their TFC start date (for TFC youth) or their referral date (for comparison youth). The estimated 2-year cost savings of \$51,058.26 for the TFC Pilot are detailed in Table 5. This estimate represents the difference between the estimated 2-year cost of a single TFC Pilot youth (\$179,491.75) and the estimated 2-year cost of a single comparison youth (\$230,550.01). Using the same calculations, the estimated 2-year cost savings for a single youth in the TFC step-down subgroup are \$38,026.32 (see Table 6) and in the TFC deflection subgroup are \$56,169.43 (see Table 7).

Table 8 shows that the overall net benefit of TFC per youth is \$94,294.26 (\$43,236.00 per WSIPP + \$51,058.26 2-year cost savings in DCFS TFC Pilot). The total benefit of TFC per youth in

the TFC step-down group is \$81,262.32 (\$43,236.00 per WSIPP + \$38,026.32 2-year cost savings in DCFS TFC step-down group, see Table 6). The total net benefit of TFC per youth in the TFC deflection subgroup is \$99,405.43 (\$43,236.00 per WSIPP + \$56,169.43 2-year cost savings in DCFS TFC deflection subgroup, see Table 7).

**Table 8. Calculation of Net Benefit per Youth in TFC**

| <b>Component</b>   | <b>Calculation</b>  |  |  |
|--|---|--|--|
| <b>WSIPP (2019) estimated lifetime benefits per youth</b><br>(FY21 dollars) in TFC compared to residential care (treatment as usual) | Benefits to taxpayers (\$12,199)<br>+<br>Benefits to participants (\$290)<br>+<br>Benefits to others (\$29,723)<br>+<br>Indirect benefits (\$1,024) |  |  |
| <b>Benefit of TFC (FY21 dollars)</b>   | <b>\$43,236.00</b>  |  |  |
| <b>DCFS TFC Pilot</b>  | <b>Overall</b>  | <b>Step-Down</b>   | <b>Deflection</b>  |
| <b>Cost savings estimates per youth in DCFS TFC Pilot</b> (FY21 dollars) compared to residential care (treatment as usual)           | \$230,551.01<br>-<br>\$179,491.75<br>=<br><b>\$51,058.26</b>  | \$225,227.17<br>-<br>\$187,200.85<br>=<br><b>\$38,026.32</b> | \$231,579.89<br>-<br>\$175,410.46<br>=<br><b>\$56,169.43</b> |
| <b>Net benefit of TFC per youth</b> (FY21 dollars)   | \$43,236.00<br>+<br>\$51,058.26<br>=<br><b>\$94,294.26</b>  | \$43,236.00<br>+<br>\$38,026.32<br>=<br><b>\$81,262.32</b>   | \$43,236.00<br>+<br>\$56,169.43<br>=<br><b>\$99,405.43</b>   |

# DISCUSSION

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The Illinois Children and Family Services Act (Illinois Public Act 099-0350) requires that DCFS arrange for an independent evaluation of a 5-year pilot program of multidimensional treatment foster care (MTFC) “to determine whether there is a long-term cost benefit to continuing the pilot program.” Chapin Hall is the independent evaluator of the DCFS 5-year TFC Pilot. Lutheran Social Services of Illinois (LSSI) was the primary provider that fully implemented Therapeutic Foster Care Oregon (TFCO), the current name of MTFC (Blueprints for Healthy Youth Development, 2022), to serve youth ages 6 to 14 years old in the Cook County, Aurora, and Rockford subregions. Because LSSI’s TFCO youth comprised 80% of all youth in the TFC Pilot, this benefit-cost study focused on the LSSI TFCO model.

During the study period (from February 2017 to June 2021), the TFC Pilot group ( $n=74$ ) on average, spent less time in and incurred less cost from residential care than the comparison group ( $n=87$ ). Youth in the TFC Pilot group stayed, on average, 5 months per TFC placement. They had up to two TFC placements during the study period, meaning they spent close to 10 months in TFC across TFC placements. However, 25 youth in the TFC Pilot group also spent time in residential care (on average, they spent more than 15 months in residential care). Youth in the comparison group, who either remained in or entered residential care after TFC referral, spent, on average, 20 months in residential care. The overall mean cost per youth in TFC for the duration of the study period was \$94,438. The 25 Pilot youth who also spent time post-TFC in residential care, incurred, on average, \$174,207 in residential placement costs. The comparison group, with an overall longer stay in residential care during the study period, incurred an average cost per youth in residential care of \$212,649. These figures represented the overall DCFS financial investment in TFC placements and residential care placements for the duration of the Pilot.

## Significant cost savings were seen after youth exited their TFC placement,

as they tended to move into less restrictive and less expensive settings such as traditional foster care/relative and specialized foster care.

However, comparison youth primarily stayed in the most expensive setting, residential care, throughout the 2-year period.

To estimate the impact of TFC on the Pilot youth’s placement trajectories after leaving TFC, Chapin Hall identified a subset of Pilot youth ( $n=52$ ) and comparison youth ( $n=67$ ) who had at least 2 years of DCFS living arrangement data available between their TFC start date (Pilot) or TFC referral date (comparison) and May 2022. Over the 2-year period, the estimated cost of care for youth in the TFC Pilot group—made up of predominantly initial placement days in TFC and subsequent placement days in specialized foster care, traditional foster care/relative, residential care—was \$179,492. In contrast, the estimated cost of care for youth in the comparison group—predominantly made up of placement days in residential care—was \$230,500. This means the overall 2-year cost savings of TFC, relative to residential care, was \$51,058 for a single youth. These cost-saving figures varied by TFC Pilot subgroups, which ranged from \$38,026 per youth in the TFC step-down group to \$56,169 per youth in the TFC deflection group. In

summary, the TFC Pilot achieved overall 2-year cost savings by providing TFC as an alternative to residential care. Significant cost savings were seen after youth exited their TFC placement, as they tended to move into less restrictive and less expensive settings such as traditional foster care/relative and specialized foster care. In contrast, comparison youth primarily stayed in the most expensive setting, residential care, throughout the 2-year period.

To estimate the net benefit of TFC, the lifetime monetary benefit of TFC from empirical literature, \$43,236 per youth, was added to the 2-year cost savings of TFC. Relative to residential care, the overall net benefit of TFC was \$94,294.26 per youth. For the TFC step-down group, the overall net benefit was \$81,262.32 per youth. For the TFC deflection group, the overall net benefit was \$99,405.43 per youth. These findings provide evidence that there is long-term cost-benefit to continuing the Pilot in Illinois.

This study has several limitations. By examining actual costs of the Pilot within the study period regardless of the duration of time youth spent in the Pilot, the average cost per youth might be because youth who entered the Pilot later in the study period would have less time and therefore lower associated costs than youth who entered earlier. Further examination of the average cost per youth across demographic characteristics (e.g., race, gender) might also shed light on equitable investment and allocation of TFC resources. Due to the recent conclusion of the 5-year DCFS TFC Pilot in FY21, Chapin Hall was only able to project TFC-related cost savings for 2 years from TFC placement (Pilot) or TFC referral (comparison). It is possible that further cost savings are realized beyond this period; therefore, the cost-saving figures shown in this report may be considered a conservative estimate. In addition, the DCFS per diem rates for TFC from FY17 through FY21 were less costly than those for residential care, which partially explained the favorable cost-savings findings attributable to TFC. In addition, cost data in this study only reflected DCFS fiscal investment in TFC and residential care and did not account for non-DCFS costs associated with TFC and residential care, such as Medicaid billable services. Finally, building on this descriptive study, future studies could take an inferential approach to examine between-group differences as well as the correlates or predictors of time and cost of TFC.

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# A DISTANCE-FROM-HOME STUDY OF THE THERAPEUTIC FOSTER CARE (TFC) PILOT

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## EXECUTIVE SUMMARY

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The Illinois Children and Family Services Act (Illinois Public Act 099-0350) requires that the Illinois Department of Children and Family Services (DCFS) “arrange for an independent evaluation of the pilot program [multi-dimensional treatment foster care (MTFC) to determine whether it is meeting the goal of maintaining children in the least restrictive, most appropriate family-like setting, near the child’s home community, while they are in the Department’s care...”

DCFS contracted with Chapin Hall at the University of Chicago to independently evaluate the 5-year DCFS TFC Pilot. In the Pilot, Lutheran Social Services of Illinois (LSSI) fully implemented the Therapeutic Foster Care Oregon (TFCO) model, the current name of MTFC (Blueprints for Healthy Youth Development, 2022). In the 5-year TFC Pilot period, 74 youth received LSSI’s TFCO intervention at three sites or geographic areas: Cook County (n=39), Aurora (n=21), and Rockford (n=14). In this report, LSSI’s program is referred to as TFC.

Chapin Hall addressed the state legislation requirement by focusing the evaluation on two research questions: (1) What were the post-initial TFC placement types while youth in the TFC Pilot remained in DCFS legal custody? and (2) What was the distance of the initial TFC placement, first post-initial TFC placement, and all post-initial TFC placements from youth’s home community?

### Research question #1: What were the post-initial TFC placement types while youth in the TFC Pilot remained in DCFS legal custody?

To examine the extent to which TFC Pilot youth were maintained in the least restrictive, most appropriate family-like setting, Chapin Hall examined youth’s first placement immediately after the initial TFC placement as well as youth’s full placement trajectories that consisted of all post-initial TFC placements through May 2022.

None of the TFC Pilot youth moved to a residential care immediately after the initial TFC placement.

## First Post-Initial TFC Placement

In the first placement after the initial TFC placement:

- 51% of the TFC Pilot youth moved to a psychiatric hospital, though most of them returned immediately to the same TFC home after the hospitalization.
- 45% of the TFC Pilot youth moved to specialized foster care, home of parent/relative/kin, or other home-based settings.
- None of the TFC Pilot youth moved to residential care.
- TFC Pilot youth stayed, on average, for 5 months in a community placement (for example, specialized foster care) after the initial TFC placement, compared to an average of 3 weeks if they moved to a non-community placement (such as a psychiatric hospital).

Across the three sites, TFC Pilot youth in the Rockford site were more likely to move to specialized foster care after the initial TFC placement. Those in the Aurora site remained in the community placement for shorter periods of time compared to their counterparts.

## All Post-Initial TFC Placements

The average length of stay among all post-initial TFC placements **was about 4 months in either community placements or noncommunity placements.**

After the initial TFC placement, the TFC Pilot youth experienced relatively infrequent placement moves—on average, less than one move per 100 days in DCFS legal custody. In all placements after the initial TFC placement:

- 59% of the post-initial TFC placements were specialized foster care, home of parent/relative/kin, or other home-based settings.
- 25% of the post-initial TFC placements were at psychiatric hospitals.
- 10% of the post-initial TFC placements were in residential care.
- The average length of stay among all post-initial TFC placements was a little over 4 months in community placements and approximately 4 months in non-community placements.



Although no major differences in post-initial TFC placement types were observed across the three sites, community placements associated with TFC Pilot youth in the Cook County site had a longer average duration (a little over 5 months) than their counterparts in the Aurora and Rockford sites (a little over 3 months).

## Research question #2: What was the distance of the initial TFC placement, first post-initial TFC placement, and all post-initial TFC placements from youth's home community?

To examine the extent to which TFC Pilot youth were placed near youth's "home community" (defined as youth's address at the time of case opening), Chapin Hall analyzed distance from youth's home community in three ways: (1) distance from youth's initial TFC placement; (2) distance from youth's first post-initial TFC placement; and (3) distance from all post-initial TFC placements. Analyzing these three aspects provided a comprehensive understanding of youth's movement.

### Distance between Initial TFC Placement and Home Community

Youth's initial TFC placements were in the three pilot sites or subregions, Cook County, Aurora, and Rockford:

- Youth's initial TFC placements were, on average, 25 miles from youth's home community.
- On average, youth at the Cook County site were placed 23 miles from home and youth at the Rockford site were placed 24 miles from home. Youth at the Aurora site were placed 29 miles from home.
- Only 22% of youth's initial TFC placements were within 10 miles of youth's home community, and no placements within 10 miles were associated with youth at the Aurora site.

### Distance between First Post-Initial TFC Placement and Home Community

Immediately after the initial TFC placement, **31% and 46%** of youth placed in home of parent/relative/kin placements were placed within five miles and 10 miles, respectively, of youth's home community.

Youth's first post-initial TFC placement was not necessarily restricted to the three pilot sites or subregions, Cook County, Aurora, and Rockford:

- Youth's first post-initial TFC placement was, on average, 30 miles from youth's home community.

- On average, youth in the Cook County site (20 miles) were placed closer to home than youth in the Aurora and Rockford sites (both 39 miles).
- Overall, 25% of youth's first post-initial TFC placements were within 10 miles of youth's home community; a greater percentage of youth in the Cook County site (39%) were placed within 10 miles of their home community, compared to youth in the Rockford site (14%) and the Aurora site (10%).
- Youth placed in a community placement immediately post-initial TFC were, on average, placed closer to their home community (24 miles) than youth in a non-community placement (34 miles); this distance difference by placement type was particularly more pronounced for youth in the Aurora and Rockford sites than for youth in the Cook County site.
- Overall, 31% and 46% of youth placed in home of parent/relative/kin placements were placed within 5 miles and 10 miles, respectively, of youth's home community, compared to only 8% and 14% of youth placed in psychiatric hospitals.

### Distance between All Post-Initial TFC Placements and Home Community

Among all post-initial TFC placements, **39% and 54%** of post-initial TFC placements in home of parent/relative/kin placements were **within five miles and 10 miles**, respectively, of youth's home community, compared to only **7% and 15%** of post-initial TFC placements in psychiatric hospitals.

Across all youth's placements after the initial TFC placement:

- The average distance from youth's home community was 44 miles. The shortest average distance was for youth in the Cook County site (28 miles) and longest for youth in the Rockford site (60 miles).
- Overall, 27% of all post-initial TFC placements were within 10 miles of youth's home community. A greater percentage of youth in the Cook County site (38%) were placed within 10 miles of their home community, compared to youth in the Rockford site (18%) and youth in the Aurora site (16%).
- Youth whose post-initial TFC placements were community placements were, on average, closer to their home community (36 miles) than youth in a non-community placement (56 miles). This distance difference by placement type was particularly more pronounced for youth in the Rockford site than for youth in the Cook County site and the Aurora site.
- Post-initial TFC placements in residential care were, on average, furthest from youth's home community (73 miles).

- 39% and 54% of post-initial TFC placements in home of parent/relative/kin placements were within 5 miles and 10 miles, respectively, of youth's home community, compared to only 7% and 15% of post-initial TFC placements in psychiatric hospitals.

## Implications

Distance from youth's home community of origin might be **less relevant for youth placed at the home of a parent/relative/kin** as potential permanency settings than for youth placed in non-community placements who are trying to return to their home community.

TFC youth can be maintained in less restrictive, home-based settings, though subsequent placement instability or placements in psychiatric hospitals can be expected. Across placement types, community placements, especially specialized foster care or home of parent/relative/kin, were closer to youth's home community than non-community placements, namely psychiatric hospitals or residential care. Thus, support for placing TFC youth in the community is bolstered by their closer proximity to youth's home community. The magnitude of an average distance of at least 20 miles poses practical concerns about youth's ability to maintain meaningful family and social connections in their home community. At the same time, distance from youth's home community of origin might be less relevant for youth placed at the home of a parent/relative/kin as potential permanency settings than for youth placed in non-community placements who are trying to return to their home community.

This study has several limitations. First, by defining a youth's address at their DCFS case opening as "home community," we could have overlooked a more nuanced understanding of "home community." For instance, this community might be defined by youth's social networks or by youth's most current home community. In addition, while quantifying the distance between a DCFS placement and youth's home community provides numerical benchmarks for defining near or far from home, we did not consider factors such as the difficulty or ease of transportation, population density, or home community characteristics. For instance, a 10-mile commute in Cook County could be more challenging than a 20-mile car ride in Aurora or Rockford. Further, it is possible that youth's home community lacks certain community placements such as specialized foster care homes, which could mean tradeoffs have to be made between finding the "right" placement versus a close placement. These tradeoffs might reflect resource constraints in youth's home community, as evidenced by cross-site differences in the percentages and distances of home-based settings between Cook County, Rockford, and Aurora. Finally, because this study focused on the placement types and their distance from home community solely among youth in the LSSI TFC Pilot in response to the state legislation, it did not compare findings with state trends in standard care. Thus, we cannot draw conclusions about the impact of TFC on youth's placement trajectories and distance from home compared to standard care.

# INTRODUCTION

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The Illinois Children and Family Services Act (Illinois Public Act 099-0350) requires that the Illinois Department of Children and Family Services (DCFS) “arrange for an independent evaluation of the pilot program [multi-dimensional treatment foster care (MTFC)] to determine whether it is meeting the goal of maintaining children in the least restrictive, most appropriate family-like setting, near the child's home community, while they are in the Department's care...”

DCFS contracted with Chapin Hall at the University of Chicago to be the independent evaluator of the 5-year DCFS TFC Pilot, Lutheran Social Services of Illinois (LSSI) fully implemented the Therapeutic Foster Care Oregon (TFCO) model, the current name of MTFC (Blueprints for Healthy Youth Development, 2022). In the five-year TFC Pilot period, 74 youth received LSSI's TFCO intervention at three sites or geographic areas: Cook County ( $n=39$ ), Aurora ( $n=21$ ), and Rockford ( $n=14$ ). In this report, LSSI's program is referred to as TFC. Chapin Hall addressed the state legislation by focusing the evaluation on two research questions:

**Research question #1: What were the post-initial TFC placement types while youth in the TFC Pilot remained in DCFS legal custody?**

**Research question #2: What was the distance of the initial TFC placement, first post-initial TFC placement, and all post-initial TFC placements from youth's home community?**

# METHOD

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The TFC Pilot evaluation was approved by the DCFS Institutional Review Board (IRB) and the Crown Family School of Social Work, Policy, and Practice and Chapin Hall Institutional Review Board (IRB #16-1125).

## Sample

DCFS contracted with four community partner agencies to implement a 5-year TFC Pilot: Children’s Home and Aid (CH+A), Jewish Children and Family Services (JCFS), Lutheran Social Services of Illinois (LSSI), and Youth Outreach Services (YOS). However, only LSSI fully implemented the Therapeutic Foster Care Oregon (TFCO) model, the current name of multi-dimensional treatment foster care (MTFC), the specific model required by the Illinois Public Act 099-0350. TFC referrals officially began on February 1, 2017. Thus, the TFC Pilot group in this study focused on the 74 youth who received LSSI’s TFCO intervention between February 1, 2017, and June 30, 2021 in the three pilot sites or subregions: Cook County ( $n=39$ ), Aurora ( $n=21$ ), and Rockford ( $n=14$ ).

## Post-initial TFC Placement Types

LSSI youth’s post-initial TFC placements were observed over time while they remained in DCFS legal custody. Chapin Hall used data from the Child and Youth Centered Information System (CYCIS) and Residential Treatment and Outcomes System (RTOS) to track placements. All LSSI youth’s placements through May 2022, or until the youth was no longer in DCFS legal custody, were used in this analysis. LSSI youth had, on average, 873 days in DCFS care post-initial TFC placement for which Chapin Hall was able to track their living arrangements.

Chapin Hall used these CYCIS living arrangement codes<sup>3</sup> to define four categories of “community placement”:

1. Home of parent/relative/kin (HMP, HMR, HFK)
2. Specialized foster care (FHS, FHT, AFC, TFH)
3. Other home-based settings (FHA, FHB, FHG, FHI, FHP, HRA, SGH, GDN, EFC, PGH, DRA, FOS, HRL, HAP)
4. Independent/transitional living (ILO, TLP)

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<sup>3</sup> HMP=Home of Parent; HMR=Home of Relative; HFK=Home of Fictive Kin; FHS=Foster Home Specialized; FHT=Foster Home Therapeutic; AFC=Adolescent Foster Care; TFH=Therapeutic Foster Home; FHA=Foster Home Adoption; FHB=Foster Home Boarding - DCFS; FHG=Foster Home Guardianship; FHI=Foster Home Indian; FHP=Foster Home Boarding - Private Agency; HRA=Home of Relative Application; SGH=Subsidized Guardian Home; GDN=Guardian Successor; EFC=Emergency Foster Care; PGH=Private Guardianship; DRA= Delegated Relative Authority; FOS=Foster Home; HRL=Home of Relative Licensed; HAP=Home of Adoptive Parent; ILO=Independent Living Only; TLP=Transitional Living Program.

Chapin Hall used these CYCIS living arrangement codes<sup>4</sup> to define three categories of “non-community placement”:

1. Residential care (GRH, IPA, QRT)
2. Psychiatric hospital (HFP)
3. All other

## TFC and Post-initial TFC Placement Distance from Home Community

“Home community” was defined as TFC Pilot youth’s address at the time of case opening. Distance was defined in miles between any two addresses. Addresses of TFC and post-initial TFC placements were examined to calculate their distances from youth’s home community in three ways:

1. Distance between TFC placement and home community
2. Distance between the first post-initial TFC placement and home community
3. Distance between all post-initial TFC placements and home community

Chapin Hall used four distance thresholds—within 5, 10, 20, or 50 miles of youth’s home community—to define a placement as being in the youth’s home community.

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<sup>4</sup> GRH=Group Home; IPA=Institution-Private Child Care Facility; QRT=Qualified Residential Treatment; HFP=Hospital Facility – Psychiatric; All other includes HFM=Hospital Facility – Medical; UAH=Unauthorized Home of Parent; UAP=Unauthorized Placement; WUK=Whereabouts Unknown; YES=Youth Emergency Shelters.

# RESULTS

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## Research question #1: What were the post-initial TFC placement types while youth in the TFC Pilot remained in DCFS legal custody?

### Initial TFC Placement

LSSI youth stayed at their initial TFC placement for an average of over 7 months (222.65 days) and a median of 6 months (178.50 days), with some differences across the three TFC sites. Rockford had the longest average placement (252.57 days) and longest median length of stay (230.50 days). Aurora had the shortest average placement (200.10 days) and shortest median length of stay (180.00 days).

### First Post-initial TFC Placement

None of the TFC Pilot youth moved to a residential care placement immediately after their initial TFC placement.

After the initial TFC placement, over half (54.93%) of the TFC Pilot youth moved to a non-community placement, mainly to a psychiatric hospital (50.70%). This was particularly true for youth in the Cook County (50.00%) and Aurora (61.90%) sites, though less so for youth in the Rockford site (37.71%). Of the 36 youth who went to a psychiatric hospital immediately after their initial TFC placement, 28 returned to TFC afterwards, 24 of whom returned to their initial TFC provider. Of note, none of the TFC Pilot youth moved to a residential care placement immediately after their initial TFC placement.

For the TFC Pilot youth who moved to a community placement (45.07%), youth tended to go to specialized foster care (25.35%) or the home of parent/relative/kin (18.31%). Youth in Cook County and Aurora equally went to specialized foster care or the home of a parent/relative/kin, (in Cook County, 22.22% in both placement types and in Aurora, 19.05% in both placement types). However, youth in the Rockford site mainly moved to specialized foster care (42.86%).

Regardless of the community placement types, TFC Pilot youth generally stayed in placement longer, for an average of 5 months (146.59 days) and a median of over 3 months (99.50 days). TFC Pilot youth's stay in non-community placement averaged over 3 weeks (25.41 days) with a median of over 2 weeks (17.00 days). Youth in the Aurora site remained in their community placements shorter (average of 3 months) and in their non-community placements longer (average of 1 month), compared to youth in the Cook County and Rockford sites.

## All Post-initial TFC Placements

Post-initial TFC placements were primarily community placements (59.42%), the majority of which were specialized foster care (32.92%) or home of parent/relative/kin (22.14%).

Looking at all post-initial TFC placements, including the first post-initial TFC placement, the TFC Pilot youth experienced relatively infrequent placement moves—on average, less than one move per 100 days in DCFS legal custody. These placements were primarily community placements (59.42%), the majority of which were specialized foster care (32.92%) or home of parent/relative/kin (22.14%). There were no major differences between the three sites. The majority of non-community placements were at psychiatric hospitals (25.05%) or residential care (10.14%), with no major differences between the three sites.

The average length of stay among all post-initial TFC placements was 4 months (127.11 days), with a shorter median length of stay of 2 months (56.00 days). Youth generally stayed in community placements over 4 months on average (133.74 days) with a median length of stay of 2 months (62.00 days). This was somewhat longer than youth in non-community placements, who had an average length of stay of 4 months (117.39 days) and a median length of stay of over 3 weeks (24.00 days).

**Table 9. TFC Placements and Post-initial TFC Placements, by Type and TFC Pilot Site**

|   | LSSI TFC<br>Cook County                                     | LSSI TFC<br>Aurora         | LSSI TFC<br>Rockford       | All LSSI TFC Pilot<br>Sites |
|---|---|----------------------------|----------------------------|-----------------------------|
| <b>Initial TFC placement (unit of analysis is TFC Pilot Youth)</b>            | <i>n</i> =39  | <i>n</i> =21               | <i>n</i> =14               | <i>n</i> =74                |
| Mean length of stay (days) in initial TFC placement (median, SD)              | 224.05<br>(126.00, 211.18)                                  | 200.10<br>(180.00, 160.57) | 252.57<br>(230.50, 173.47) | 222.65<br>(178.50, 189.62)  |
| <b>First post-initial TFC placement (unit of analysis is TFC pilot youth)</b> | <i>n</i> =36<br>(3 youth had no post-initial TFC placement) | <i>n</i> =21               | <i>n</i> =14               | <i>n</i> =71                |
| Community placement <sup>a</sup> (n, %)                                       | 16 (44.44)  | 8 (38.1)                   | 8 (57.14)                  | 32 (45.07)                  |
| Home of parent/relative/kin   | 8 (22.22)   | 4 (19.05)                  | 1 (7.14)                   | 13 (18.31)                  |
| Specialized foster care   | 8 (22.22)   | 4 (19.05)                  | 6 (42.86)                  | 18 (25.35)                  |
| Other home-based settings   | 0 (0)   | 0 (0)                      | 1 (7.14)                   | 1 (1.41)                    |
| Independent/transitional living   | 0 (0)   | 0 (0)                      | 0 (0)                      | 0 (0)                       |
| Non-community placement <sup>b</sup> (n, %)                                   | 20 (55.56)  | 13 (61.9)                  | 6 (42.86)                  | 39 (54.93)                  |
| Residential care  | 0 (0)   | 0 (0)                      | 0 (0)                      | 0 (0)                       |
| Psychiatric hospital  | 18 (50.00)  | 13 (61.90)                 | 5 (35.71)                  | 36 (50.70)                  |
| All other   | 2 (5.56)  | 0 (0)                      | 1 (7.14)                   | 3 (4.23)                    |
| Mean length of stay (days) in first post-initial TFC placement (median, SD)   | 91.67<br>(20.00, 126.12)                                    | 53.90<br>(25.00, 79.31)    | 89.29<br>(49.00, 113.34)   | 80.03<br>(29.00, 111.48)    |



|  | LSSI TFC<br>Cook County    | LSSI TFC<br>Aurora        | LSSI TFC<br>Rockford      | All LSSI TFC Pilot<br>Sites |
|--|----------------------------|---------------------------|---------------------------|-----------------------------|
| Community placement <sup>a</sup>   | 175.94<br>(180.50, 150.95) | 91.75<br>(45.50, 119.98)  | 142.75<br>(99.00, 127.00) | 146.59<br>(99.50, 138.36)   |
| Non-community placement <sup>b</sup>   | 24.25<br>(15.00, 23.44)    | 30.62<br>(20, 23.33)      | 18.00<br>(15.5, 12.17)    | 25.41<br>(17.00, 22.02)     |
| <b>All post initial-TFC placements<br/>(unit of analysis is number of<br/>post-initial TFC placements<br/>associated with TFC Pilot youth)</b> | <i>n</i> =230              | <i>n</i> =145             | <i>n</i> =108             | <i>n</i> =483               |
| Mean number of post-initial TFC<br>placements per 100 days in DCFS<br>legal custody (median, SD)   | 0.73<br>(2.27, 0.47)       | 0.85<br>(1.92, 0.60)      | 0.85<br>(2.04, 0.56)      | 0.79<br>(2.08, 0.52)        |
| Community placement <sup>a</sup> (n, %)  | 138 (60.00)                | 91 (62.76)                | 58 (53.7)                 | 287 (59.42)                 |
| Home of parent/relative/kin  | 47 (20.43)                 | 38 (26.21)                | 22 (20.37)                | 107 (22.15)                 |
| Specialized foster care  | 81 (35.22)                 | 49 (33.79)                | 29 (26.85)                | 159 (32.92)                 |
| Other home-based settings  | 10 (4.35)                  | 4 (2.76)                  | 6 (5.56)                  | 20 (4.14)                   |
| Independent/transitional living  | 0 (0)                      | 0 (0)                     | 1 (0.93)                  | 1 (0.21)                    |
| Non-community placement <sup>b</sup> (n, %)  | 92 (40.00)                 | 54 (37.24)                | 50 (46.30)                | 196 (40.58)                 |
| Residential care   | 20 (8.70)                  | 12 (8.28)                 | 17 (15.74)                | 49 (10.14)                  |
| Psychiatric hospital   | 60 (26.09)                 | 33 (22.76)                | 28 (25.93)                | 121 (25.05)                 |
| All other  | 12 (5.22)                  | 9 (6.21)                  | 5 (4.63)                  | 26 (5.38)                   |
| Mean length of stay (days) in post-<br>initial TFC placements (median, SD)   | 137.59<br>(51.00, 213.56)  | 117.39<br>(57.00, 166.71) | 117.81<br>(55.00, 179.27) | 127.11<br>(56.00, 192.89)   |
| Community placement <sup>a</sup>   | 163.92<br>(62.50, 230.07)  | 105.84<br>(70.00, 118.92) | 105.72<br>(58.50, 144.55) | 133.74<br>(62.00, 186.59)   |
| Non-community placement <sup>b</sup>   | 98.10<br>(21.00, 180.17)   | 136.87<br>(32.50, 225.56) | 131.84<br>(21.00, 213.31) | 117.39<br>(24.00, 201.85)   |

<sup>a</sup> Community placement: Home of parent/relative/kin (HMP, HMR, HFK); Specialized foster care (FHS, FHT, AFC, TFH); Other home-based settings (FHA, FHB, FHG, FHI, FHP, HRA, SGH, GDN, EFC, PGH, DRA, FOS, HRL, HAP); Independent/transitional living (ILO, TLP).

<sup>b</sup> Non-community placement: Residential care (GRH, IPA, QRT); Psychiatric hospital (HFP); All other (HFM, UAH, UAP, WUK, YES).

## Research question #2: What was the distance of the initial TFC placement, first post-initial TFC placement, and all post-initial TFC placements from youth's home community?

### Distance between Initial TFC Placement and Home Community

Initial TFC placements were, on average, 25 miles from the youth's home community. The distance from home was shortest among youth in the Cook County site (23 miles) and longest among youth in the Aurora site (29 miles; see Table 10). Overall, only 5% of TFC Pilot youth were placed within 5 miles from their home community, 22% were placed within 10 miles, 46% were placed within 20 miles, and 91% were placed within 50 miles, with

notable cross-site differences. Among youth in the Cook County site, 5% were placed in TFC within 5 miles, 26% within 10 miles, and nearly 50% within 20 miles. In contrast, among youth in the Aurora site, no youth were placed in TFC within 10 miles, which means 38% of the youth were placed in TFC within 11-20 miles. In the Rockford site, 14% of the youth were placed in TFC within 5 miles and 43% within 10 miles.

**Table 10. Distance between Initial TFC Placement and Home Community, by TFC Pilot Site**

| Initial TFC Placement (Unit of Analysis is TFC Pilot Youth)    | LSSI TFC Cook County (n=39) | LSSI TFC Aurora (n=21) | LSSI TFC Rockford (n=14) | All LSSI TFC Pilot Sites (n=74) |
|--|-----------------------------|------------------------|--------------------------|---------------------------------|
| Mean distance (miles) from child's home community (median, SD) | 23.33 (21.90, 19.63)        | 28.53 (24.31, 14.97)   | 24.09 (20.85, 22.33)     | 24.95 (22.52, 18.87)            |
| Same as child's home community (n, %) - 5 miles                | 2 (5.13)                    | 0 (0)                  | 2 (14.29)                | 4 (5.41)                        |
| Same as child's home community (n, %) - 10 miles               | 10 (25.64)                  | 0 (0)                  | 6 (42.86)                | 16 (21.62)                      |
| Same as child's home community (n, %) - 20 miles               | 19 (48.72)                  | 8 (38.1)               | 7 (50)                   | 34 (45.95)                      |
| Same as child's home community (n, %) - 50 miles               | 36 (92.31)                  | 19 (90.48)             | 12 (85.71)               | 67 (90.54)                      |

### Distance between First Post-Initial TFC Placement and Home Community

Of all first post-initial TFC placement types, **Home of parent/relative/kin placements** (n=13) were, on average, **closest to youth's home community (20 miles)**.

In contrast, **psychiatric hospital placements** (n=36) were, on average, **furthest from youth's home community (34 miles)**.

Youth's first post-initial TFC placement was, on average, 30 miles from their home community. The distance from home was shortest among youth in the Cook County site (20 miles) and longest among youth in the Aurora site (39 miles; see Table 11). Youth who went to a community placement immediately post-initial TFC were, on average, placed closer to their home community than youth who went to a non-community placement (24 miles vs. 34 miles, respectively). This difference in distance from home between community and non-community placement was particularly pronounced among youth in the Aurora site (20 miles vs. 51 miles, respectively) and the Rockford site (32 miles vs. 48 miles, respectively). In the Cook County site, although community placements were, on average, further away from home than non-community placements (23 miles vs. 18 miles, respectively), the median distance between a community placement and home community was 9 miles. Across placement types, home of parent/relative/kin placements (n=13) were, on

average, closest to youth's home community (20 miles). In contrast, psychiatric hospital placements (n=36) were, on average, furthest from youth's home community (34 miles).

Nearly all noncommunity placements immediately after TFC were placements in psychiatric hospitals.

Overall, 13% of youth's first post-initial TFC placements were within 5 miles of their home community, 25% were within 10 miles, 44% were within 20 miles, and 85% were within 50 miles. These percentages are skewed by youth in the Cook County site who were generally placed closer to their home community (22% within 5 miles, 39% within 10 miles, and 61% within 20 miles). However, only 29% of youth in the Aurora site and 21% of youth in the Rockford site were within 20 miles of their home community as of their first post-initial TFC placement. Across sites, the first post-initial TFC community placement was closer to youth's home community than the first post-initial TFC non-community placement. Across placement types, home of parent/relative/kin placements had 31% and 46% of the youth placed within 5 miles and 10 miles, respectively. In contrast, psychiatric hospital placements had only 8% and 14% of the youth placed within 5 miles and 10 miles, respectively. An important finding from Research Question #1 (shown in Table 9) is that nearly all non-community placements immediately after TFC were placements in psychiatric hospitals.

**Table 11. Distance between First Post-initial TFC Placement and Home Community, by TFC Pilot Site**

| First Post-Initial TFC Placement (Unit of Analysis is TFC Pilot Youth)           | LSSI TFC Cook County    | LSSI TFC Aurora         | LSSI TFC Rockford       | All LSSI TFC Pilot Sites |
|--|-------------------------|-------------------------|-------------------------|--------------------------|
| <b>All placement types (community<sup>a</sup> and non-community<sup>b</sup>)</b> | <i>n</i> =36            | <i>n</i> =21            | <i>n</i> =14            | <i>n</i> =71             |
| Mean distance (miles) from child's home community (median, SD)                   | 20.25<br>(13.38, 26.44) | 39.30<br>(30.61, 39.24) | 38.48<br>(32.86, 25.52) | 29.61<br>(22.63, 31.66)  |
| Same as child's home community* (n, %) - 5 miles                                 | 8 (22.22)               | 0 (0)                   | 1 (7.14)                | 9 (12.68)                |
| Same as child's home community* (n, %) - 10 miles                                | 14 (38.89)              | 2 (9.52)                | 2 (14.29)               | 18 (25.35)               |
| Same as child's home community* (n, %) - 20 miles                                | 22 (61.11)              | 6 (28.57)               | 3 (21.43)               | 31 (43.66)               |
| Same as child's home community* (n, %) - 50 miles                                | 33 (91.67)              | 17 (80.95)              | 10 (71.43)              | 60 (84.51)               |
| <b>Community placement<sup>a</sup></b>   | <i>n</i> =16            | <i>n</i> =8             | <i>n</i> =8             | <i>n</i> =32             |
| Mean distance (miles) from child's home community (median, SD)                   | 22.54<br>(8.84, 37.51)  | 19.71<br>(18.76, 9.95)  | 31.57<br>(30.15, 28.07) | 24.09<br>(15.47, 30.03)  |
| Same as child's home community* (n, %) - 5 miles                                 | 5 (31.25)               | 0 (0)                   | 1 (12.5)                | 6 (18.75)                |
| Same as child's home community* (n, %) - 10 miles                                | 9 (56.25)               | 2 (25)                  | 2 (25)                  | 13 (40.62)               |
| Same as child's home community* (n, %) - 20 miles                                | 11 (68.75)              | 5 (62.5)                | 3 (37.5)                | 19 (59.38)               |
| Same as child's home community* (n, %) - 50 miles                                | 14 (87.5)               | 8 (100)                 | 7 (87.5)                | 29 (90.62)               |
| <b>Home of parent/relative/kin<sup>a</sup></b>                                   | <i>n</i> =8             | <i>n</i> =4             | <i>n</i> =1             | <i>n</i> =13             |
| Mean distance (miles) from child's home community (median, SD)                   | 22.40<br>(3.92, 48.68)  | 18.25<br>(17.82, 9.77)  | 11.18<br>(11.18, NA)    | 20.26<br>(11.18, 37.65)  |
| Same as child's home community* (n, %) - 5 miles                                 | 4 (50.00)               | 0 (0)                   | 0 (0)                   | 4 (30.77)                |
| Same as child's home community* (n, %) - 10 miles                                | 5 (62.5)                | 1 (25)                  | 0 (0)                   | 6 (46.15)                |
| Same as child's home community* (n, %) - 20 miles                                | 7 (87.5)                | 3 (75)                  | 1 (100)                 | 11 (84.62)               |
| Same as child's home community* (n, %) - 50 miles                                | 7 (87.5)                | 4 (100)                 | 1 (100)                 | 12 (92.31)               |

| First Post-Initial TFC Placement (Unit of Analysis is TFC Pilot Youth) | LSSI TFC Cook County    | LSSI TFC Aurora         | LSSI TFC Rockford       | All LSSI TFC Pilot Sites |
|--|-------------------------|-------------------------|-------------------------|--------------------------|
| <b>Specialized foster care<sup>a</sup></b>                             | <i>n</i> =8             | <i>n</i> =4             | <i>n</i> =6             | <i>n</i> =18             |
| Mean distance (miles) from child's home community (median, SD)         | 22.67<br>(15.65, 25.41) | 21.16<br>(20.61, 11.4)  | 40.15<br>(36.42, 27.18) | 28.16<br>(22.81, 24.13)  |
| Same as child's home community* (n, %) - 5 miles                       | 1 (12.50)               | 0 (0)                   | 0 (0)                   | 1 (5.56)                 |
| Same as child's home community* (n, %) - 10 miles                      | 4 (50.00)               | 1 (25.00)               | 1 (16.67)               | 6 (33.33)                |
| Same as child's home community* (n, %) - 20 miles                      | 4 (50.00)               | 2 (50.00)               | 1 (16.67)               | 7 (38.89)                |
| Same as child's home community* (n, %) - 50 miles                      | 7 (87.50)               | 4 (100.00)              | 5 (83.33)               | 16 (88.89)               |
| <b>Other home-based settings<sup>a</sup></b>                           | <i>n</i> =0             | <i>n</i> =0             | <i>n</i> =1             | <i>n</i> =1              |
| Mean distance (miles) from child's home community (median, SD)         | N/A                     | N/A                     | 0.48<br>(0.48, NA)      | 0.48<br>(0.48, NA)       |
| Same as child's home community* (n, %) - 5 miles                       | N/A                     | N/A                     | 1 (100.00)              | 1 (100.00)               |
| Same as child's home community* (n, %) - 10 miles                      | N/A                     | N/A                     | 1 (100.00)              | 1 (100.00)               |
| Same as child's home community* (n, %) - 20 miles                      | N/A                     | N/A                     | 1 (100.00)              | 1 (100.00)               |
| Same as child's home community* (n, %) - 50 miles                      | N/A                     | N/A                     | 1 (100.00)              | 1 (100.00)               |
| <b>Non-community placement<sup>b</sup></b>                             | <i>n</i> =20            | <i>n</i> =13            | <i>n</i> =6             | <i>n</i> =39             |
| Mean distance (miles) from child's home community (median, SD)         | 18.32<br>(16.32, 11.82) | 51.36<br>(32.99, 45.77) | 47.70<br>(42.61, 20.27) | 34.26<br>(26.74, 32.64)  |
| Same as child's home community* (n, %) - 5 miles                       | 3 (15.00)               | 0 (0)                   | 0 (0)                   | 3 (7.69)                 |
| Same as child's home community* (n, %) - 10 miles                      | 5 (25.00)               | 0 (0)                   | 0 (0)                   | 5 (12.82)                |
| Same as child's home community* (n, %) - 20 miles                      | 11 (55.00)              | 1 (7.69)                | 0 (0)                   | 12 (30.77)               |
| Same as child's home community* (n, %) - 50 miles                      | 19 (95.00)              | 9 (69.23)               | 3 (50)                  | 31 (79.49)               |
| <b>Psychiatric hospital<sup>b</sup></b>                                | <i>n</i> =18            | <i>n</i> =13            | <i>n</i> =5             | <i>n</i> =36             |
| Mean distance (miles) from child's home community (median, SD)         | 17.93<br>(15.71, 12.03) | 51.36<br>(32.99, 45.77) | 50.58<br>(51.94, 21.24) | 34.54<br>(26.74, 33.53)  |
| Same as child's home community* (n, %) - 5 miles                       | 3 (16.67)               | 0 (0)                   | 0 (0)                   | 3 (8.33)                 |
| Same as child's home community* (n, %) - 10 miles                      | 5 (27.78)               | 0 (0)                   | 0 (0)                   | 5 (13.89)                |
| Same as child's home community* (n, %) - 20 miles                      | 11 (61.11)              | 1 (7.69)                | 0 (0)                   | 12 (33.33)               |
| Same as child's home community* (n, %) - 50 miles                      | 18 (100)                | 9 (69.23)               | 2 (40)                  | 29 (80.56)               |

<sup>a</sup> Community placement: Home of parent/relative/kin (HMP, HMR, HFK); specialized foster care (FHS, FHT, AFC, TFH); other home-based settings (FHA, FHB, FHG, FHI, FHP, HRA, SGH, GDN, EFC, PGH, DRA, FOS, HRL, HAP); independent/transitional living (ILO, TLP).

<sup>b</sup> Non-community placement: Residential care (GRH, IPA, QRT); psychiatric hospital (HFP); all other (HFM, UAH, UAP, WUK, YES).

## Distance between All Post-initial TFC Placements and Home Community

Across all youth's post-initial TFC placements, including the immediate post-initial TFC placement, the average distance of the placement from their home community was 44 miles. The average distance from home was shortest among youth in the Cook County site (28 miles) and was furthest among youth in the Rockford site (60 miles; see Table 12). The average distance from home in community placements (36 miles) was smaller than the average distance in non-community placements (56 miles). This difference holds true across sites, but especially so for youth in the Rockford site (42 miles vs. 80 miles).

On average, specialized foster care placements were closer to youth's home community (**24 miles**) than home of parent/relative/kin placements (**47 miles**).

Across the placement types of all post-initial TFC placements, specialized foster care ( $n=159$ ) and home of parent/relative/kin placements ( $n=107$ ) made up most of the community placements. On average, specialized foster care placements were closer to youth's home community (24 miles) than home of parent/relative/kin placements (47 miles). For youth in the Aurora site, however, their home of parent/relative/kin placements were, on average, 78 miles from their home community; youth in the Cook County site and Rockford site were placed relatively closer (31 miles and 25 miles, respectively). Among non-community placements, residential care placements ( $n=49$ ) were, on average, further away from youth's home community (73 miles) than psychiatric hospital placements ( $n=121$ , 43 miles). This was not the case for youth in the Cook County site, whose average distance from their home community, when placed in psychiatric hospitals, was 22 miles, compared to 66 miles in the Aurora site and 60 miles in the Rockford site.

Overall, 17% of youth's all post-initial TFC placements were within 5 miles of their home community, 27% were within 10 miles, 46% were within 20 miles, and 74% were within 50 miles. These percentages tended to be higher among youth in the Cook County site (indicating more youth placed closer to home community), and lower among youth in the Rockford and Aurora sites (indicating more youth placed further from home community). Across placement types, home of parent/relative/kin placements had 39% and 54% of the youth placed within 5 miles and 10 miles, respectively. In contrast, residential care placements had only 2% and 4% of the youth placed within 5 miles and 10 miles, respectively, and psychiatric hospital placements had only 7% and 15% of the youth placed within 5 miles and 10 miles, respectively.

**Table 12. Distance between All Post-initial TFC Placements and Home Community, by TFC Pilot Site**

| <b>All Post-initial TFC Placements (Unit of Analysis is Number of Post-initial TFC Placements Associated with TFC Pilot Youth)</b> | <b>LSSI TFC Cook County</b> | <b>LSSI TFC Aurora</b>   | <b>LSSI TFC Rockford</b> | <b>All LSSI TFC Pilot Sites</b> |
|--|-----------------------------|--------------------------|--------------------------|---------------------------------|
| <b>All placement types (community<sup>a</sup> and non-community<sup>b</sup>)</b>   | $n=230$                     | $n=145$                  | $n=108$                  | $n=483$                         |
| Mean distance (miles) from child's home community (median, SD)   | 28.27<br>(13.64, 49.61)     | 55.48<br>(28.96, 100.24) | 59.91<br>(32.86, 122.66) | 43.58<br>(21.90, 88.05)         |
| Same as child's home community* (n, %) - 5 miles   | 53 (23.04)                  | 17 (11.72)               | 11 (10.19)               | 81 (16.77)                      |
| Same as child's home community* (n, %) - 10 miles  | 88 (38.26)                  | 23 (15.86)               | 19 (17.59)               | 130 (26.92)                     |
| Same as child's home community* (n, %) - 20 miles  | 138 (60.00)                 | 46 (31.72)               | 37 (34.26)               | 221 (45.76)                     |
| Same as child's home community* (n, %) - 50 miles  | 201<br>(87.39%)             | 96 (66.21)               | 62 (57.41)               | 359 (74.33)                     |
| <b>Community placement<sup>a</sup></b>   | $n=138$                     | $n=91$                   | $n=58$                   | $n=287$                         |
| Mean distance (miles) from child's home community (median, SD)   | 22.80<br>(9.92, 42.40)      | 51.03<br>(21.70, 119.47) | 41.90<br>(11.18, 120.07) | 35.60<br>(13.88, 91.48)         |
| Same as child's home community* (n, %) - 5 miles   | 42 (30.43)                  | 16 (17.58)               | 10 (17.24)               | 68 (23.69)                      |
| Same as child's home community* (n, %) - 10 miles  | 68 (49.28)                  | 20 (21.98)               | 18 (31.03)               | 106 (36.93)                     |
| Same as child's home community* (n, %) - 20 miles  | 91 (65.94)                  | 41 (45.05)               | 33 (56.9)                | 165 (57.49)                     |
| Same as child's home community* (n, %) - 50 miles  | 127 (92.03)                 | 71 (78.02)               | 46 (79.31)               | 244 (85.02)                     |
| <b>Home of parent/relative/kin<sup>a</sup></b>   | $n=47$                      | $n=38$                   | $n=22$                   | $n=107$                         |
| Mean distance (miles) from child's home community (median, SD)   | 30.85<br>(5.04, 68.48)      | 78.37<br>(12.34, 180.05) | 25.15<br>(11.18, 52.16)  | 46.55<br>(8.78, 120.23)         |
| Same as child's home community* (n, %) - 5 miles   | 23 (48.94)                  | 14 (36.84)               | 5 (22.73)                | 42 (39.25)                      |
| Same as child's home community* (n, %) - 10 miles  | 34 (72.34)                  | 16 (42.11)               | 8 (36.36)                | 58 (54.21)                      |
| Same as child's home community* (n, %) - 20 miles  | 41 (87.23)                  | 26 (68.42)               | 18 (81.82)               | 85 (79.44)                      |

| <b>All Post-initial TFC Placements (Unit of Analysis is Number of Post-initial TFC Placements Associated with TFC Pilot Youth)</b> | <b>LSSI TFC Cook County</b> | <b>LSSI TFC Aurora</b>  | <b>LSSI TFC Rockford</b> | <b>All LSSI TFC Pilot Sites</b> |
|--|-----------------------------|-------------------------|--------------------------|---------------------------------|
| Same as child's home community* (n, %) - 50 miles  | 41 (87.23)                  | 30 (78.95)              | 19 (86.36)               | 90 (84.11)                      |
| <b>Specialized foster care<sup>a</sup></b>   | <i>n</i> =81                | <i>n</i> =49            | <i>n</i> =29             | <i>n</i> =159                   |
| Mean distance (miles) from child's home community (median, SD)   | 19.26<br>(18.24, 16.40)     | 30.44<br>(28.33, 19.79) | 27.46<br>(27.87, 24.12)  | 24.20<br>(22.28, 19.61)         |
| Same as child's home community* (n, %) - 5 miles   | 17 (20.99)                  | 2 (4.08)                | 3 (10.34)                | 22 (13.84)                      |
| Same as child's home community* (n, %) - 10 miles  | 31 (38.27)                  | 4 (8.16)                | 8 (27.59)                | 43 (27.04)                      |
| Same as child's home community* (n, %) - 20 miles  | 42 (51.85)                  | 15 (30.61)              | 13 (44.83)               | 70 (44.03)                      |
| Same as child's home community* (n, %) - 50 miles  | 78 (96.3)                   | 39 (79.59)              | 25 (86.21)               | 142 (89.31)                     |
| <b>Other home-based settings<sup>a</sup></b>   | <i>n</i> =10                | <i>n</i> =4             | <i>n</i> =6              | <i>n</i> =20                    |
| Mean distance (miles) from child's home community (median, SD)   | 11.35<br>(14.22, 7.20)      | 40.95<br>(20.24, 35.88) | 29.04<br>(25.34, 33.52)  | 21.99<br>(16.13, 24.63)         |
| Same as child's home community* (n, %) - 5 miles   | 2 (20.00)                   | 0 (0)                   | 2 (33.33)                | 4 (20.00)                       |
| Same as child's home community* (n, %) - 10 miles  | 3 (30.00)                   | 0 (0)                   | 2 (33.33)                | 5 (25.00)                       |
| Same as child's home community* (n, %) - 20 miles  | 8 (80.00)                   | 0 (0)                   | 2 (33.33)                | 10 (50.00)                      |
| Same as child's home community* (n, %) - 50 miles  | 8 (80.00)                   | 2 (50)                  | 2 (33.33)                | 12 (60.00)                      |
| <b>Non-community placement<sup>b</sup></b>   | <i>n</i> =92                | <i>n</i> =54            | <i>n</i> =50             | <i>n</i> =196                   |
| Mean distance (miles) from child's home community (median, SD)   | 36.91<br>(17.43, 58.49)     | 63.51<br>(49.16, 49.75) | 80.09<br>(55.86, 123.58) | 55.67<br>(33.93, 81.33)         |
| Same as child's home community* (n, %) - 5 miles   | 11 (11.96)                  | 1 (1.85)                | 1 (2)                    | 13 (6.63)                       |
| Same as child's home community* (n, %) - 10 miles  | 20 (21.74)                  | 3 (5.56)                | 1 (2)                    | 24 (12.24)                      |
| Same as child's home community* (n, %) - 20 miles  | 47 (51.09)                  | 5 (9.26)                | 4 (8)                    | 56 (28.57)                      |
| Same as child's home community* (n, %) - 50 miles  | 74 (80.43)                  | 25 (46.3)               | 16 (32)                  | 115 (58.67)                     |
| <b>Residential care<sup>b</sup></b>  | <i>n</i> =20                | <i>n</i> =12            | <i>n</i> =17             | <i>n</i> =49                    |
| Mean distance (miles) from child's home community (median, SD)   | 76.32<br>(24.10, 95.11)     | 62.09<br>(54.51, 34.19) | 75.57<br>(55.86, 67.14)  | 72.58<br>(52.07, 73.40)         |
| Same as child's home community* (n, %) - 5 miles   | 1 (5.00)                    | 0 (0)                   | 0 (0)                    | 1 (2.04)                        |
| Same as child's home community* (n, %) - 10 miles  | 2 (10.00)                   | 0 (0)                   | 0 (0)                    | 2 (4.08)                        |
| Same as child's home community* (n, %) - 20 miles  | 10 (50.00)                  | 1 (8.33)                | 0 (0)                    | 11 (22.45)                      |
| Same as child's home community* (n, %) - 50 miles  | 13 (65.00)                  | 6 (50)                  | 5 (29.41)                | 24 (48.98)                      |
| <b>Psychiatric hospital<sup>b</sup></b>  | <i>n</i> =60                | <i>n</i> =33            | <i>n</i> =28             | <i>n</i> =121                   |
| Mean distance (miles) from child's home community (median, SD)   | 22.49<br>(16.95, 20.59)     | 66.26<br>(35.88, 57.02) | 60.31<br>(70.08, 28.11)  | 43.18<br>(31.47, 41.01)         |
| Same as child's home community* (n, %) - 5 miles   | 7 (11.67)                   | 0 (0)                   | 1 (3.57)                 | 8 (6.61)                        |
| Same as child's home community* (n, %) - 10 miles  | 15 (25.00)                  | 2 (6.06)                | 1 (3.57)                 | 18 (14.88)                      |
| Same as child's home community* (n, %) - 20 miles  | 33 (55.00)                  | 3 (9.09)                | 3 (10.71)                | 39 (32.23)                      |
| Same as child's home community* (n, %) - 50 miles  | 56 (93.33)                  | 18 (54.55)              | 9 (32.14)                | 83 (68.6)                       |

<sup>a</sup> Community placement: Home of parent/relative/kin (HMP, HMR, HFK); specialized foster care (FHS, FHT, AFC, TFH); other home-based settings (FHA, FHB, FHG, FHI, FHP, HRA, SGH, GDN, EFC, PGH, DRA, FOS, HRL, HAP); independent/transitional living (ILO, TLP).

<sup>b</sup> Non-community placement: Residential care (GRH, IPA, QRT); Psychiatric hospital (HFP); All other (HFM, UAH, UAP, WUK, YES).

## DISCUSSION

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TFC youth can be maintained in **less restrictive, home-based settings**, though subsequent placement instability or placements in psychiatric hospitals can be expected.

The Illinois Children and Family Services Act (Illinois Public Act 099-0350) requires that DCFS “arrange for an independent evaluation of the pilot program [multi-dimensional treatment foster care (MTFC)] to determine whether it is meeting the goal of maintaining children in the least restrictive, most appropriate family-like setting, near the child’s home community, while they are in the Department’s care. . . .” In the 5-year DCFS TFC Pilot, Lutheran Social Services of Illinois (LSSI) fully implemented the Therapeutic Foster Care Oregon (TFCO) model, the current name of MTFC (Blueprints for Healthy Youth Development, 2022), in three sites: Cook County, Aurora, and Rockford. This evaluation of placement types and distance from home focused on the 74 youth who were placed in LSSI TFC homes during the TFC Pilot.

After the initial TFC placement, over half of the LSSI TFC Pilot youth immediately moved to a non-community placement, mainly to a psychiatric hospital (though the majority would return to a TFC placement post-psychiatric hospitalization). For the other TFC Pilot youth who moved to a community placement, the majority moved to specialized foster care or the home of parent/relative/kin. Youth’s length of stay in the first post-initial TFC placement tended to be longer in a community placement, approximately 5 months, than in a non-community placement. Most non-community placements were psychiatric hospitalizations with brief 2- to 3-week stays. Looking at all post-initial TFC placements, TFC Pilot youth experienced relatively infrequent placement moves and generally remained in a community placement, mostly specialized foster care or home of parent/relative/kin. When the TFC Pilot youth did move to non-community placements, the placements were mainly at psychiatric hospitals. Taken together, these findings suggest that TFC youth can be maintained in less restrictive, home-based settings, though subsequent placement instability or placements in psychiatric hospitals can be expected.

Regarding placement distance from youth’s home community, TFC homes were, on average, closest to youth’s home community (25 miles), followed by the first post-initial TFC placement (30 miles), and across all post-initial TFC placements more generally (44 miles). Less than 20% of TFC Pilot youth were placed within 5 miles of their home community at any point. However, youth in the Cook County site were placed consistently closer to their home community, regardless of placement type, than youth in the Aurora and Rockford sites. Across placement types, community placements, especially specialized foster care or home of parent/relative/kin, were closer to youth’s home community than non-community placements, namely psychiatric hospitals or residential care. In summary, these findings suggest that the stabilization of TFC youth in community placements is also bolstered by their closer proximity to youth’s home community. The magnitude of placements being an average distance of at least 20 miles from the home community poses practical concerns about youth’s ability to maintain meaningful

family and social connections in their home community. At the same time, distance from youth's home community of origin might be less relevant for youth placed at the home of parent/relative/kin as potential permanency settings, than for youth placed in non-community placements and who are trying to return to their home community.

This study has several limitations. First, by defining a youth's address at their DCFS case opening as "home community," we could have overlooked a more nuanced understanding of that term. For instance, "home community" could be defined by youth's social networks, or by youth's most current home community. In addition, while quantifying the distance between a DCFS placement and youth's home community provides numerical benchmarks for defining near or far from home, we did not consider factors such as the difficulty or ease of transportation, population density, or home community characteristics. For instance, a 10-mile commute in Cook County could be more challenging than a 20-mile car ride in Aurora or Rockford. Further, it is possible that youth's home community lacks certain community placement options such as specialized foster care homes, which could mean tradeoffs have to be made between finding the "right" placement vs. a close placement. These tradeoffs might reflect resource constraints in youth's home community, as evidenced by cross-site differences in the percentages and distances of home-based settings between Cook County, Rockford, and Aurora. Finally, because this study focused on the placement types and their distance from home community solely among youth in the LSSI TFC Pilot in response to the state legislation, it did not compare findings with state trends in standard care. Thus, we cannot draw conclusions about the impact of TFC on youth's placement trajectories and distance from home compared to the control group.



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# THERAPEUTIC FOSTER CARE (TFC) PILOT OUTCOME EVALUATION

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## EXECUTIVE SUMMARY

DCFS contracted with four community partner providers to implement the TFC Pilot—

**Children’s Home and Aid (CH+A), Jewish Children and Family Services (JCFS), Lutheran Social Services of Illinois (LSSI), and Youth Outreach Services (YOS)**—to serve eligible children ages 6 to 17 in the Cook County, Aurora, and Rockford subregions.

The Illinois Children and Family Services Act (Illinois Public Act 099-0350) requires that DCFS “implement a 5-year pilot program of multi-dimensional treatment foster care, or a substantially similar evidence-based program of professional foster care, for (i) children entering care with severe trauma histories, with the goal of returning the child home or maintaining the child in foster care instead of placing the child in congregate care or a more restrictive setting or placement, (ii) children who require placement in foster care when they are ready for discharge from a residential treatment facility, and (iii) children who are identified for residential or group home care and who, based on a determination made by the Department, could be placed in a foster home if higher level interventions are provided.”

Under the B.H. consent decree (B.H. v. Smith, 1988), DCFS is also required to implement the TFC Pilot and arrange for an independent evaluation through its contract with Chapin Hall at the University of Chicago (Chapin Hall) between July 1, 2016 and

June 30, 2021. Staffing, training, and foster parent recruitment occurred in the first 7 months. TFC referrals officially began on February 1, 2017. The TFC Pilot aimed to provide a home-based setting to serve youth with a history of trauma or severe behavioral challenges who would otherwise enter or remain in residential care or be discharged from residential care to other non-TFC community-based settings such as home of relative, fictive kin, or specialized foster care.

DCFS contracted with four purchase of service (POS) community providers to implement the TFC Pilot—Children’s Home and Aid (CH+A), Jewish Children and Family Services (JCFS), Lutheran Social Services of Illinois (LSSI), and Youth Outreach Services (YOS)—to serve eligible children ages 6 to 17 in the Cook County, Aurora, and Rockford subregions. TFC was defined by the specific model a provider implemented. CH+A used the Therapeutic Crisis Intervention-Family (TCI-F) Model (Nunno et al., 2003), JCFS used the Together Facing the Challenge Model (Farmer et al., 2010), and both LSSI and YOS used the Therapeutic Foster Care Oregon (TFCO) Model (Chamberlain et al., 2007).

During the 5-year TFC Pilot period, TFC providers spent the first 7 months, from July 1, 2016 to January 31, 2017, on implementation ramp-up, which included training and recruitment of TFC homes and TFC team members. However, JCFS and YOS ended their participation in the TFC Pilot in April 2018 and May 2018, respectively. Since then, LSSI and CH+A had been the remaining active TFC providers. Beyond June 30, 2021, LSSI continued to implement TFCO outside the purview of the Pilot evaluation. This final evaluation report used information and data that covered the TFC Pilot period from the inception of TFC referrals on February 1, 2017 to June 30, 2021.

The TFC Pilot served three target populations (see Table ES-1).

1. **Deflection:** Youth who were not in residential care at the time of TFC referral, though were indicated to need residential care based on the Child and Adolescent Service Intensity Instrument (CASII) assessment (CASII Level=5). JCFS, LSSI, and YOS served this target population.
2. **Step-Down:** Youth who were in residential care at the time of TFC referral and were indicated to need residential care based on the CASII assessment (CASII Level=5). JCFS, LSSI, and YOS served this target population.
3. **Step-Down (CH+A):** Youth who were in residential care at the time of TFC referral and were not indicated to need residential care and therefore deemed ready for discharge (on residential “Phase II” list). Only CH+A served this target population.

**Table 13. Distribution of Youth in the Three TFC Target Populations/Intervention Groups—Deflection, Step-down, Step-down (CH+A)—and Their Respective Comparison Groups from February 1, 2017 to June 30, 2021**

| TFC Target Population/Intervention Group   | TFC Comparison  |   |
|--|---|---|
| <b>1. Deflection</b> (need residential care but are not in residential care)   | TFC youth ( <i>n</i> =52) <ul style="list-style-type: none"> <li>• LSSI (<i>n</i>=50)</li> <li>• YOS (<i>n</i>=2)</li> </ul>                              | Referred to TFC but placed in residential care ( <i>n</i> =77)  |
| <b>2. Step-Down</b> (need residential care and are in residential care)  | TFC youth ( <i>n</i> =28) <ul style="list-style-type: none"> <li>• JCFS (<i>n</i>=2)</li> <li>• LSSI (<i>n</i>=24)</li> <li>• YOS (<i>n</i>=2)</li> </ul> | Referred to TFC but remained in residential care ( <i>n</i> =27)  |
| <b>3. Step-Down (CH+A)</b> (in residential care but do not need residential care and are ready to step-down from residential care) | TFC youth at CH+A ( <i>n</i> =13)   | Referred to TFC but discharged from residential care to home of relative, home of fictive kin, specialized foster care, or adolescent foster care ( <i>n</i> =12) |
| <b>Total</b>   | <b>93</b>   | <b>116</b>  |

*Note.* Residential care is defined as paid GRH (Group Home) or IPA (Institution – Private Agency) and excluding shelters (i.e., excluding service type codes 0221, 0222, 0223, 7221, 0000, N/A, or missing).

The outcome study combined program data provided by the TFC providers and DCFS administrative data, as of June 30, 2021, to examine **13 outcomes associated with the three TFC intervention groups and their respective TFC comparison groups** for the three target populations.

The TFC Pilot evaluation consisted of an output study and an outcome study. The output study examined outputs and fidelity associated with the two TFC providers that implemented TFC during the entire Pilot period, CH+A and LSSI. The outcome study evaluated the three target populations separately. It compared the outcomes—safety, well-being, and permanency—between the three target populations and their counterparts of eligible TFC youth who did not receive TFC (see Table 13).

The output study used program data provided by the four TFC providers. From February 1, 2017 to June 30, 2021, there were 367 TFC referrals, 141 TFC referral acceptances, and 93 unique youth ever placed in TFC. Of the 93 youth placed in TFC, 39 youth completed/graduated from TFC, 34 youth disrupted/were not in

TFC, and 20 youth remained in TFC placement. The TFC Pilot fielded 613 TFC inquiries from potential families and certified 43 homes, of which 26 were active and 20 (76.9%) were filled as of June 30, 2021. In the final 6 months of the TFC Pilot from January 1, 2021 to June 30, 2021, CH+A and LSSI continued to maintain productivity and fidelity to select Foster Family Treatment Association (FFTA) standards and to their specific interventions, despite challenges presented by the COVID-19 pandemic.

The outcome study used a concurrent, non-randomized comparison group design. Specifically, the outcome study combined program data provided by the TFC providers (such as TFC referrals or youth placed in TFC) and DCFS administrative data, as of June 30, 2021, to examine 13 outcomes associated with the three TFC intervention groups and their respective TFC comparison groups for the three target populations (see Table 13). Thus, the outcome study examined the three sets of intervention groups—deflection, step-down, and step-down (CH+A)—and their comparison groups separately. Since youth in the comparison groups were referred to but not placed in TFC, they still met the same TFC eligibility criteria (for example, age, geography, CASII Level, etc.) at the referral stage. Therefore, in practice, the comparison groups were considered “matched” to their respective intervention groups. Table 14 summarizes results of the outcome study with respect to the hypothesized effect of the TFC interventions on the 13 outcomes.

**Table 14. Summary of Outcome Comparisons between TFC Intervention Groups (Deflection, Step-down, and CH+A) and Their Comparison Groups as of June 30, 2021**

| Outcome   | Hypothesized Outcome Difference between Intervention and Comparison (< or >) | TFC Deflection vs. Deflection Comparison | TFC Step-Down vs. Step-Down Comparison | Step-Down (CH+A) vs. Step-Down (CH+A) Comparison |
|---|--|--|--|--|
| <b>Proximal Outcome (PO)</b>  |  |  |  |  |
| <b>PO1:</b> Percentage of youth with one or more substantiated investigations | Intervention < Comparison  | ✓ (n.s.)                                 | ⊘ (n.s.)                               | No difference (n.s.)                             |
| <b>Intermediate Outcomes (IO)</b>   |  |  |  |  |
| <b>IO1:</b> Percentage of discharge to home-based care                        | Intervention > Comparison  | ✓***                                     | ✓*                                     | ⊘ (n.s.)   |

| <b>Outcome</b>   | <b>Hypothesized Outcome Difference between Intervention and Comparison (&lt; or &gt;)</b>       | <b>TFC Deflection vs. Deflection Comparison</b> | <b>TFC Step-Down vs. Step-Down Comparison</b> | <b>Step-Down (CH+A) vs. Step-Down (CH+A) Comparison</b> |
|--|---|---|---|---|
| <b>IO2:</b> Percentage of discharge to permanency  | Intervention > Comparison   | √ (n.s.)  | ⊗ (n.s.)                                      | √ (n.s.)  |
| <b>IO3:</b> Length of stay   | Intervention < Comparison (deflection and step-down)  | √***  | √ (n.s.)                                      | ⊗ (n.s.)  |
| Intervention > Comparison (CH+A)   |   |   |   |   |
| <b>Distal Outcomes (DO)</b>  |   |   |   |   |
| <b>During TFC/residential care and within 6 months of TFC/residential care discharge:</b>      |   |   |   |   |
| <b>DO1:</b> Percentage of days in detention  | Intervention < Comparison   | ⊗ (n.s.)  | √ (n.s.)                                      | √ (n.s.)  |
| <b>DO2:</b> Percentage of days in psychiatric hospital   | Intervention < Comparison   | ⊗***  | ⊗ (n.s.)                                      | √ (n.s.)  |
| <b>DO3:</b> Percentage of days in runaway  | Intervention < Comparison   | √ (n.s.)  | √ (n.s.)                                      | √ (n.s.)  |
| <b>DO4:</b> Change in school achievement CANS item score from baseline to follow-up            | Intervention follow-up score minus baseline score is negative and the magnitude is > Comparison | √ (n.s.)  | ⊗ (n.s.)                                      | No difference (n.s.)                                    |
| <b>DO5:</b> Change in traumatic stress symptoms CANS domain score from baseline to follow-up   | Intervention follow-up score minus baseline score is negative and the magnitude is > Comparison | √ (n.s.)  | No difference (n.s.)                          | √ (n.s.)  |
| <b>DO6:</b> Change in emotional/behavioral needs CANS domain score from baseline to follow-up  | Intervention follow-up score minus baseline score is negative and the magnitude is > Comparison | ⊗ (n.s.)  | ⊗ (n.s.)                                      | √ (n.s.)  |
| <b>DO7:</b> Change in risk behaviors CANS domain score from baseline to follow-up              | Intervention follow-up score minus baseline score is negative and the magnitude is > Comparison | No difference (n.s.)                            | ⊗ (n.s.)                                      | No difference (n.s.)                                    |
| <b>DO8:</b> Change in social functional behaviors CANS domain score from baseline to follow-up | Intervention follow-up score minus baseline score is negative and the magnitude is > Comparison | ⊗ (n.s.)  | ⊗ (n.s.)                                      | ⊗ (n.s.)  |
| <b>Within 6 months of TFC/residential care discharge:</b>                                      |   |   |   |   |
| <b>DO9:</b> Number of placement moves per day in care  | Intervention < Comparison   | ⊗**   | √ (n.s.)                                      | √ (n.s.)  |

Note. "√" denotes outcome difference between intervention and comparison that is consistent with the hypothesis; "⊗" denotes outcome difference between intervention and comparison that is inconsistent with the hypothesis. n.s.=Not significant; \* $p < .05$ ; \*\* $p < .01$ ; \*\*\* $p < .001$ .

The three TFC intervention groups were

**demographically similar to their respective comparison groups,**

which consisted of eligible TFC youth who entered residential care, remained in residential care, or were discharged from residential care to non-TFC alternatives.

The outcome study showed that, in terms of age, race, and gender, the three TFC intervention groups were demographically similar to their respective comparison groups, which consisted of eligible TFC youth who entered residential care, remained in residential care, or were discharged from residential care to non-TFC alternatives. Collective outcomes associated with the three intervention groups showed modest but promising evidence that, as hypothesized, youth generally benefited more from the interventions compared with youth in the residential or non-TFC comparison groups. Across the 13 outcomes and the associated 39 outcome comparisons between the intervention groups and the comparison groups, only five outcome comparisons yielded statistically significant differences. Three of the differences favored the intervention: discharge to home-based care (for the TFC deflection and the TFC step-down groups) and length of stay (for the TFC deflection group). Two of the differences favored the

comparison: percentage of days in psychiatric hospital (for the TFC deflection comparison group) and number of placement moves per day in care (for the TFC deflection comparison group). Of the 34 outcome comparisons that were not statistically significant, 16 favored the intervention, 13 favored the comparison, and 5 showed no difference between the intervention and comparison.

The effect of TFC varied by target population across the 13 outcomes. On seven outcomes, the youth in the deflection intervention group performed better than youth in the comparison group (that is, eligible TFC youth who entered residential care). Two of these differences were statistically significant. On five outcomes, the youth in the deflection intervention group performed worse (two of which were statistically significant). On one outcome, there was no difference. The step-down intervention group performed better than their comparison group (eligible TFC youth who remained in residential care) on five outcomes, one of which was statistically significant. The step-down intervention group performed, worse on seven outcomes, and had no difference on one outcome. The step-down (CH+A) intervention group performed better than their comparison group (eligible TFC youth who were discharged from residential care to home of relative, home of fictive kin, specialized foster care, or adolescent foster care) on seven outcomes, and worse on three outcomes, with no difference on three outcomes. None of the outcome differences in CH+A were statistically significant.

The outcome study had several limitations. First, because the majority of TFC placements were with LSSI, outcome findings more or less represented the effectiveness of TFCO for the LSSI target population rather than that of other TFC models. Second, although the youth in the three intervention groups and their respective comparison groups were demographically similar, there was an imbalance between the number of youth in the intervention groups and youth in the comparison groups. In particular, the step-down (CH+A) intervention group and the step-down (CH+A) comparison group were both small, with fewer than 15 youth in each. Because CH+A stopped accepting TFC youth in January 2021, the sample size difference between the CH+A intervention group and the comparison group limited the generalizability of the CH+A TFC findings. Third, not all youth in the intervention

The TFC Pilot showed that TFC was implemented with **fidelity and yielded modestly improved outcomes.**

Most differences in outcomes observed between the intervention and comparison groups were not statistically significant.

groups and the comparison groups had received both a baseline CANS and a follow-up CANS, which limited the generalizability of five out of the nine distal outcomes. Further, youth who were placed in TFC in the final months of the Pilot had a shorter observation period, even if all time-dependent outcomes were standardized to proportion of days in care.

Taken together, the TFC Pilot showed that TFC was implemented with fidelity and yielded modestly improved outcomes. Most differences in outcomes observed between the intervention and comparison groups were not statistically significant. Nonetheless, these findings have implications for how DCFS might embed TFC within the continuum of care relative to residential care. If the intention is to “deflect” high-need youth from entering residential care, DCFS might expect a briefer length of stay in TFC placement (as intended) that would lead to continued placement in home-based settings for youth

who are placed in TFC rather than in residential care. If the intention is to step-down high-need youth from residential care, DCFS might also expect youth who are placed in TFC to remain in home-based settings after TFC. Both applications, however, were associated with mixed findings regarding non-statistical differences in clinical changes over time, per changes in CANS domain scores. Further, there were tradeoffs associated with a greater percentage of care days in psychiatric hospitalization, likely due to elevated needs that could otherwise be monitored and managed in residential care. ca

On the other hand, CH+A TFC, as a comparable step-down option for youth who would otherwise be discharged from residential care, did not show any significant outcome difference. In addition, because CH+A’s TFC model targeted potentially permanent homes as opposed to building ongoing TFC capacity for high-need youth, it remains unclear how the CH+A TFC model would expand the foster care continuum. Nevertheless, both LSSI and CH+A demonstrate a commitment to the provision of TFC after the Pilot. LSSI is adding a new team and expanding the geographic service area of their TFCO model while CH+A is expanding TCI-F training to all of their caregivers.

# INTRODUCTION

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## Background

Youth who are removed from their families due to abuse or neglect (hereafter referred to as youth in care) are at increased risk of developmental, behavioral, and emotional problems (Baker et al., 2007; McCue Horwitz et al., 2012). Most youth in care will be placed with family members or in foster care. However, some youth in care will require additional support to address their developmental, behavioral, and emotional problems.

Therapeutic foster care (TFC) is also referred to as treatment, specialized, enhanced, intensive, or multidimensional foster care, among other terms. TFC offers a community-based alternative to residential placement or congregate care for youth with behavioral or emotional problems and other co-occurring disorders. TFC can be described as family-based placement with additional supports, such as comprehensive and coordinated professional services, to ensure that youth receive individualized, therapeutic care. The Family-Based Foster Care Services Act of 2015 defines TFC as therapeutic foster care services for children under the age of 21 and who, as a result of mental illness, other emotional or behavioral disorders, medically fragile conditions, or developmental disabilities, require a level of care provided in an institution, but who can be cared for or maintained in a community placement. The 2015 act indicates that a qualified TFC program includes the following components: 1) structured daily activities, including developing, improving, monitoring, and reinforcing age-appropriate social, communication and behavioral skills; 2) trauma-informed and gender responsive services; 3) crisis intervention and crisis support services; 4) medication monitoring; 5) counseling and case management; and 6) other intensive community services. In addition, TFC programs should provide biological parents, kinship caregivers, and foster care parents with specialized training and consulting to manage children with mental illness, trauma, emotional or behavioral disorders, medically fragile conditions, or developmental disabilities. Programs should also address the impact of trauma on child and caregiver and offer additional training to meet the individual needs of each child receiving services (Canady, 2015).

In a recent evidence review of TFC conducted by Chapin Hall at the University of Chicago, 12 studies using a randomized controlled trial design published between 1991 and 2019 reported 45 outcomes related to the effectiveness of TFC on youth (such as alcohol and substance use, criminal activity and juvenile justice, problem behavior, social skills and function, strengths, mental health, placement stability, and permanency) and foster parents (such as parenting and caregiver stress). Comparison groups in these studies included youth in regular foster care (see Fisher & Kim, 2007) receiving usual caseworker services (see Chamberlain et al., 2008) or other usual care (see Price et al., 2015). The studies in this evidence review of TFC tended to focus on various youth outcomes (such as behavioral, mental health, placement, and permanency, among 43 outcomes) as opposed to caregiver outcomes (two outcomes). Most of the outcomes were measured using standardized measures (31

Studies in this evidence review of TFC tended to focus on **various youth outcomes (such as behavioral, mental health, placement, and permanency) as opposed to caregiver outcomes.**



outcomes were measured using standardized measures such as the Parent Daily Report Checklist and Behavioral and Emotional Rating Scale). Other outcomes were measured by official records/administrative data (six outcomes), nonstandardized scales (four outcomes), and observations (four outcomes; see Table 15).<sup>5</sup>

**Table 15. Forty-Five Outcomes Were Reported in the Selected Randomized Controlled Trial Studies (N=12) in Chapin Hall’s Evidence Review of TFC**

|  | Outcome Measure Type |                 |                      |             | Grand Total |
|--|----------------------|-----------------|----------------------|-------------|-------------|
|  | Observation          | Official Record | Standardized Measure | Other Scale |             |
| <b>Foster Parent Outcomes and Measures</b>   |                      |                 | <b>2</b>             |             | <b>2</b>    |
| <b>Caregiver stress</b>  |                      |                 |                      |             |             |
| PDR: Parent Daily Report Checklist   |                      |                 | 1                    |             | 1           |
| <b>Parenting</b>   |                      |                 |                      |             |             |
| PDR: Parent Daily Report Checklist   |                      |                 | 1                    |             | 1           |
| <b>Youth Outcomes and Measures</b>   | <b>4</b>             | <b>6</b>        | <b>29</b>            | <b>4</b>    | <b>43</b>   |
| <b>Alcohol and substance use</b>   |                      |                 |                      |             |             |
| Questionnaire  |                      |                 |                      | 4           | 4           |
| <b>Criminal activity and juvenile justice</b>  |                      |                 |                      |             |             |
| SRD: Self-Report Delinquency scale   |                      |                 | 2                    |             | 2           |
| <b>Permanency</b>  |                      |                 |                      |             |             |
| Parent report  | 2                    |                 |                      |             | 2           |
| Administrative data  |                      | 6               |                      |             | 6           |
| <b>Placement stability</b>   |                      |                 |                      |             |             |
| <i>(Measurement tool not available)</i>  | 2                    |                 |                      |             | 2           |
| <b>Problem behavior</b>  |                      |                 |                      |             |             |
| PAD: Parent Attachment Diary   |                      |                 | 2                    |             | 2           |
| PDR: Parent Daily Report Checklist   |                      |                 | 7                    |             | 7           |
| SDQ: Strengths and Difficulties Questionnaire  |                      |                 | 2                    |             | 2           |
| SRD: Self-Report Delinquency scale   |                      |                 | 1                    |             | 1           |
| SSIS: Social Skills Improvement System Rating Scale  |                      |                 | 3                    |             | 3           |
| <b>Social skills and function</b>  |                      |                 |                      |             |             |
| CAFAS: Child and Adolescent Functioning Assessment Scale (CAFAS); PECFAS: Preschool and Early Childhood Functional Scale |                      |                 | 3                    |             | 3           |
| Taxonomy of Problematic Social Situations (TOPS) for <12; Adolescent Problem Inventory (API) for 12 and older            |                      |                 | 1                    |             | 1           |
| <b>Strengths</b>   |                      |                 |                      |             |             |
| BERS: Behavioral and Emotional Rating Scale  |                      |                 | 2                    |             | 2           |
| PAD: Parent Attachment Diary   |                      |                 | 1                    |             | 1           |
| PDR: Parent Daily Report Checklist   |                      |                 | 1                    |             | 1           |
| SSIS: Social Skills Improvement System Rating Scale  |                      |                 | 3                    |             | 3           |
| <b>Mental health</b>   |                      |                 |                      |             |             |
| Brief Symptom Inventory (BSI), Global Symptom Index  |                      |                 | 1                    |             | 1           |
| <b>Grand Total</b>   | <b>4</b>             | <b>6</b>        | <b>31</b>            | <b>4</b>    | <b>45</b>   |

<sup>5</sup> In this rapid review, the Chapin Hall research team obtained and reviewed the full text of 160 records of TFC studies and identified 12 records reporting RCT studies on effectiveness of TFC. Further information on the scope of the rapid review, methods for selecting studies and extracting data, and findings are available upon request.

## Current Study

The Illinois Children and Family Services Act (Illinois Public Act 099-0350) requires that DCFS “implement a 5-year pilot program of multi-dimensional treatment foster care, or a substantially similar evidence-based program of professional foster care, for (i) children entering care with severe trauma histories, with the goal of returning the child home or maintaining the child in foster care instead of placing the child in congregate care or a more restrictive setting or placement, (ii) children who require placement in foster care when they are ready for discharge from a residential treatment facility, and (iii) children who are identified for residential or group home care and who, based on a determination made by the Department, could be placed in a foster home if higher level interventions are provided” (Illinois Children and Family Services Act, Public Act 099-0350).

Under the B.H. consent decree, DCFS is also required to arrange for an independent evaluation of the TFC pilot through its contract with Chapin Hall at the University of Chicago between July 1, 2016 and June 30, 2021. Staffing, training, and foster parent recruitment occurred in the first 7 months. TFC referrals officially began on February 1, 2017. The Pilot aimed to provide a home-based setting, TFC, to serve youth with a history of trauma or severe behavioral challenges who would otherwise enter or remain in residential care or be discharged from residential care to other non-TFC community-based settings.

During the five-year period, DCFS contracted with four purchase of service (POS) providers to implement the TFC Pilot—Children’s Home and Aid (CH+A), Jewish Children and Family Services (JCFS), Lutheran Social Services of Illinois (LSSI), and Youth Outreach Services (YOS)—to serve eligible children ages 6 to 17 in the Cook County, Aurora, and Rockford subregions. TFC was defined by the specific model a provider implemented (see Table 16). CH+A used the Therapeutic Crisis Intervention-Family (TCI-F) model (Nunno et al., 2003), JCFS used the Together Facing the Challenge model (Farmer et al., 2010), and both LSSI and YOS used the Therapeutic Foster Care Oregon (TFCO) model (Chamberlain et al., 2007). However, JCFS and YOS ended their participation in the TFC Pilot in April 2018 and May 2018, respectively. Since then, LSSI and CH+A had been the remaining active TFC providers. Beyond June 30, 2021, LSSI continued to implement TFCO outside the purview of the Pilot evaluation.

**Table 16. Summary of TFC Pilot Providers**

|   | CH+A | JCFS | LSSI | YOS |
|---|------|------|------|-----|
| <b>TFC evidence-based model</b>   |      |      |      |     |
| Together Facing the Challenge   |      | ○    |      |     |
| Therapeutic Foster Care Oregon (TFCO)   |      |      | ○    | ○   |
| Therapeutic Crisis Intervention – Family (TCI-F)                                    | ○    |      |      |     |
| <b>Trauma-informed intervention</b>   |      |      |      |     |
| Trauma-Focused Cognitive Behavioral Therapy (TF-CBT): Together Facing the Challenge |      | ○    |      |     |
| Trauma-informed TFCO and therapists trained in TF-CBT                               |      |      | ○    | ○   |
| All staff trained in both TFC evidence-based model and trauma-focused care          | ○    |      |      | ○   |
| Therapists providing TF-CBT   |      | ○    |      |     |
| <b>Subregion (child’s legal/home county)</b>  |      |      |      |     |
| Aurora (Kane, DuPage, Kendall, Will counties)                                       |      |      | ○    |     |
| Cook  | ○    | ○    | ○    | ○   |

|  | CH+A             | JCFS        | LSSI       | YOS        |
|--|------------------|-------------|------------|------------|
| Rockford (Boone, Ogle, Stephenson, Winnebago counties)   |                  |             | ○          |            |
| <b>Youth's age range (in years)</b>  |                  |             |            |            |
| 6-11   | ○                |             | ○          |            |
| 12-14  | ○                | ○           | ○          | ○          |
| 15-17  | ○                | ○           |            | ○          |
| <b>TFC caregiver</b>   |                  |             |            |            |
| Foster parent  |                  | ○           | ○          | ○          |
| Home of relative or home of parent   | ○                |             |            |            |
| <b>Anticipated length of program</b>   | Until permanency | 6–12 months | 6–9 months | 6–9 months |
| <b>Target population</b>   |                  |             |            |            |
| <b>1. Deflection:</b> Youth who need residential care but are not currently in residential care                          |                  | ○           | ○          | ○          |
| <b>2. Step-Down:</b> Youth who need residential care and are currently in residential care                               |                  | ○           | ○          | ○          |
| <b>3. Step-Down (CH+A):</b> Youth who are ready to step-down from residential care but are currently in residential care | ○                |             |            |            |

The TFC Pilot served three target populations:

- 1. Deflection:** Youth who were not in residential care at the time of TFC referral, though *were* indicated to need residential care based on the Child and Adolescent Service Intensity Instrument (CASII) assessment (CASII Level=5). JCFS, LSSI, and YOS served this target population.
- 2. Step-Down:** Youth who were in residential care at the time of TFC referral and *were* indicated to need residential care based on the CASII assessment (CASII Level=5). JCFS, LSSI, and YOS served this target population.
- 3. Step-Down (CH+A):** Youth who were in residential care at the time of TFC referral and were not indicated to need residential care and therefore deemed ready for discharge (on residential “Phase II” list). Only CH+A served this target population.

The TFC Pilot evaluation consisted of an output study and an outcome study. The output study examined activities and fidelity associated with the two TFC providers that implemented TFC during the entire Pilot period, CH+A and LSSI. The outcome study evaluated the three target populations separately. It focused on and compared the outcomes—safety, well-being, and permanency—between the three target populations and their counterparts of eligible TFC youth who did not receive TFC. This final evaluation report used information and data that covered the TFC Pilot period from the inception of TFC referrals on February 1, 2017 to June 30, 2021.

# METHOD

The TFC Pilot evaluation received approval from the DCFS Research Review Committee and the University of Chicago Social Services Administration-Chapin Hall Institutional Review Board.

## Sample

In this reporting period, between February 1, 2017 and June 30, 2021, a total of 93 unique youth were referred to, accepted, and placed in TFC offered by the four providers. As Table 17 shows, of these 93 youth, 52 youth were in the deflection intervention group, 28 youth in the step-down intervention group, and 13 youth in the step-down (CH+A) intervention group. Most youth in the deflection and step-down intervention groups were served by LSSI.

In the same period between February 1, 2017 and June 30, 2021, youth who were referred to but not placed in TFC comprised the comparison groups, provided they also met the comparison group criteria described in Table 17. The three comparison groups were comprised of 77 youth in the deflection comparison group (i.e., youth referred to TFC but placed in residential care), 27 youth in the step-down comparison group (i.e., youth referred to TFC but remained in residential care), and 12 youth in the step-down (CH+A) comparison group (i.e., youth referred to TFC but discharged from residential care to home of relative, home of fictive kin, specialized foster care, or adolescent foster care).

**Table 17. Distribution of Youth in the Three TFC Target Populations/Intervention Groups—Deflection, Step-down, Step-down (CH+A)—and Their Respective Comparison Groups from February 1, 2017 to June 30, 2021**

| TFC Target Population/Intervention Group   |   | TFC Comparison  |
|--|---|---|
| <b>1. Deflection</b> (need residential care but are not in residential care)   | TFC youth ( <i>n</i> =52) <ul style="list-style-type: none"> <li>LSSI (<i>n</i>=50)</li> <li>YOS (<i>n</i>=2)</li> </ul>                            | Referred to TFC but placed in residential care ( <i>n</i> =77)  |
| <b>2. Step-Down</b> (need residential care and are in residential care)  | TFC youth ( <i>n</i> =28) <ul style="list-style-type: none"> <li>JCFS (<i>n</i>=2)</li> <li>LSSI (<i>n</i>=24)</li> <li>YOS (<i>n</i>=2)</li> </ul> | Referred to TFC but remained in residential care ( <i>n</i> =27)  |
| <b>3. Step-Down (CH+A)</b> (in residential care but do not need residential care and are ready to step-down from residential care) | TFC youth at CH+A ( <i>n</i> =13)   | Referred to TFC but discharged from residential care to home of relative, home of fictive kin, specialized foster care, or adolescent foster care ( <i>n</i> =12) |
| <b>Total</b>   | <b>93</b>   | <b>116</b>  |

*Note.* Residential care is defined as paid GRH (Group Home) or IPA (Institution – Private Agency) and excluding shelters (that is, excluding service type codes 0221, 0222, 0223, 7221, 0000, N/A, or missing).

## Output Study

The output study uses program data tracked and provided by the four TFC providers to examine three groups of intervention outputs—capacity, fidelity to FFTA standards, and fidelity to program standards—as of June 30, 2021.

### TFC Capacity

TFC capacity outputs cover the period from February 1, 2017 to June 30, 2021 and include:

- Number of TFC referrals
- Number of TFC referral acceptances
- Number of unique youth ever placed in TFC
- Number of unique youth who completed/graduated from TFC
- Number of unique youth who disrupted/were not in TFC placement
- Number of unique youth who were in TFC placement
- Number of TFC inquiries from potential foster families
- Number of certified TFC homes
- Number of filled TFC homes

### TFC Fidelity to FFTA Standards

Family Focused Treatment Association (FFTA) standards (Foster Family-based Treatment Association, 2013) informed the TFC request for proposal when the TFC providers were selected. This report summarizes fidelity in the final 6 months of the TFC Pilot, between January 1, 2021 and June 30, 2021. We report fidelity data on the two active TFC providers, CH+A and LSSI, which provided narrative updates and relevant numbers on the following FFTA standards for the period from October 1, 2020 to June 30, 2021.

1. FFTA #10: Provide foster parents with at least 20 hours of preservice training and at least 24 annual hours of ongoing training. At their best, trainings are individualized to the specific needs and strengths of the foster parents.
2. FFTA #11: Provide supports for foster parents, including 24/7 crisis intervention, respite care, close (at least weekly) in-home supervision, parent support groups, and assistance in helping foster parents address their own needs and those of their own biological children.
3. FFTA #12: Consider and treat foster parents as full professional members of the treatment team.
4. FFTA #14: Emphasize the role of and frequently involve biological families in the TFC process.
5. FFTA #16: Provide for aftercare for TFC foster parents and biological families.
6. FFTA #18: Provide resources for independent and transitional living for older TFC-Enrolled youth.
7. FFTA #20: Frequently seek the input of TFC foster parents, biological families, children, and professional.
8. Trauma-Informed EBP requirement: Must include trauma-informed interventions in a model of TFC.

## TFC Fidelity to Intervention

We report fidelity data on the two active TFC providers, CH+A and LSSI. CH+A and LSSI follow different fidelity criteria unique to the model they use (TCI-F and TFCO, respectively). CH+A and LSSI provided narrative updates and relevant numbers on the following model-specific fidelity criteria for the final Pilot period from January 1 to June 30, 2021.

1. CH+A tracks fidelity regarding:
  - Therapeutic Crisis Intervention – Family (TCI-F)
  - Attachment, Self-Regulation, and Competency (ARC)
  - Excellence Academy
  
2. LSSI tracks fidelity to the Therapeutic Foster Care Oregon (TFCO) model regarding:
  - Criterion 1: Successful completion
  - Criterion 2: Therapy components
  - Criterion 3: Behavioral components
  - Criterion 4: Foster parent meetings
  - Criterion 5: Clinical team meetings
  - Criterion 6: Program staff
  - Criterion 7: Training

## Outcome Study

The outcome study uses a concurrent, non-randomized comparison group design. Specifically, the outcome study combines program data provided by the TFC providers (for example, data on TFC referrals or on youth placed in TFC) and DCFS administrative data, as of June 30, 2021 to examine outcomes associated with the three TFC intervention groups and their respective three TFC comparison groups that correspond to different target populations (see Table 2 and Table 17). Thus, the outcome study examines the three sets of intervention groups—deflection, step-down, and step-down (CH+A)—and their comparison groups separately. Since youth in the comparison groups are referred to but not placed in TFC, they still meet the same TFC eligibility criteria (such as age, geography, CASII Level, and other criteria) at the referral stage. Therefore, in practice the comparison groups are considered “matched” to their respective intervention groups.

The outcome study examines the following 13 outcomes: one proximal outcome, three intermediate outcomes, and nine distal outcomes (see detailed operationalization and hypotheses in Table 18):

### **Proximal Outcome (PO)**

**PO1:** Percentage of youth with one or more substantiated investigation

### **Intermediate Outcomes (IO)**

**IO1:** Percentage of discharge to home-based care

**IO2:** Percentage of discharge to permanency

**IO3:** Length of stay

## **Distal Outcomes (DO)**

**DO1:** Percentage of days in detention

**DO2:** Percentage of days in psychiatric hospital

**DO3:** Percentage of days in runaway

**DO4:** Change in school achievement Child and Adolescent Needs and Strengths (CANS) item score from baseline to follow-up

**DO5:** Change in traumatic stress symptoms CANS domain score from baseline to follow-up

**DO6:** Change in emotional/behavioral needs CANS domain score from baseline to follow-up

**DO7:** Change in risk behaviors CANS domain score from baseline to follow-up

**DO8:** Change in social functional behaviors CANS domain score from baseline to follow-up

**DO9:** Number of placement moves per day in care

All analyses for the outcome study are conducted using Stata 16.1 (StataCorp, 2019). To examine statistical significance of the outcome difference between the intervention groups and the comparison groups, we use the chi-square test of independence for PO1, IO1, and IO2; the two-sample t-test for the remaining outcomes: IO3, DO1, DO2, DO3, DO4, DO5, DO6, DO7, DO8, and DO9. We also use the chi-square test of independence to compare demographic differences between the intervention groups and the comparison groups.

**Table 18. Outcome Definitions and Hypotheses**

| Outcome   | Definition  | Hypothesis  |
|---|---|---|
| <b>Proximal Outcome (PO)</b>  |   |   |
| <b>PO1:</b> Percentage of youth with one or more substantiated investigation              | Defined by substantiated investigation during TFC (intervention groups) or during residential care (comparison groups), using report date of investigation.   | Intervention PO1 is lower than (<) Comparison PO1   |
| <b>Intermediate Outcomes (IO)</b>   |   |   |
| <b>IO1:</b> Percentage of discharge to home-based care                                    | Defined by the placement type of FHA (Foster Home Adoption), FHB (Foster Home Boarding), FHI (Foster Home Indian), FHP (Foster Home Boarding – Private Agency), FHS (Foster Home Specialized), FHT (Foster Home Therapeutic), HMP (Home of Parent), HMR (Home of Relative), HRA (Home of Relative Application), SGH (Subsidized Guardian Home), GDN (Guardian Successor), HFK (Home of Fictive Kin), EFC (Emergency Foster Care), PGH (Private Guardianship), HAP (Home of Adoptive Parent), TFH (Therapeutic Foster Home), DRA (Delegated Relative Authority), FHG (Foster Home Guardianship), FOS (Foster Home), or HRL (Home of Relative Licensed) that immediately follows the initial TFC placement (intervention groups) or residential care (comparison groups). | Intervention IO1 is higher than (>) Comparison IO1  |
| <b>IO2:</b> Percentage of discharge to permanency   | Defined by the end of a youth’s legal spell immediately following TFC (intervention groups) or residential care (comparison groups). Permanency exit includes reunification (a closed legal spell with a final placement type of HMP [Home of Parent]), adoption (a closed legal spell with a final placement type of HAP [Home of Adoptive Parent]), guardianship (a closed legal spell with a final placement type of PGH [Private Guardianship], SGH [Subsidized Guardian Home], GDN, or FHG [Foster Home Guardianship]), or living with relative (a closed legal spell with a final placement type of HMR [Home of Relative] or HFK [Home of Fictive Kin]).   | Intervention IO2 is higher than (>) Comparison IO2  |
| <b>IO3:</b> Length of stay  | Defined by number of days in TFC (intervention groups) or residential care (comparison groups).   | Intervention (deflection and step-down) IO3 is lower than (<) than Comparison IO3 because non-permanent TFC is intended to be a temporary placement.<br><br>Intervention (CH+A) IO3 is higher than (>) Comparison IO3 because CH+A TFC is a potentially permanent home. |
| <b>Distal Outcomes (DO)</b>   |   |   |
| <b>During TFC/residential care and within 6 months of TFC/residential care discharge:</b> |   |   |



| Outcome   | Definition  | Hypothesis  |
|---|---|---|
| <b>DO1:</b> Percentage of days in detention   | Defined by the placement type of DET (Detention).   | Intervention DO1 is lower than (<) Comparison DO1   |
| <b>DO2:</b> Percentage of days in psychiatric hospital                              | Defined by the placement type of HHF (Hospital/Healthcare Facility) or HFP (Hospital Facility Psychiatric).   | Intervention DO2 is lower than (<) Comparison DO2   |
| <b>DO3:</b> Percentage of days in runaway   | Defined by the placement type of RNY (Runaway), WCC (Whereabouts Unknown), WUK (Whereabouts Unknown), UAH (Unauthorized Home of Parent), UAP (Unauthorized Placement), or UNK (Unknown).  | Intervention DO3 is lower than (<) Comparison DO3   |
| <b>DO4:</b> Change in school achievement CANS item score from baseline to follow-up | <p>School achievement is defined by the school achievement item on the CANS. Each CANS item is rated on a scale of 0, 1, 2, or 3. A score of 2 or 3 indicates an “actionable” need. Thus, a higher CANS score indicates a greater level of need.</p> <p>Baseline CANS is defined by:</p> <ul style="list-style-type: none"> <li>- the most recent CANS prior to and within 90 days of TFC placement date (intervention groups), TFC referral date (step-down comparison group), or residential care placement date (deflection comparison group and step-down [CH+A] comparison group); <u>OR</u></li> <li>- the CANS closest to and within 30 days after TFC placement date (intervention groups), TFC referral date (step-down comparison group), or residential care placement date (deflection comparison group and step-down [CH+A] comparison group).</li> </ul> <p>If a youth has more than 1 baseline CANS that meet both of the above criteria, we select the CANS with the smallest absolute number of days from the TFC placement date (intervention groups), TFC referral date (step-down comparison group), or residential care placement date (deflection comparison group and step-down [CH+A] comparison group).</p> <p>Follow-up CANS is defined by the CANS closest to the 6-month point after TFC placement date (intervention groups), TFC referral date (step-down comparison group), or residential care placement date (deflection comparison group and step-down [CH+A] comparison group). If a youth has more than 1 follow-up CANS that meet this criterion (for example, 1 CANS 10 days before the 6-month point and 1 CANS 10 days after the 6-month point), we select the most current CANS.</p> | Intervention DO4—follow-up score minus baseline score—is negative and the magnitude, or absolute difference, is greater than (>) Comparison DO4 |

| Outcome   | Definition   | Hypothesis  |
|---|--|---|
| <b>DO5:</b> Change in traumatic stress symptoms CANS domain score from baseline to follow-up  | <p>Only youth with both a baseline CANS and a follow-up CANS are included in the CANS analysis.</p> <p>Change from baseline to follow-up is defined as the follow-up CANS score on the school achievement item minus the baseline CANS score on the school achievement item. Thus, a negative difference indicates improvement and a positive difference indicates an increase in severity.</p> <p>Traumatic stress symptoms are defined by the average score of six CANS items: adjustment to trauma, traumatic grief/separation, re-experiencing, avoidance, numbing, and dissociation. Each CANS item is rated on a scale of 0, 1, 2, or 3. A score of 2 or 3 indicates an “actionable” need. Thus, a higher CANS score indicates a greater level of need.</p>  | <p>Intervention DO5—follow-up score minus baseline score—is negative and the magnitude, or absolute difference, is greater than (&gt;)<br/>Comparison DO5</p> |
| <b>DO6:</b> Change in emotional/behavioral needs CANS domain score from baseline to follow-up | <p>See <b>DO4</b> above for definitions of baseline CANS and follow-up CANS.</p> <p>Only youth with both a baseline CANS and a follow-up CANS are included in the CANS analysis. Change from baseline to follow-up is defined as the average follow-up CANS traumatic stress symptoms score minus the average baseline CANS traumatic stress symptom score. Thus, a negative difference indicates improvement and a positive difference indicates an increase in severity.</p> <p>Emotional/behavioral needs are defined by the average score of 13 CANS items: psychosis, attention deficit/impulse control, depression, anxiety, oppositional behavior, conduct, substance abuse, attachment difficulties, eating disturbances, affect dysregulation, behavioral regressions, somatization, and anger control. Each CANS item is rated on a scale of 0, 1, 2, or 3. A score of 2 or 3 indicates an “actionable” need. Thus, a higher CANS score indicates a greater level of need.</p> | <p>Intervention DO6—follow-up score minus baseline score—is negative and the magnitude, or absolute difference, is greater than (&gt;)<br/>Comparison DO6</p> |
|   | <p>See <b>DO4</b> above for definitions of baseline CANS and follow-up CANS.</p> <p>Only youth with both a baseline CANS and a follow-up CANS are included in the CANS analysis. Change from baseline to follow-up is defined as the average follow-up CANS emotional/behavioral needs score minus the average baseline CANS emotional/behavioral needs score. Thus, a negative difference indicates improvement and a positive difference indicates an increase in severity.</p>  |   |

| Outcome  | Definition  | Hypothesis  |
|--|---|---|
| <b>DO7:</b> Change in risk behaviors CANS domain score from baseline to follow-up              | <p>Risk behaviors are defined by the average score of 10 CANS items: suicide risk, self-mutilation, other self-harm, danger to others, sexual aggression, runaway, delinquency, judgment, fire-setting, and sexually reactive behavior. Each CANS item is rated on a scale of 0, 1, 2, or 3. A score of 2 or 3 indicates an “actionable” need. Thus, a higher CANS score indicates a greater level of need.</p> <p>See <b>DO4</b> above for definitions of baseline CANS and follow-up CANS.</p> <p>Only youth with both a baseline CANS and a follow-up CANS are included in the CANS analysis. Change from baseline to follow-up is defined as the average follow-up CANS risk behaviors score minus the average baseline CANS risk behaviors score. Thus, a negative difference indicates improvement and a positive difference indicates an increase in severity.</p> | <p>Intervention DO7—follow-up score minus baseline score—is negative and the magnitude, or absolute difference, is greater than (&gt;)<br/>Comparison DO7</p> |
| <b>DO8:</b> Change in social functional behaviors CANS domain score from baseline to follow-up | <p>Social functional behaviors are defined by the average score of three CANS items: social functioning, school behavior, and social behavior. Each CANS item is rated on a scale of 0, 1, 2, or 3. A score of 2 or 3 indicates an “actionable” need. Thus, a higher CANS score indicates a greater level of need.</p> <p>See <b>DO4</b> above for definitions of baseline CANS and follow-up CANS.</p> <p>Only youth with both a baseline CANS and a follow-up CANS are included in the CANS analysis. Change from baseline to follow-up is defined as the average follow-up CANS social functional behaviors score minus the average baseline CANS social functional behaviors score. Thus, a negative difference indicates improvement and a positive difference indicates an increase in severity.</p>  | <p>Intervention DO8—follow-up score minus baseline score—is negative and the magnitude, or absolute difference, is greater than (&gt;)<br/>Comparison DO8</p> |
| <b>Within 6 months of TFC/residential care discharge:</b>                                      |   |   |
| <b>DO9:</b> Number of placement moves per day in care  | <p>Placement moves are considered for three placement groups:</p> <ul style="list-style-type: none"> <li>- Foster Group: DRA (Delegated Relative Authority), FHA (Foster Home Adoption), FHB (Foster Home Boarding), FHG (Foster Home Guardianship), FHI (Foster Home Indian), FHP (Foster Home Boarding – Private Agency), FHS (Foster Home Specialized), FOS (Foster Home), HFK (Home of Fictive Kin), HMR (Home of Relative), HRA (Home of Relative Applicant), HRL (Home of Relative Licensed), TFH (Therapeutic Foster Home), EFC (Emergency Foster Care)</li> </ul>   | <p>Intervention DO9 is lower than (&lt;)<br/>Comparison DO9</p>   |

| Outcome | Definition  | Hypothesis |
|---------|---|------------|
|         | <ul style="list-style-type: none"> <li>- Independent Living Group: ASD (Abducted), CUS (College/University Scholarship), ILO (Independent Living Only), IND (Independent Living), JTP (Job Training Program), SEY (Supporting Emancipated Youth), TLP (Transitional Living Program), YIC (Youth In College), YIE (Youth In Employment)</li> <li>- Residential Group: GRH (Group Home), IPA (Institution – Private Child Care Facility) with a non-missing service type code not equal to 0221, 0222, 0223, 7221</li> </ul> <p>Moves within the same placement group are not considered moves if any of the following conditions are true:</p> <ul style="list-style-type: none"> <li>- Open code is AA (Adoption Assistance)</li> <li>- Event = End event &amp; Provider ID = End provider ID or 000000 or is missing</li> <li>- Event = 000 (beginning of a case)</li> <li>- End event = ZZZ (end of a case or CEN [Censored, whereby the case was still open as of June 30, 2021])</li> </ul> |            |

# RESULTS

## Sample

The three intervention groups and their respective comparison groups were demographically comparable (see Table 19). Youth did not differ significantly in the distribution of age, race, and gender between the deflection intervention group and the deflection comparison group, or between the step-down (CH+A) intervention group and the step-down (CH+A) comparison group. Youth in the step-down intervention group and the step-down comparison group were similar in age and gender, though the former had a higher percentage of Black youth (75.0% vs. 44.4%,  $p < .05$ ).

**Table 19. Demographic Comparisons of the Three TFC Target Population/intervention Groups—Deflection, Step-down, Step-down (CH+A)—and Their Respective Comparison Groups**

|                            | Deflection             |                      |      | Step-Down              |                      |      | Step-Down (CH+A)       |                      |      |
|----------------------------|------------------------|----------------------|------|------------------------|----------------------|------|------------------------|----------------------|------|
|                            | Intervention<br>(n=52) | Comparison<br>(n=77) | p    | Intervention<br>(n=28) | Comparison<br>(n=27) | p    | Intervention<br>(n=13) | Comparison<br>(n=12) | p    |
| <b>Age at TFC referral</b> |                        |                      | n.s. |                        |                      | n.s. |                        |                      | n.s. |
| 0–5 (%)                    | 3.9                    | 0.0                  |      | 7.1                    | 0.0                  |      | 0.0                    | 0.0                  |      |
| 6–11 (%)                   | 65.4                   | 68.8                 |      | 53.6                   | 44.4                 |      | 46.1                   | 50.0                 |      |
| ≥12 (%)                    | 30.8                   | 31.2                 |      | 39.3                   | 56.6                 |      | 53.9                   | 50.0                 |      |
| <b>Race</b>                |                        |                      | n.s. |                        |                      | *    |                        |                      | n.s. |
| White (%)                  | 40.4                   | 22.1                 |      | 25.0                   | 48.2                 |      | 30.8                   | 33.3                 |      |
| Black (%)                  | 59.6                   | 75.3                 |      | 75.0                   | 44.4                 |      | 69.2                   | 66.7                 |      |
| Other (%)                  | 0.0                    | 2.6                  |      | 0.0                    | 7.4                  |      | 0.0                    | 0.0                  |      |
| <b>Gender</b>              |                        |                      | n.s. |                        |                      | n.s. |                        |                      | n.s. |
| Female (%)                 | 48.1                   | 50.7                 |      | 32.1                   | 48.2                 |      | 30.8                   | 66.7                 |      |
| Male (%)                   | 51.9                   | 49.3                 |      | 67.9                   | 51.8                 |      | 69.2                   | 33.3                 |      |

Note. n.s.=Not significant; \* $p < .05$ .

## Output Study

### TFC Capacity

Of the TFC-certified homes in LSSI, **26 were active and 20 of them (76.9%) were filled** as of June 30, 2021.

From February 1, 2017 to June 30, 2021, there were 367 TFC referrals, 141 TFC referral acceptances, and 93 unique youth ever placed in TFC. Of the unique youth ever placed, 39 youth completed/graduated from TFC, 28 youth were disrupted/were not in TFC, and 20 youth remained in TFC placement. In this reporting period, the TFC Pilot fielded 573 TFC inquiries from potential families and certified 43 homes. Of the certified homes, 26 were active and 20 of them (76.9%) were filled as of June 30, 2021. Table 20 further shows the provider breakdown of these capacity outputs.

**Table 20. TFC Capacity from February 1, 2017 to June 30, 2021**

| <b>Output</b>   | <b>CH+A</b> | <b>JCFS</b> | <b>LSSI</b>   | <b>YOS</b> | <b>Total</b>         |
|---|-------------|-------------|---------------|------------|----------------------|
| Number of TFC referrals (row %)   | 59 (16.1%)  | 4 (1.1%)    | 288 (78.5%)   | 16 (4.3%)  | <b>367 (100.0%)</b>  |
| Number of TFC referral acceptances, which may or may not result in TFC placement (row %)        | 25 (17.7%)  | 2 (1.4%)    | 109 (77.3%)   | 5 (3.6%)   | <b>141 (100.0%)</b>  |
| Number of unique youth ever placed in TFC (row %)   | 13 (15.6%)  | 2 (2.4%)    | 74 (89.2%)    | 4 (4.8%)   | <b>93 (100.0%)</b>   |
| Age < 12 at TFC placement date (column %)   | 5 (38.5%)   | 0 (0.0%)    | 53 (71.6%)    | 0 (0.0%)   | <b>58 (62.4%)</b>    |
| Age ≥ 12 at TFC placement date (column %)   | 8 (61.5%)   | 2 (100.0%)  | 21 (28.4%)    | 4 (100.0%) | <b>35 (37.6%)</b>    |
| Number of unique youth who completed/graduated from TFC (row %)                                 | 1 (2.6%)    | 0 (0.0%)    | 36 (92.3%)    | 2 (5.1%)   | <b>39 (100.0%)</b>   |
| Number of unique youth who were disrupted/were not in TFC placement as of June 30, 2021 (row %) | 10 (29.4%)  | 2 (5.9%)    | 20 (58.8%)    | 2 (5.9%)   | <b>34 (100.0%)</b>   |
| Number of unique youth who were in TFC placement as of June 30, 2021 (row %)                    | 2 (10.0%)   | 0 (0.0%)    | 18 (90.0%)    | 0 (0.0%)   | <b>20 (100.0%)</b>   |
| Number of TFC inquiries from potential foster families (row %)                                  | N/A         | 46 (7.5%)   | 475 (77.5%)   | 92 (15.0%) | <b>613 (100.0%)</b>  |
| Number of certified TFC homes   | N/A         | 3 (6.0%)    | 43 (86.0%)    | 4 (8.0%)   | <b>50 (100.0%)</b>   |
| Filled TFC homes  | N/A         | N/A         | 20/26 (76.9%) | N/A        | <b>20/26 (76.9%)</b> |

Note. CH+A used potential permanent home of relative or home of parent and therefore did not track TFC inquiries or certified homes. JCFS and YOS discontinued participation in the TFC Pilot and therefore did not have filled TFC homes.

## TFC Fidelity to FFTA

CH+A and LSSI provided fidelity data to select FFTA standards for the final Pilot period from January 1 to June 30, 2021, as detailed in Table 21. In summary, LSSI met the minimum training hours for TFC foster parents (FFTA #10) while CH+A did not because no new caregivers joined the Pilot. Both CH+A and LSSI reported 24-hour on-call availability. LSSI reported weekly home visits completed. CH+A reported phone/virtual contact with youth and families (FFTA #11). TFC foster parent participation in weekly meetings remains high at LSSI; half of the TFC cases participated in child and family team meetings (FFTA #12). Biological parents were engaged in LSSI team meetings when engaged in the youth's case more broadly; no biological parents participated in the CH+A team meetings during this period (FFTA #14). LSSI provided aftercare support to youth. Three CH+A youth continued to receive services in Specialized Foster Care (FFTA #16). At CH+A, the Ansell-Casey Life Skills Assessment was conducted but was not tracked because a file review did not take place due to the COVID-19 pandemic (FFTA #18). Both CH+A and LSSI reported parent attendance in child and family team meetings (FFTA #20). LSSI used TF-CBT coaching/consultation (trauma-informed EBP). At CH+A, no additional coaching/consultation took place while regular case management visits continued during this reporting period.

**Table 21. TFC Fidelity to Select FFTA Standards from January 1 to June 30, 2021**

| FFTA Standard  | CH+A  | LSSI   |
|--|---|--|
| <b>FFTA #10:</b> Provide foster parents with at least 20 hours of preservice training and at least 24 annual hours of ongoing training. At best, trainings are individualized to the specific needs and strengths of the foster parents  | No new caregivers became licensed during this reporting period due to the closing of the program. One parent has been working to obtain a relative license.   | Families complete an average of 42 hours of training, with 12 focused on TFCO. Six new TFC families received TFCO-C (Childhood) training during this reporting period and five families became TFC families.<br><br>Average of 1.5 hours/week of annual ongoing training for foster families completed.  |
| <b>FFTA #11:</b> Provide supports for foster parents including 24/7 crisis intervention, respite care, close (at least weekly) in-home supervision, parent support groups, and assistance in helping foster parent(s) address their own needs and those of their own biological children | TFC team has 24-hour on-call availability. All calls were routed through the CH+A on-call line. There were no calls during this reporting period.<br><br>No respite requests have been fulfilled for youth in placement. Four youth remained in the program.<br><br>Due to the COVID-19 pandemic, the agency has been in contact with youth and families through a total of 55 visits (11 virtual and 44 in-person) for 4 youth during this reporting period.<br><br>No support groups occurred in this reporting period. The Family Support Specialist, Excellence Academy | TFC team has 24-hour on-call availability.<br><br>Completed 100.0% (716/716) of visits, averaging 1.9 visits by a team member per week per child.<br><br>85.4% (88/103) of foster parents attended 1.5-hour weekly meetings convened this reporting period.<br><br>100% (2,865/2,865) of possible Parent Daily Report (PDR) calls initiated. PDR calls are expected daily in the TFCO model. |

| FFTA Standard  | CH+A   | LSSI   |
|--|--|--|
|  | staff, and case managers worked with the families one-on-one.  |  |
| <b>FFTA #12:</b> Consider and treat foster parent(s) as full professional members of the treatment team            | <p>50.0% (2/4) of the TFC cases participated in Child and Family Team Meetings during this reporting period.</p> <p>No DCFS Educational Surrogate training took place during this reporting period.</p> <p>No educational advocacy training took place during this reporting period.</p> | <p>74.1% (280/378) foster parent attendance in weekly team meetings has been tracked.</p> <p>99.4% (2,848/2,865) of PDR calls initiated were completed with the foster parents (17 calls went unanswered).</p>   |
| <b>FFTA #14:</b> Emphasize the role of and frequently involve biological families in the TFC process               | No biological parents participated in Child and Family Team Meetings during this reporting period. All four youth have a goal of termination of parental rights, adoption, or independence.  | <p>143 of 293 (48.8%) possible family therapy sessions delivered with 76.9% of youth served having an identified aftercare family as some point in TFC. Of the 15 youth at the end of the reporting period, 12 (75.0%) have an identified aftercare family.</p> <p>19 of 33 (57.6%) possible Child and Family Team Meetings were held. Of these meetings, 52.6% (10/19) had biological parent participation.</p> |
| <b>FFTA #16:</b> Provide for aftercare for TFC foster parent(s) and biological families                            | Three cases will continue in Specialized Foster Care to receive services. One youth was placed in a transitional living program on July 1, 2021.   | 100.0% (6/6) of youth successfully completed the program in this reporting period and staff supported the aftercare families.  |
| <b>FFTA #18:</b> Provide resources for independent and transitional living for older TFC-enrolled youth            | CH+A did not track this metric in this reporting period: The Ansell-Casey assessment was conducted but a file review could not take place due to the COVID-19 pandemic.  | N/A  |
| <b>FFTA #20:</b> Frequently seek the input of TFC foster parents, biological families, children, and professionals | 25.0% (2/8) Child and Family Team Meetings took place during this reporting period.  | <p>87.4% (90/103) of weekly team meetings completed.</p> <p>100.0% (716/716) of weekly in-home visits by TFCA team member completed, averaging 1.9 visits by a team member per week per child.</p>   |



| FFTA Standard  | CH+A  | LSSI  |
|--|---|---|
| <b>Trauma-Informed EBP requirement:</b> Must include trauma-informed interventions in model of therapeutic foster care | No additional training or consultation took place during this reporting period. Regular case management visits continued. | 46.2% (12/26) of youth had Child and Family Team Meetings completed. Four of these youth had two Child and Family Team Meetings. One youth had four Child and Family Team Meetings. The Aurora 1 Team became certified on May 12, 2021. The Chicago 2 Team submitted the certification application on July 2, 2021. |

## TFC Fidelity to Intervention

For the period from January 1 to June 30, 2021, Table 22 details CH+A's fidelity to TCI-F, ARC, and the Excellence Academy.

**Table 22. CH+A: Fidelity to TCI-F, ARC, and the Excellence Academy for the Period from January 1 to June 30, 2021**

| Program                   | Report   |
|---------------------------|--|
| <b>TCI-F</b>              | Due to the closing of the program, no coaching or training occurred during this reporting period.  |
| <b>ARC</b>                | Due to the closing of the program, no weekly coaching sessions occurred during this reporting period.  |
| <b>Excellence Academy</b> | Of the nine youth under the TFC/Excellence Academy contract, seven youth were actively involved in the Excellence Academy service. Two of the youth were hospitalized in a residential setting. Excellence Academy provided biweekly mentoring sessions for youth and families who agreed to have workers come to the home. Excellence Academy discontinued online (Zoom) sessions and hosted in-person sessions on Monday–Friday after school or based on youth availability. |

Table 23 details LSSI’s fidelity to the TFCO model. For CH+A, the Excellence Academy sessions were provided to youth and families, while no TCI-F coaching or training occurred due to the closing of the program. For LSSI, all of the TFCO criteria were either completed or in progress.

**Table 23. LSSI: Fidelity to the TFCO model, for the Period from January 1 to June 30, 2021**

| <b>Criterion</b>                                  | <b>Report</b>   |
|---|---|
| <b>Criterion 1:<br/>Successful Completion</b>     | <p>Six youth successfully graduated from the program during this time period, spending 11.6 months in treatment. Treatment spells ranged from 5.4 months to 18.6 months. Of these six youth, five were discharged to kin or fictive kin, including one to the youth’s mother. The last youth stayed in their TFC home and was adopted.</p> <p>Four youth were unsuccessfully discharged without completing treatment into residential care.</p> <p>16 youth remained in TFCO placement as of June 30, 2021.</p> |
| <b>Criterion 2:<br/>Therapy Components</b>        | <p>65.1% (246/378) of individual therapy sessions were delivered.</p> <p>59.8% (226/378) of skills coaching sessions were delivered.</p> <p>48.8% (143/293) of family therapy sessions were delivered, with 76.9% of youth served having an identified aftercare family.</p> <p>75.0% (12/16) of youth in the program at the end of the reporting period have an identified aftercare family.</p>   |
| <b>Criterion 3:<br/>Behavioral<br/>Components</b> | <p>100.0% (26/26) of youth had/have behavior charts and school cards.</p> <p><i>Note:</i> This reporting period has been under the COVID-19 pandemic with many children finishing the school year remotely or in a hybrid model. Team Leaders have modified school cards with guidance from the developers.</p>   |
| <b>Criterion 4:<br/>Foster Parent Meetings</b>    | <p>85.4% (88/103) of foster parent meetings (virtual) were held.</p>  |
| <b>Criterion 5:<br/>Clinical Team Meetings</b>    | <p>87.4% (90/103) of weekly clinical meetings (virtual) were held.</p>  |
| <b>Criterion 6:<br/>Program Staff</b>             | <p>Program staff checklist completed with all current staff.</p>  |
| <b>Criterion 7:<br/>Training</b>                  | <p>100% of team members and leadership staff have participated in initial training activities. Three teams turned over Skills Coaches during this reporting period. A TFCO-C Clinical training was held in May 2021 with three therapists attending, which brought the program up to all staff fully trained.</p>   |

## Outcome Study

**Three** of the significant outcome comparisons favored the intervention groups. **Two** favored the comparison group.

Table 24 summarizes results of the outcome study with respect to the hypothesized effect of the TFC interventions on the 13 outcomes. Overall, of all 39 statistical comparisons (13 comparisons per deflection/step-down/step-down [CH+A]), only five comparisons yielded statistical significance. Three of the significant comparisons favored the intervention groups (IO1 for the deflection intervention and step-down intervention groups; IO3 for the deflection intervention group). Two favored the comparison group (DO2 and DO9 for the deflection comparison group). Of the remaining 34 non-statistically significant comparisons, 16 comparisons favored the intervention groups, 13 favored the comparison groups, five comparisons yielded no difference between the intervention groups and the comparison groups. Below we describe results of the outcome study separately for the deflection group, the step-down group, and the step-down (CH+A) group (see Table 25).

**Table 24. Summary of Outcome Comparisons between TFC Intervention Groups (Deflection, Step-down, and Step-down (CH+A)) and Their Comparison Groups as of June 30, 2021**

| Outcome   | Hypothesized Outcome Difference between Intervention and Comparison (< or >) | TFC Deflection (n=52) vs. Deflection Comparison (n=77) | TFC Step-Down (n=28) vs. Step-Down Comparison (n=27) | Step-Down (CH+A) (n=13) vs. Step-Down (CH+A) Comparison (n=12) |
|---|--|--|--|--|
| <b>Proximal Outcome (PO)</b>  |  |  |  |  |
| <b>PO1:</b> Percentage of youth with at least one substantiated investigation | Intervention < Comparison  | ✓<br>(consistent with hypothesis; n.s.)                | ⊗<br>(inconsistent with hypothesis; n.s.)            | No difference (n.s.)   |
| <b>Intermediate Outcomes (IO)</b>   |  |  |  |  |
| <b>IO1:</b> Percentage discharged to home-based care                          | Intervention > Comparison  | ✓***   | ✓*   | ⊗ (n.s.)   |
| <b>IO2:</b> Percentage discharged to permanency                               | Intervention > Comparison  | ✓ (n.s.)   | ⊗ (n.s.)   | ✓ (n.s.)   |

| <b>Outcome</b>   | <b>Hypothesized Outcome Difference between Intervention and Comparison (&lt; or &gt;)</b>       | <b>TFC Deflection (n=52) vs. Deflection Comparison (n=77)</b> | <b>TFC Step-Down (n=28) vs. Step-Down Comparison (n=27)</b> | <b>Step-Down (CH+A) (n=13) vs. Step-Down (CH+A) Comparison (n=12)</b> |
|--|---|---|---|---|
| <b>IO3:</b> Length of stay   | Intervention < Comparison (deflection and step-down)  | √***  | √ (n.s.)  | ⊗ (n.s.)  |
|  | Intervention > Comparison (CH+A)  |   |   |   |
| <b>Distal Outcomes (DO)</b>  |   |   |   |   |
| <b>During TFC/residential care and within six months of TFC/residential care discharge:</b>    |   |   |   |   |
| <b>DO1:</b> Percentage of days in detention  | Intervention < Comparison   | ⊗ (n.s.)  | √ (n.s.)  | √ (n.s.)  |
| <b>DO2:</b> Percentage of days in psychiatric hospital   | Intervention < Comparison   | ⊗***  | ⊗ (n.s.)  | √ (n.s.)  |
| <b>DO3:</b> Percentage of days in runaway  | Intervention < Comparison   | √ (n.s.)  | √ (n.s.)  | √ (n.s.)  |
| <b>DO4:</b> Change in school achievement CANS item score from baseline to follow-up            | Intervention follow-up score minus baseline score is negative and the magnitude is > Comparison | √ (n.s.)  | ⊗ (n.s.)  | No difference (n.s.)  |
| <b>DO5:</b> Change in traumatic stress symptoms CANS domain score from baseline to follow-up   | Intervention follow-up score minus baseline score is negative and the magnitude is > Comparison | √ (n.s.)  | No difference (n.s.)  | √ (n.s.)  |
| <b>DO6:</b> Change in emotional/behavioral needs CANS domain score from baseline to follow-up  | Intervention follow-up score minus baseline score is negative and the magnitude is > Comparison | ⊗ (n.s.)  | ⊗ (n.s.)  | √ (n.s.)  |
| <b>DO7:</b> Change in risk behaviors CANS domain score from baseline to follow-up              | Intervention follow-up score minus baseline score is negative and the magnitude is > Comparison | No difference (n.s.)  | ⊗ (n.s.)  | No difference (n.s.)  |
| <b>DO8:</b> Change in social functional behaviors CANS domain score from baseline to follow-up | Intervention follow-up score minus baseline score is negative and the magnitude is > Comparison | ⊗ (n.s.)  | ⊗ (n.s.)  | ⊗ (n.s.)  |
| <b>Within six months of TFC/residential care discharge:</b>                                    |   |   |   |   |

| Outcome  | Hypothesized Outcome Difference between Intervention and Comparison (< or >) | TFC Deflection (n=52) vs. Deflection Comparison (n=77) | TFC Step-Down (n=28) vs. Step-Down Comparison (n=27) | Step-Down (CH+A) (n=13) vs. Step-Down (CH+A) Comparison (n=12) |
|--|--|--|--|--|
| DO9: Number of placement moves per day in care | Intervention < Comparison  | ∞**  | √ (n.s.)   | √ (n.s.)   |

Note. "√" denotes outcome difference between intervention and comparison that is consistent with the hypothesis; "∞" denotes outcome difference between intervention and comparison that is inconsistent with the hypothesis. n.s.=Not significant; \* $p < .05$ ; \*\* $p < .01$ ; \*\*\* $p < .001$ .

**Table 25. Outcome Comparisons between TFC Intervention Groups (Deflection, Step-down, Step-down (CH+A)) and Their Comparison Groups as of June 30, 2021**

| Outcome   | TFC Deflection             |                            |          | TFC Step-Down              |                            |          | TFC Step-Down (CH+A)       |                            |          |
|---|----------------------------|----------------------------|----------|----------------------------|----------------------------|----------|----------------------------|----------------------------|----------|
|   | Intervention (n=52)        | Comparison (n=77)          | <i>p</i> | Intervention (n=28)        | Comparison (n=27)          | <i>p</i> | Intervention (n=13)        | Comparison (n=12)          | <i>p</i> |
| <b>Proximal Outcome (PO)</b>  |                            |                            |          |                            |                            |          |                            |                            |          |
| PO1: Percentage of youth with one or more substantiated investigation | 0.0                        | 6.5                        | n.s.     | 7.1                        | 0.0                        | n.s.     | 0.0                        | 0.0                        | n.s.     |
| <b>Intermediate Outcomes (IO)</b>                                     |                            |                            |          |                            |                            |          |                            |                            |          |
| IO1: Percentage of discharge to family and fictive kin caregivers     | 69.2                       | 32.5                       | ***      | 67.9                       | 40.7                       | *        | 53.9                       | 66.7                       | n.s.     |
| IO2: Percentage of discharge to permanency                            | 5.8                        | 5.2                        | n.s.     | 0.0                        | 11.1                       | n.s.     | 15.4                       | 8.3                        | n.s.     |
| IO3: Mean length of stay (SD)   | 262.8 days (SD=196.4 days) | 507.4 days (SD=333.8 days) | ***      | 241.3 days (SD=179.7 days) | 269.0 days (SD=205.9 days) | n.s.     | 184.3 days (SD=105.6 days) | 275.4 days (SD=240.3 days) | n.s.     |

**Distal Outcomes (DO)**

During TFC/residential care and within 6 months of TFC/residential care discharge:

| Outcome   | TFC Deflection         |                      |          | TFC Step-Down          |                      |          | TFC Step-Down (CH+A)   |                      |          |
|---|------------------------|----------------------|----------|------------------------|----------------------|----------|------------------------|----------------------|----------|
|   | Intervention<br>(n=52) | Comparison<br>(n=77) | <i>p</i> | Intervention<br>(n=28) | Comparison<br>(n=27) | <i>p</i> | Intervention<br>(n=13) | Comparison<br>(n=12) | <i>p</i> |
| <b>DO1:</b> Percentage of days in detention (SD)  | 1.7(SD=12.4%)          | 0.0<br>(SD=0.1%)     | n.s.     | 0.0<br>(SD=0.0%)       | 0.9<br>(SD=2.9%)     | n.s.     | 1.3<br>(SD=4.7%)       | 2.9<br>(SD=10.0%)    | n.s.     |
| <b>DO2:</b> Percentage of days in psychiatric hospital (SD)                                   | 7.5<br>(SD=11.2%)      | 0.8<br>(SD=2.2%)     | ***      | 8.9<br>(SD=14.8%)      | 4.8<br>(SD=13.5%)    | n.s.     | 6.1<br>(SD=10.9%)      | 6.7<br>(SD=12.4%)    | n.s.     |
| <b>DO3:</b> Percentage of days in runaway (SD)  | 0.3<br>(SD=1.3%)       | 1.0<br>(SD=3.9%)     | n.s.     | 0.7<br>(SD=3.7%)       | 1.4<br>(SD=5.6%)     | n.s.     | 0.6<br>(SD=1.7%)       | 1.0<br>(SD=2.4%)     | n.s.     |
| <b>DO4:</b> Change in school achievement CANS item score from baseline to follow-up           |                        |                      |          |                        |                      |          |                        |                      |          |
| <i>n</i>  | 15                     | 19                   |          | 5                      | 8                    |          | 5                      | 5                    |          |
| Mean difference (SD):<br>Follow-up score minus baseline score                                 | -0.6 (SD=1.3)          | -0.4 (SD=1.0)        | n.s.     | 0.0 (SD=1.0)           | -0.4 (SD=1.1)        | n.s.     | +0.2 (SD=1.5)          | +0.2 (SD=0.8)        | n.s.     |
| <b>DO5:</b> Change in traumatic stress symptoms CANS domain score from baseline to follow-up  |                        |                      |          |                        |                      |          |                        |                      |          |
| <i>n</i>  | 16                     | 19                   |          | 5                      | 8                    |          | 5                      | 5                    |          |
| Mean difference (SD):<br>Follow-up score minus baseline score                                 | -0.2 (SD=0.4)          | -0.0 (SD=0.5)        | n.s.     | -0.3 (SD=1.0)          | -0.3 (SD=0.5)        | n.s.     | -0.1 (SD=0.7)          | -0.0 (SD=0.4)        | n.s.     |
| <b>DO6:</b> Change in emotional/behavioral needs CANS domain score from baseline to follow-up |                        |                      |          |                        |                      |          |                        |                      |          |
| <i>n</i>  | 32                     | 48                   |          | 15                     | 15                   |          | 8                      | 8                    |          |

| Outcome   | TFC Deflection         |                      |          | TFC Step-Down          |                      |          | TFC Step-Down (CH+A)   |                      |          |
|---|------------------------|----------------------|----------|------------------------|----------------------|----------|------------------------|----------------------|----------|
|   | Intervention<br>(n=52) | Comparison<br>(n=77) | <i>p</i> | Intervention<br>(n=28) | Comparison<br>(n=27) | <i>p</i> | Intervention<br>(n=13) | Comparison<br>(n=12) | <i>p</i> |
| Mean difference (SD):<br>Follow-up score minus<br>baseline score  | +0.0 (SD=0.5)          | -0.1 (SD=0.7)        | n.s.     | -0.2 (SD=0.5)          | -0.3 (SD=0.5)        | n.s.     | -0.1 (SD=0.6)          | +0.2 (SD=0.7)        | n.s.     |
| <b>DO7:</b> Change in risk<br>behaviors CANS domain<br>score from baseline to<br>follow-up              |                        |                      |          |                        |                      |          |                        |                      |          |
| <i>n</i>  | 32                     | 48                   |          | 15                     | 15                   |          | 8                      | 8                    |          |
| Mean difference (SD):<br>Follow-up score minus<br>baseline score  | -0.1 (SD=0.4)          | -0.1 (SD=0.6)        | n.s.     | +0.1 (SD=0.7)          | -0.2 (SD=0.4)        | n.s.     | -0.2 (SD=0.8)          | -0.2 (SD=0.5)        | n.s.     |
| <b>DO8:</b> Change in social<br>functional behaviors CANS<br>domain score from<br>baseline to follow-up |                        |                      |          |                        |                      |          |                        |                      |          |
| <i>n</i>  | 16                     | 19                   |          | 5                      | 8                    |          | 5                      | 5                    |          |
| Mean difference (SD):<br>Follow-up score minus<br>baseline score  | -0.4 (SD=0.7)          | -0.5 (SD=0.7)        | n.s.     | +0.2 (SD=0.4)          | -0.1 (SD=0.6)        | n.s.     | +0.7 (SD=0.7)          | +0.3 (SD=0.4)        | n.s.     |
| <b>Within 6 months of discharge from TFC/residential care:</b>  |                        |                      |          |                        |                      |          |                        |                      |          |
| <b>DO9:</b> Mean number of<br>placement moves per day<br>in care (SD)                                   | 0.003<br>(SD=0.004)    | 0.001<br>(SD=0.002)  | **       | 0.002<br>(SD=0.002)    | 0.003<br>(SD=0.002)  | n.s.     | 0.002<br>(SD=0.002)    | 0.003<br>(SD=0.001)  | n.s.     |

Note. SD=Standard deviation; n.s.=Not significant; \* $p < .05$ ; \*\* $p < .01$ ; \*\*\* $p < .001$ .

## Deflection Intervention vs. Deflection Comparison

The deflection intervention group had a **significantly greater percentage of discharges from TFC to family and fictive kin caregivers** than the deflection comparison group.

**Outcomes consistent with hypotheses.** The deflection intervention group did not experience any indicated investigations during placement (PO1), while the deflection comparison group did (6.5%). The deflection intervention group had a significantly greater percentage of discharges from TFC to family and fictive kin caregivers (IO1) than the deflection comparison group (69.2% vs. 32.5%, respectively,  $p < .001$ ). Although TFC placement in the deflection intervention group was not designed to be a permanent home, it had a slightly greater percentage of youth discharged from TFC to permanency (IO2) than the percentage of youth discharged from residential care to permanency in the deflection comparison group (5.8% vs. 5.2%, respectively). As intended, the deflection intervention group also had a significantly shorter average length of stay in TFC (IO3) than the deflection comparison group in

residential care (262.8 days vs. 507.4 days, respectively,  $p < .001$ ). The deflection intervention group had a lower percentage of care days in runaway (DO3) during placement or within 6 months of discharge from placement than the deflection comparison group (0.3% vs. 1.0%, respectively). The deflection intervention group had greater improvement than the deflection comparison group from baseline to follow-up in average CANS score on school achievement (DO4; -0.6 vs. -0.4, respectively) and on social traumatic stress symptoms (DO5; -0.2 vs. -0.0, respectively).

**Outcomes inconsistent with hypotheses.** The deflection intervention group, on average, spent a greater percentage of care days in detention (DO1; 1.7% vs. 0.0%, respectively) and in psychiatric hospital (DO2; 7.5% vs. 0.8%, respectively,  $p < .001$ ) during placement or within 6 months of discharge from placement than the deflection comparison group. The deflection intervention group increased in severity (that is, they had a higher score) somewhat from baseline to follow-up in average CANS score on emotional/behavioral needs (DO6; +0.0 vs. -0.1, respectively) and did not improve as much on social functional behaviors (DO8; -0.4 vs. -0.5, respectively). The deflection intervention group had significantly more placement moves per day in care (DO9) within 6 months of discharge from placement than the deflection comparison group (0.003 vs. 0.001, respectively,  $p < .01$ ).

**No outcome differences.** The deflection intervention group did not differ from the deflection comparison group on the change from baseline to follow-up in average CANS score on risk behaviors (DO7; -0.1 in both groups).



## Step-Down Intervention vs. Step-Down Comparison

The step-down intervention group had a **significantly greater percentage of discharge to family and fictive kin caregivers** than the step-down comparison group.

**Outcomes consistent with hypotheses.** The step-down intervention group had a greater percentage of discharge to family and fictive kin caregivers (IO1) than the step-down comparison group (67.9% vs. 40.7%, respectively,  $p < .05$ ). As intended, the step-down intervention group had a shorter average length of stay (IO3) than the step-down comparison group that remained in residential care (241.3 days vs. 269.0 days, respectively). The step-down intervention group spent fewer care days in detention (DO1) during placement or within 6 months of discharge from placement than the step-down comparison group (0.0% vs. 0.9%, respectively), as well as in runaway (DO3; 0.7% vs. 1.4%, respectively). The step-down intervention group had fewer placement moves per day in care (DO9) within 6 months of discharge from placement than the deflection comparison group (0.002 vs. 0.003, respectively).

**Outcomes inconsistent with hypotheses.** The step-down intervention group had a greater percentage of youth with an indicated investigation during placement (PO1) than the step-down comparison group (7.1% vs. 0.0%, respectively). No youth in the step-down intervention group were directly discharged from TFC to permanency (IO2) compared to 11.1% of youth in the step-down comparison group who were directly discharged from residential care to permanency. In the period during placement or within 6 months of discharge from placement, the step-down intervention group had a higher average percentage of care days in psychiatric hospital (DO2) than the step-down comparison group (8.9% vs. 4.8%, respectively). From baseline to follow-up, the step-down intervention group did not experience changes in average CANS score on school achievement (DO4) relatively to the step-down comparison group (0.0 vs. -0.4, respectively), did not improve as much on emotional/behavioral needs (DO6; -0.2 vs. -0.3, respectively), and worsened on risk behaviors (DO7; +0.1 vs. -0.2, respectively) and on social functional behaviors (DO8; +0.2 vs. -0.1, respectively).

**No outcome differences.** The step-down intervention group did not differ from the step-down comparison group on improvement from baseline to follow-up in average CANS scores on traumatic stress symptoms (DO5) (-0.3 in both groups).

## Step-Down (CH+A) Intervention vs. Step-Down (CH+A) Comparison

**Outcomes consistent with hypotheses.** The step-down (CH+A) intervention group had a greater percentage of youth discharged from TFC placement to permanency (IO2) than percentage of youth who were discharged from residential care to permanency in the step-down (CH+A) comparison group (15.4% vs. 8.3%, respectively). During placement or within 6 months of discharge from placement, the step-down (CH+A) intervention group had a lower percentage of care days in detention (DO1) than the step-down (CH+A) comparison group (1.3% vs. 2.9%, respectively), in psychiatric hospitalization (DO2; 6.1% vs. 6.7%, respectively), and runaway (DO3; 0.6% vs. 1.0%,

respectively). The step-down (CH+A) intervention group had greater improvement than the step-down comparison group from baseline to follow-up in average CANS score on traumatic stress symptoms (DO5; -0.1 vs. -0.0, respectively) and emotional/behavioral needs (DO6; -0.1 vs. +0.2, respectively). The step-down (CH+A) intervention group had a lower average number of placement moves per day in care within 6 months of discharge from placement (DO9) than the step-down (CH+A) comparison group (0.002 vs. 0.003, respectively).

**Outcomes inconsistent with hypotheses.** The step-down (CH+A) intervention group had a smaller percentage of discharge from TFC to family and fictive kin caregivers (IO1) than the step-down (CH+A) comparison group (53.9% vs. 66.7%, respectively). The step-down (CH+A) intervention group had a shorter average length of stay (IO3) than the step-down CH+A comparison group (184.3 days vs. 275.4 days). The step-down (CH+A) intervention group increased in severity (in other words, they had higher scores) from baseline to follow-up in average CANS score on social functional behaviors (DO8; +0.7 vs. +0.3, respectively).

**No outcome differences.** Neither the step-down (CH+A) intervention group nor the step-down (CH+A) comparison group experience a substantiated investigation (PO1). The step-down (CH+A) intervention group increased in severity (that is, they had higher scores) from baseline to follow-up in average CANS score on school achievement (DO4) by the same amount as the step-down (CH+A) comparison group (+0.2 in both groups). But the step-down (CH+A) intervention group but also improved by the same amount in average CANS score on risk behaviors (DO7; -0.2 in both groups).

# DISCUSSION

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The Illinois Children and Family Services Act (Illinois Public Act 099-0350) requires that DCFS “implement a 5-year pilot program of multi-dimensional treatment foster care, or a substantially similar evidence-based program of professional foster care, for (i) children entering care with severe trauma histories, with the goal of returning the child home or maintaining the child in foster care instead of placing the child in congregate care or a more restrictive setting or placement, (ii) children who require placement in foster care when they are ready for discharge from a residential treatment facility, and (iii) children who are identified for residential or group home care and who, based on a determination made by the Department, could be placed in a foster home if higher level interventions are provided.”

Under the B.H. consent decree, DCFS is also required to implement a therapeutic foster care (TFC) Pilot and arrange for an independent evaluation through its contract with Chapin Hall between July 1, 2016 and June 30, 2021. Staffing, training, and foster parent recruitment occurred in the first 7 months. TFC referrals officially began on February 1, 2017. The TFC Pilot aimed to provide a home-based setting to serve youth with a history of trauma or severe behavioral challenges who would otherwise enter or remain in residential care or be discharged from residential care to other non-TFC community-based settings.

This is a final report on the evaluation of the 5-year TFC Pilot that began on July 1, 2016 and ended on June 30, 2021. This report used information and data that covered the TFC Pilot period from the inception of TFC referrals to June 30, 2021. At the conclusion of the TFC Pilot, 93 youth were placed in TFC via three different pathways: deflection, step-down, and step-down (CH+A). Over 60% of TFC youth were younger than age 12 or Black, and over 50% were male.

Of the 93 youth placed in TFC, 39 youth completed TFC, 34 youth disrupted from TFC, and 20 youth remained in TFC placement as of June 30, 2021.

The output study showed that of the 93 youth placed in TFC, 39 youth completed TFC, 34 youth disrupted from TFC, and 20 youth remained in TFC placement as of June 30, 2021. Two of the four TFC providers, JCFS and YOS, withdrew from the TFC Pilot in April 2018 and May 2018, respectively. The two remaining TFC providers, LSSI and CH+A, provided TFC for the entirety of the Pilot period. LSSI represented the majority of TFC recruitment, acceptance, and placement in the Pilot. Because JCFS and YOS were discontinued, and because TFC homes were converted to permanent homes in CH+A’s TFC model, only LSSI would provide ongoing TFC capacity in which foster parents could provide TFC supports to different youth over time. In the final 6 months of the Pilot, CH+A and LSSI continued to maintain productivity and fidelity to FFTA standards and the providers’ interventions despite challenges presented by the COVID-19 pandemic.

The outcome study showed that the three TFC intervention groups were demographically similar in age, race, and gender to their respective comparison groups, which consisted of eligible TFC youth who entered residential care, remained in residential care, or were discharged from residential care to non-TFC alternatives. Collective outcomes associated with the three intervention groups showed modest but promising evidence that, as hypothesized, youth generally benefited more from the interventions compared with youth in the residential or non-TFC comparison groups. Across the 13 outcomes and the associated 39 outcome comparisons between the intervention groups and the comparison groups, only five outcome comparisons yielded statistically significant differences, three of which favored the intervention—discharge to home-based care (for the TFC deflection and the TFC step-down groups) and length of stay (for the TFC deflection group)—and two of which favored the comparison—percentage of days in a psychiatric hospital (for the TFC deflection comparison group) and number of placement moves per day in care (for the TFC deflection comparison group). Of the 34 outcome comparisons that were not statistically significant, 16 favored the intervention, 13 favored the comparison, and five showed no difference between the intervention and comparison.

Collective outcomes associated with the three intervention groups showed modest but promising evidence that, as hypothesized, **youth generally benefited more from the interventions compared with youth in the residential or non-TFC comparison groups.**

The effect of TFC varied by target population across the 13 outcomes. Specifically, the youth in the deflection intervention group performed better than youth in the comparison group (that is, eligible TFC youth who entered residential care) on seven outcomes (two of which were statistically significant), worse on five outcomes (two of which were statistically significant), and showed no difference on one outcome. The step-down intervention group performed better than their comparison group (which consisted of eligible TFC youth who remained in residential care) on five outcomes (one of which was statistically significant), worse on seven outcomes, and showed no difference on one outcome. The step-down (CH+A) intervention group performed better than their comparison group (that is, eligible TFC youth who were discharged from residential care to home of relative, home of fictive kin, specialized foster care, or adolescent foster care) on seven outcomes, and worse on three outcomes, and showed no difference on three outcomes. None of the outcome differences in CH+A were statistically significant.

The outcome study had several limitations. First, because the majority of TFC placements were with LSSI, outcome findings more or less represented the effectiveness of TFCO for the LSSI target population rather than that of other TFC models. Second, although the youth in the three intervention groups and their respective comparison

To “deflect” high-need youth from entering residential care, **DCFS might expect a briefer length of stay in TFC placement** (as intended) and continued placements in home-based settings subsequently.

To step high-need youth down from residential care, **DCFS might also expect youth who are placed in TFC to remain in home-based settings after TFC.**

groups were demographically similar, there was an imbalance between the number of youth in the intervention groups and youth in the comparison groups. In particular, the step-down (CH+A) intervention group and the step-down (CH+A) comparison group were both small. Each consisted of fewer than 15 youth. Because CH+A stopped accepting TFC youth in January 2021, the sample size difference between the CH+A intervention group and the comparison group limited the generalizability of the CH+A TFC findings. A conservative statistical power analysis suggests at least 500 youth (i.e., 250 youth per group) to detect a small outcome effect size. Third, not all youth in the intervention groups and the comparison groups had received both a baseline CANS and a follow-up CANS, which limited the generalizability of five out of the nine distal outcomes. Further, youth who were placed in TFC in the final months

of the Pilot had a shorter observation period, even if all time-dependent outcomes were standardized to proportion of days in care.

The TFC Pilot showed that TFC was implemented with fidelity and yielded modestly improved outcomes. Most differences in outcomes observed between the intervention and comparison groups were not statistically significant. Nonetheless, these findings have implications for how DCFS might embed TFC within the continuum of care relative to residential care. If the intention is to “deflect” high-need youth from entering residential care, DCFS might expect a briefer length of stay in TFC placement (as intended). This would lead to continued placement in home-based settings for youth who are placed in TFC rather than in residential care. If the intention is to step high-need youth down from residential care, DCFS might also expect youth who are placed in TFC to remain in home-based settings after TFC. Both applications, however, were associated with mixed findings regarding non-statistical differences in clinical changes over time per changes in CANS domain scores. Further, there were tradeoffs associated with a greater percentage of care days in psychiatric hospitalization, likely due to elevated needs that could otherwise be monitored and managed in residential care. On the other hand, CH+A TFC, as a comparable step-down option for youth who would otherwise be discharged from residential care, did not show any significant outcome difference. In addition, because CH+A’s TFC model targeted potentially permanent homes as opposed to building ongoing TFC capacity for high-need youth, it remains unclear how the CH+A TFC model would expand the foster care continuum. Nevertheless, both LSSI and CH+A demonstrate a commitment to the provision of TFC after the Pilot. LSSI is adding a new team and expanding the geographic service area of their TFCO model while CH+A is expanding TCI-F training to all of their caregivers.

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# THERAPEUTIC FOSTER CARE (TFC) PILOT EVALUATION: PROCESS STUDY

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## EXECUTIVE SUMMARY

The Illinois Department of Children and Family Services (DCFS) sponsored an evaluation of the 5-year Therapeutic Foster Care (TFC) Pilot between July 2016 and June 2021 through its contract with Chapin Hall at the University of Chicago. The Pilot aimed to provide a home-based setting, TFC, to serve youth with a history of trauma or severe behavioral challenges who would otherwise enter or remain in residential care or be discharged from residential care to other non-TFC community-based settings. This study component examined how the TFC Pilot, with a focus on the Lutheran Social Services of Illinois (LSSI) TFCO Model, was implemented in Illinois.

The research team conducted focus groups in November and December 2021 to better understand the context and processes of the TFC Pilot implementation and to explore the feasibility of the TFC Model as a community-based alternative to residential treatment in Illinois's child welfare system. Two research questions guided the focus groups to inform services and structures of the TFC Model, facilitators of and barriers to the program implementation, and implications for further program development:

- Was the TFC Pilot implemented as planned?
- Can the TFC Model be implemented as a community-based alternative to residential treatment?

The three focus groups were conducted with LSSI staff members ( $n=4$ ), LSSI leaders ( $n=5$ ), and DCFS leaders ( $n=5$ ) involved in the TFC Pilot. The research team coded and analyzed the focus group transcripts and extracted themes from the coded data. To validate the data, the research team sent member checking surveys to the focus group participants, asking their level of agreement/disagreement with the themes

### Box 1. Key Themes

- TFC Model provides youth with trauma-informed support
- TFC parents and aftercare families play vital roles in the TFC Model and successful outcomes of youth
- TFC parents need to understand, buy in to, and follow the Model
- More successes are observed among younger TFC youth
- Team communication, support, and continuity are key
- Finding a stable aftercare home is both essential for successful youth outcomes and a major challenge

the research team extracted from the focus groups. Researchers integrated responses from the member checking survey into the analysis.

Key themes endorsed by all three groups of participants highlighted successes and challenges in the implementation of the TFC Model (see Box 1). Focus group participants reported that the TFC Model provides youth with trauma-informed support. However, participants expressed that TFC is not for everyone, and more successes were observed with younger children. TFC parents and aftercare families were identified as vital components of the TFC Model and the successful outcomes of youth. All groups also mentioned that TFC parents need to understand, buy into, and follow the Model.

Focus group participants reflected on several challenges that affected the implementation of the TFC Model. Challenges described related to the TFC Model (such as lack of communication and clarity about the TFC Model), the rollout (for example, recruitment and figuring out the referral stream was difficult), and systemic issues that affected implementation (such as staff turnover caused inconsistent adherence to the Model).

Recommendations suggested by the focus group participants included themes around developing support and resources, aftercare planning and support, and changes to the TFC Model, including modifying therapy engagement within the Model (for example, involving the child and TFC parents and aftercare families together in sessions). While the Model includes family therapy and trauma-informed support, some participants thought that the TFC Model is not trauma-informed *enough*. Additionally, participants recommended identifying the aftercare home early, which would allow for consistent continuation of learning and skills obtained from TFC.

Focus group findings regarding the implementation context, mechanisms, and processes suggest that, despite some challenges experienced during the Pilot years, TFC has great potential to lead to positive outcomes in youth. Because of the benefits that TFC has demonstrated in this Pilot, several leaders recommended training all caseworkers and agencies in TFC. Themes from this study suggest that TFC could be a viable, community-based alternative to residential programs.



# INTRODUCTION

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As part of the evaluation of the 5-year Therapeutic Foster Care (TFC) Pilot, Chapin Hall conducted a process study. This study component examined how the TFC pilot, with a focus on the LSSI TFCO model, was implemented in Illinois between February 2017 and June 2021. Two research questions guided our data collection to inform services and structures of the TFC program, facilitators of and barriers to the program implementation, and implications for further program development:

1. Was the TFC Pilot implemented as planned?
2. Can the TFC Model be implemented as a community-based alternative to residential treatment?

# METHOD

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## Design

Chapin Hall collected qualitative data to understand the experiences and views of TFC providers (LSSI staff and leadership teams) and the Illinois DCFS liaisons regarding TFC Pilot rollout and implementation. We conducted focus groups to gain an in-depth understanding of the context, mechanisms, and processes that affected the TFC Pilot installation and implementation stages, and to explore the feasibility of the TFC Model implementation as a community-based alternative to residential treatment in Illinois' child welfare system.

## Participants

LSSI and DCFS liaisons were contacted via email and informed about the study. Those who agreed to participate were asked to complete a brief demographic background survey prior to the focus group session to inform the characteristics of focus group participants.

The focus groups involved three types of study subjects in separate virtual focus groups:

- TFC staff from LSSI who were involved in the TFC Pilot outcome evaluation study ( $n = 18$ ), including caseworkers, individual therapists, skills coaches, and foster parent specialists
- Leadership teams at LSSI ( $n = 9$ ), including the team leaders and local program directors
- DCFS liaisons ( $n = 6$ ), including program directors and other local field office staff who were involved in the TFC Pilot evaluation study

Approximately 8 months following the conclusion of the focus groups, LSSI and DCFS liaisons were contacted via e-mail to complete a member check survey regarding their agreement/disagreement with the focus group themes summarized by Chapin Hall. We distributed the member check surveys to focus group participants ( $n = 14$ ), as well as those who initially agreed to participate in the focus group but could not attend due to schedule conflicts ( $n = 5$ ). None of the LSSI staff participated in the member checking survey, while 5 LSSI leaders and 5 DCFS leaders participated (see Table 26).

**Table 26. Sample Sizes by Focus Group**

| <b>Group</b>        | <b>Invited to focus groups, <i>N</i></b> | <b>Responded expressing interest, <i>N</i></b> | <b>Participated in focus group, <i>N</i></b> | <b>Completed member check survey, <i>N</i></b> |
|---------------------|--|--|--|--|
| <b>DCFS leaders</b> | 6  | 6  | 5  | 5  |
| <b>LSSI leaders</b> | 9  | 7  | 5  | 5  |
| <b>LSSI staff</b>   | 18                                       | 6  | 4  | 0  |
| <b>Total</b>        | 33                                       | 19   | 14   | 10   |

## Data Collection

Focus groups occurred over Zoom in November and December of 2021. Each focus group lasted 90 minutes. All participants consented to participation and recording. Every LSSI participant received a \$20 gift card for their participation. An online member check survey was administered via REDCap in August of 2022 to focus group participants, as well as those who initially agreed to participate in the focus group but could not attend due to schedule conflicts. This study was approved by the DCFS Institutional Review Board (IRB) and the Crown Family School of Social Work, Policy, and Practice and Chapin Hall IRB (#IRB21-1264).

## Analysis

Focus groups were recorded and transcribed. The research team cleaned the transcripts and checked their accuracy. Transcripts were uploaded to Atlas.ti, a qualitative software package, to conduct coding. Prior to the analysis of the transcript, the research team created a codebook containing initial codes and their definitions based on the focus groups' guiding topics and questions. These codes were a word or short phrase intended to capture the main content and essence of the focus group guide (Saldaña, 2013), including successes and challenges of the TFC Model implementation, youth outcomes, and suggestions (see Appendix A). Thus, each of these codes summarized the primary topic of the excerpt from the transcripts. Using the codebook, the research team reviewed the transcripts and applied the codes to "segments of data selected as representative of the code" (Fereday & Muir-Cochrane, 2006, p. 87) and identified descriptors for each segment (small chunks of data). We then assigned categories to these descriptors and developed themes by comparing and connecting categories. The research team reviewed and reorganized themes and categories hierarchically and refined the hierarchy. We created a table of themes and added the count of participants who mentioned each theme and which participant groups endorsed each theme (see Table A-1).

To validate the focus group data, we conducted member checking. Recommended by Lincoln and Guba (1985), the member check is a means of verifying the accuracy of the researcher's interpretations of participant responses. Member checking strengthens the rigor of qualitative research (Tong et al., 2007). It also equalizes power relationships between researchers and participants by giving participants the opportunity to provide feedback and correct any inaccuracies in the data (Koelsch, 2013). We conducted member checks with focus group participants by developing and administering a survey for each target subject group with the list of themes we found for each group. Respondents then selected their agreement/disagreement with each theme (a 5-point Likert-type scale from "strongly disagree" to "strongly agree") and provided comments if they chose to do so. The research team integrated the responses from the member checking survey into the analysis.

# FINDINGS

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## Key Themes

Key themes endorsed by all three groups of participants highlighted successes and challenges in the implementation of the TFC Model.

### Trauma-Informed Support Approach

All groups mentioned that the TFC Model provides youth with trauma-informed support. TFC parents and aftercare families were identified as vital components of the TFC Model and the successful outcomes of youth.

All groups also mentioned that TFC parents need to understand, buy in to, and follow the Model. Some TFC parents struggled with buy-in because they were giving up control to the team lead. It could be difficult to tell them that they need to change the way they are parenting; however, some TFC parents started using the Model with their other children (children not participating in TFC) and identified clear expectations of being TFC parents:

I think there were really clear expectations of what being a TFC foster parent meant... and role definition for everybody who was involved on the team. Which leads to no ambiguity about what the expectations are. – DCFS leader 105

### Characteristics of Youth in TFC

Themes emerged around the characteristics of youth who participated in TFC. One DCFS leader stated, “[The TFC program] took kids who didn’t look good on paper and gave them a chance to figure things out.” All three groups observed more successes among younger TFC youth. Children ages 6–14 were eligible for TFC, yet DCFS leadership, LSSI leadership, and LSSI staff all noted that the Model worked better for the younger children (those ages 10 and under). They also mentioned that TFC is not for everyone and that the Model does not fit for some children and youth, depending on their needs and circumstances. However, the focus group participants did not all agree for which youth TFC is most successful. For example, in the member check survey, half of the LSSI leaders said that TFC was less successful for children who have an extensive history of psychiatric hospitalization, while the other half of this group disagreed.

I think the kids that we've been very most successful with are brand new to the system. They tend to be lockouts and they're in the psychiatric hospital because their parents won't take them back because they don't have the resources. And then the second population I think that we're really pretty successful with are kids stepping down out of residential, particularly if they do have a relative or family that they're going to. – LSSI leader 201

## Team Support and Communication

Regarding the TFC staff, team communication, support, and continuity are key to the success of TFC. Several examples of team support were noted.

The TFC team—they're all supporting each other, they're supporting the client, fulfilling different needs for the clients, together as a team. Whereas your traditional foster care teams are often kind of siloed, they're all on a team, but they all have their own clients and their own jobs to do. An especially good functioning TFC team pulled together in a common mission to support the client. – LSSI leader 206

## Identifying Aftercare Plans

Finding stable aftercare homes is one of the biggest challenges of TFC, which is crucial to successful outcomes for youth. LSSI leaders and staff and DCFS leaders all mentioned that a major challenge was when the child did not have an assigned aftercare family at the time of referral. Without an assigned aftercare family, LSSI had to contract with a family-finding organization to identify aftercare family connections during TFC. See the section “Aftercare Plans for Supporting Youth” in this chapter for further findings on challenges regarding aftercare.

[When] we accept the case without an aftercare plan. . . if we don't have that continuity of care in the aftercare, how [can] all the healing of the TFC Model be sustainable? – LSSI leader 204

## Implementation Challenges

Focus group participants reflected on several challenges that affected the implementation of the TFC Model. This section discusses various challenges related to the TFC Model, its rollout, and systemic issues.

### TFC Model Challenges

**DCFS leaders.** DCFS leaders mentioned several challenges with implementation of the TFC Model. Two DCFS leaders saw a discrepancy between the B.H. plan's initial scope regarding youth recruitment and actual capacity. (Note: The B.H. plan initially imposed a capacity providers could not reach: 40 children in year 1, 100 kids in year 2. After lessons learned from the year 1 ramp-up period, in year 2 of the Pilot the capacity requirement was removed.)

Another implementation challenge was that the pilot lost some TFC provider agencies over time. JCFS and YOS ended their participation in the TFC Pilot in the spring of 2018 due to a lack of referrals. CH+A accepted their final referral in fall of 2020 and continued to serve their existing cases through end of FY 2021, after which the cases were moved to CH+A's existing contracts that also provided comparable supports, according to CH+A. LSSI was the only provider that continued to implement TFC throughout the Pilot and beyond.

TFC providers experienced different challenges at different timepoints, according to a DCFS leader. Earlier issues involved problems finding appropriate referrals for the program. Once referred, for some youth there were engagement issues, and for others it was difficult to help youth sustain participation in the program when they had a crisis. There were also barriers to getting youth to complete the program.

Two DCFS leaders observed some struggles with TFC team capacity and self-sufficiency in implementing the TFC Model. TFC teams required more support from DCFS to navigate the DCFS system and other issues (for example, case management, clinical issues, court issues) than DCFS expected.

Sustaining the TFC Model was challenging and required ongoing support for implementation.

I think it's fair to say that training is only training. If you can't implement it on the ground to sustain that implementation support over time, this would never have worked had the department not had. . . a bunch of supports doing the actual implementation over time and sustained focus, which is not necessarily something that we do well, given the variety of changes in administration and things. One of the lessons learned is on the implementation side: it takes a lot. – DCFS leader 102

**DCFS leaders and LSSI leaders.** Several participants in both the DCFS and LSSI leaders focus groups mentioned a lack of communication and clarity about the TFC Model. For example, a DCFS leader reported confusion and a lack of clarity about youth eligibility criteria. Two LSSI leaders discussed surprises about the Model occurring during implementation, such as understanding needs and fit for foster parents.

DCFS leaders and LSSI leaders mentioned that one implementation challenge was getting buy-in from stakeholders at all levels. One LSSI leader said, "It really was moving away from business as usual. . . . This was a shift in the way this was being done. So, yeah, just trying to get the buy-in of all these different players [was a challenge]."

Some of the DCFS and LSSI leaders noticed a discrepancy between DCFS's vision and the TFC Model, while some disagreed or were not certain. According to a DCFS leader, TFC has a planned move to an aftercare home at the end of treatment, which conflicts with the DCFS vision of fewer movements and more stability. Three DCFS leaders believed that TFC can help youth achieve their permanency goal, while one DCFS leader strongly disagreed with this. One LSSI leader mentioned that the permanency goal can be an issue in TFC because TFC is a temporary treatment program:

Permanency does definitely become an issue when you have kids who have been in care for quite a long time. The GAL [guardian ad litem] and court systems are looking for permanency for our kids, and because TFC is a program and a service, they don't understand why they cannot have the same level of permanency with the caregivers. And that has been a little bit of a struggle when we're telling them that we are providing their services for the aftercare for the next step, so that when I go back to a family worker that they can continue that process of permanency,

that we've already laid the groundwork but we're not going to finish it. We're stabilizing these kids, we're giving them an opportunity to have better permanency and better outcomes. – LSSI leader 207

**Different perspectives.** DCFS leaders and LSSI staff had different opinions on TFC fidelity. A DCFS leader said that adhering to the TFC Model and not being able to make changes or adjustments to meet youth needs was challenging. On the other hand, an LSSI staff said that they thought stricter fidelity to the TFC Model would be best.

## Rollout Challenges

**Recruitment.** Leaders in both DCFS and LSSI discussed ways in which recruitment was difficult. Several LSSI leaders said that figuring out the referral stream was challenging. Both DCFS and LSSI leaders reported that finding youth who fit in the TFC Model and met pilot criteria was a struggle, although three DCFS and LSSI leaders disagreed. DCFS leaders said that there was pressure to place children who did not meet the criteria, although one disagreed with this statement. All DCFS leaders agreed that the narrow scope of the TFC Model (especially population and fidelity criteria) left out some youth who could have benefited from TFC. In addition, there were different youth criteria among different provider agencies, according to a DCFS leader. Two LSSI leaders said that the hybrid Model of the TFC Model for children ages 6–11 and the Model for adolescents (ages 12–14) made it difficult to recruit youth. An LSSI leader mentioned that recruitment has been very different in each of the three subregions.

**Staffing.** DCFS leaders and LSSI leaders mentioned another rollout challenge: staffing. Building the TFC teams, including program staff and foster parents, presented a challenge. One LSSI leader said, “Finding the right fit for each position was a struggle.” It often was a struggle for onboarding program staff to “embrace an evidence-based Model” which had been communicated at hiring interviews.

## Systemic Issues that Affected Implementation

DCFS leaders pointed out issues in the system that affected implementation. Primarily, they discussed turnover. Three DCFS leaders stated that staff turnover caused the department to inconsistently adhere to the TFC Model, while two disagreed with this statement. One participant pointed out that staff turnover varied across the TFC teams. According to one LSSI leader, “Unfortunately, the turnover rate spiked in FY22 after remaining low for the first 5 years.” This was also evident in the member check survey outreach in which 2 of the 4 LSSI staff focus group participants were no longer with LSSI.

DCFS leaders agreed that changes in DCFS administration with different priorities led to challenges with implementation. An LSSI leader mentioned that the relationship between the provider agency and the GAL office was challenging but improved over time. Two LSSI staff discussed the effect of the COVID-19 pandemic on implementation. The pandemic affected levels of interaction with youth and staff’s ability to provide youth with resources virtually, which made TFC programming and engagement even more challenging, they said.

# Developing a TFC Model as a Community-based Alternative to Residential Treatment

The way TFC is a really viable option to residential, I think, is how it impacts kids most. It's not just a step-down resource, it's an actual treatment program that they can be in place of a residential program, so I love that aspect of the program and having that as another tool." – LSSI leader 206

Focus group participants reflected on if and how the TFC Model supported youth, as well as some of the key factors for sustaining the Model.

## TFC Experiences Varied among Youth

There were variations in TFC youth experience, with some youth having more success than others. Five participants across the three groups said that more successes are observed among younger TFC youth. One LSSI leader said TFC works successfully with youth who are new to the child welfare system. Another LSSI leader reported that TFC works successfully with youth stepping down from residential care. An LSSI staff person noted that TFC works best when aftercare is established prior to entering the TFC program. Leaders and staff from LSSI said that the TFC Model cannot meet the needs of Beyond Medical Necessity (BMN) youth. One LSSI staff person said TFC was less successful for children who have an extensive history of hospitalizations for acute and complex clinical reasons beyond behavioral problems (such as suicidal ideation) that TFC is designed to support.

I think TFC has worked the least well with kids who have been in psych hospitals BMN for 4 months or longer. And I think that has been our hardest population to get settled in a home. Also with that population, they rarely have an identified aftercare home. – LSSI leader 201

**Supporting youth goals.** TFC can help youth achieve their permanency goal, said three DCFS leaders, although one strongly disagreed with this. Two LSSI leaders said that TFC can also help youth achieve academic and social-emotional outcomes. Additional features of TFC were mentioned as being helpful for youth. DCFS leaders shared that TFC helps youth by providing them with opportunities, an incentive system, and a home-like, community setting. LSSI staff and leaders stated that the TFC Model helps youth by providing trauma-informed support through aftercare services, which, for example, allowed youth to work through their trauma with their aftercare families. In the member check survey, all LSSI leaders and DCFS leaders agreed that TFC provides youth with trauma-informed support. A leader shared one success story about a young child who was repeatedly hospitalized who joined the TFC Pilot:

It kind of gave us another tool to bring to the table to figure out the best way for this all when [the child] was little. And [this child] was one of the ones that actually ended up achieving permanency with TFC with wonderful therapeutic foster care parents. - DCFS leader 102



**Building rapport with youth.** While some of the focus group participants agreed that the TFC Model can support youth's permanency goals and social-emotional outcomes, they also reported a number of challenges related to TFC youth. While four participants—DCFS leaders and LSSI staff—mentioned that youth engagement was a success of the TFC Pilot, two LSSI staff said that building rapport with youth was challenging. One LSSI staff person talked about the difficulty of addressing the youth's situation and needs to access resources and supports, especially during the COVID-19 pandemic. Finding youth that fit in the TFC program was discussed by three participants (DCFS leaders and LSSI leaders), while several DCFS leaders and LSSI leaders disagreed that it was a challenge.

## **TFC Foster Parents as Crucial Team Members**

Leaders saw TFC parents as a crucial part of the TFC team. Matching children to homes was an essential part of the process, said DCFS leaders, and the clear expectations for TFC parents contributed to their success. LSSI leaders mentioned the importance of buy-in and practice for TFC parents; they said that learning and following the TFC Model requires much practice. All five DCFS leaders and all five LSSI leaders who completed the member check survey agreed or strongly agreed that for TFC to be successful, TFC parents need to understand the TFC Model, buy in to the TFC Model, and follow the Model.

Certain TFC parent practices are needed for the Model to be successful. A DCFS leader reported that TFC parents modeled effective parenting skills and used the incentive system to help youth achieve goals. In the member check survey, all five DCFS leaders reiterated the importance of TFC parent roles and strongly agreed that TFC parents *need* to model effective parenting skills in order for the intervention to be successful. An LSSI staff person said that TFC parents need to engage in activities and involve the child in goals and incentives. An LSSI leader noted that TFC parents need to understand trauma—"what trauma is, and how it can affect the child as a whole, and [not taking] anything personal" (LSSI Leader 205)—in order to be successful. The majority of the LSSI and DCFS leaders in the member checking survey support this idea, with one LSSI leader disagreeing.

In addition, building and maintaining relationships with the TFC team and licensing team is necessary for retaining TFC parents, according to an LSSI leader. A benefit of being a TFC parent was that they received ongoing support, according to DCFS and LSSI leaders, something with which the member check survey confirmed that all five DCFS leaders and all five LSSI leaders agreed. DCFS leaders also mentioned the higher pay and additional training TFC parents receive. Both DCFS and LSSI leaders stated that TFC parents are respected members of the child welfare team, as is demonstrated in the following quote. LSSI leader 205 said, "When you have people who understand the mission, and understand their part in the mission, that is what creates success."

Focus group participants discussed several challenges related to TFC parents. A major challenge, reported by all three groups, was recruiting TFC homes, which is vital to sustaining the TFC Model. Two LSSI leaders said that TFC parent buy-in and understanding of the Model can be a challenge, while one LSSI leader disagreed with this idea in the member checking survey. Several LSSI leaders also asserted that the Model is not trauma-informed enough and is rather behavioral focused. As a result, it does not address the traumatic history of youth, which can pose challenges for the parents as well as others on the TFC team. However, two LSSI leaders disagreed, meaning that they thought TFC was sufficiently trauma informed. Four DCFS leaders agreed that the youth's duration at the treatment home was longer than specified by the Model, while one DCFS leader disagreed. LSSI staff discussed

different challenges related to therapy. For example, TFC therapists' roles are unclear to some TFC parents. In addition, the individual therapist has no contact with foster parents, which can create communication difficulties.

## Aftercare Plans for Supporting Youth

The role of the TFC aftercare home was discussed in the focus groups. Two DCFS leaders shared that early identification of an aftercare home allows for training and consistent learning and improving skills. Three participants (LSSI leaders and LSSI staff) asserted that buy-in and sustaining the TFC Model in the aftercare home is necessary for maintaining treatment progress. It is important to discuss aftercare plans with the child, said an LSSI staff member, so they understand what to expect.

**Aftercare challenges.** Many challenges related to the aftercare home were discussed by the focus group participants (see the earlier section, "Identifying aftercare plans," in this Findings chapter). TFC is focused on the challenge of finding a stable aftercare home because such a home is vital to successful outcomes of youth, said participants in all three groups. Another major challenge with aftercare mentioned by five participants (LSSI leaders and LSSI staff) is that the TFC Model does not require the aftercare family to follow the Model and does not contain treatment components for aftercare, which can diminish any positive effects of TFC (a few participants disagreed with this statement in the member checking survey). As one DCFS leader put it, "The [long-term] success of the TFCO program is highly dependent on the quality of the aftercare home."

Other aftercare challenges include that court goals can sometimes conflict with the aftercare plan and can create challenges for discharge planning, something the majority of the DCFS leaders agreed with. Two DCFS leaders mentioned that another issue was posed by the lack of formal discharge resources. Disruption sometimes occurred when a child was transferred from the TFC home to the aftercare home and there was not a process in place to address this.

We've seen that a lot of this success or nonsuccess for the youth and families, aftercare has definitely played an essential role in that. And also in some of the nuances that were not accounted for, like when a youth disrupts, getting that case transferred back to that agency to where the case came from should have been something also that I look at. . . now, I can see where some work maybe could have been done on the onset to kind of get that process squared away and more concrete. – DCFS leader 101

LSSI staff discussed several additional challenges regarding aftercare planning. Two LSSI staff members said that family therapy does not include the child from the beginning of the TFC program (for example, some of the children are included in family therapy sessions only before they return home). The staff members expressed this was difficult. In addition, the Model does not include child and family team meetings, which LSSI staff thought would streamline communications among the TFC team. Another LSSI staff member said that therapists cannot testify in court and some wish they could. Further, engaging aftercare families can be challenging, as they might feel burned out by the intensity of TFC engagement.

One of my parents is just like, “I don't care, I'm so over all agencies, I just want my kids back. . . I'm done, I don't need any sort of help, I don't need any sort of tools, I got all the tools I need, I've been working with this forever.” And so there's that that burnout on [the parent's] end that is the motivation. – LSSI staff 302

The lack of streamlined support system for transition to aftercare was another challenge mentioned by LSSI staff. Some saw the Model as not being culturally responsive; one LSSI staff member said that lack of cultural fit presented a challenge. Furthermore, the Model does not address parents' own trauma and intergenerational trauma. One LSSI staff member pointed out that the TFC Model was not originally designed for children and youth in the child welfare system, and it is a complicated model to learn and implement.

### **Key Factors for Sustaining TFC**

When asked what is needed to sustain the TFC program, focus group participants offered several suggestions. All three groups (seven participants) said that team communication, support, and continuity are key. A DCFS leader commented that buy-in and support from stakeholders in the community is necessary for maintaining the TFC program:

[One of the challenges was] getting the buy-in from the other stakeholders in the child welfare system, from the casework team to the residential programs that we're looking at discharge planning to the courts to everybody and above.  
– DCFS leader 105

An LSSI leader asserted that having the right person in the recruiter role is integral to the TFC program functioning. A DCFS leader shared their perspective that the same obstacles will continue, such as finding children for the program. Two other DCFS leaders agreed with this statement, while one disagreed. Additionally, four of the five LSSI leaders disagreed with this statement in the member checking survey. One stated that sustaining a TFC team is the obstacle rather than finding youth for the program. Another LSSI leader said that to sustain TFC, there are three key ingredients:

Three real strong ingredients that you need to make it successful: you have to have this solid team, you have to have a team of foster parents, and then you need enough referrals coming in. And if you have all three of those elements, you can have a successful [program]. Where any of those fall down is where you start seeing it falter. – LSSI leader 201

## Recommendations

### Recommendations for Developing Support and Resources

A DCFS leader recommended implementing the TFC Model when a child comes into placement. To successfully implement TFC, DCFS needs monitoring support, according to another DCFS leader. An LSSI staff person suggested that TFC staff receive training on cultural humility and systemic racism prior to the TFC training.

For scaling TFC, a DCFS leader and an LSSI staff person recommended training all caseworkers and agencies in TFC. Several other DCFS leaders strongly agreed with this idea, and another DCFS leader disagreed. During the focus group, LSSI leaders suggested applying the lower caseloads of TFC to all child cases in DCFS, such as a ratio of 10 cases to one worker. One LSSI leader disagreed with this idea in the member check survey. Another LSSI leader indicated that “having a lower caseload and applying that across Illinois would be the first advantage, because then you can really do excellent work.”

Two LSSI leaders said therapy should be immediately available to all children in DCFS like it is in TFC. One leader mentioned that “when you have the availability of a therapist, a family therapist, and a skill coach that is able to start services immediately, that has such a strong positive impact on treatment plan outcomes.” A DCFS leader suggested TFC-level support built in for all foster parents in addition to a “generalized training [about a TFC Model]” which could promote sustained support for the foster parents.

Three participants recommended paying all foster parents the TFC rate, at least for a period of time (DCFS and LSSI leaders), yet a few DCFS and LSSI leaders disagreed with this suggestion. While discussing the benefits of TFC, two DCFS leaders recommended considering the cost-benefit of scaling the program.

How many kids have been served in TFCO? . . . There really is a cost benefit analysis that needs to be looked at if you're only serving 20 kids a year and you're paying X amount of dollars. Can that large sum of money be used differently, or can the program be used differently to expand [to] more kids?

– DCFS leader 105

### Recommendations for TFC Model

Focus group participants recommended changes to the TFC Model. As mentioned earlier, both DCFS leaders and LSSI staff said that while the Model includes family therapy and trauma-informed support, the TFC Model is not trauma-informed *enough*. LSSI leaders had mixed opinions: half agreed and half disagreed that the Model is not trauma-informed enough. Four DCFS leaders and LSSI staff suggested that trauma-informed work should be built into the TFC Model to understand youth behavior and needs.

What we hear from staff and foster parents is because it's such a strong behavioral, social learning theory Model, that there is a common thread that this does not address the traumatic history of the children that are entrusted to our care.

– LSSI leader 204

One DCFS leader recommended that the Model allow providers to decline cases for TFC, yet three other DCFS leaders disagreed with this suggestion. As mentioned above, some think TFC is not a good fit for all youth. LSSI staff discussed cultural variation and improving the cultural relevance of the Model. Two staff stated that the Model should be more culturally relevant for families of color. They also suggested more research be conducted to inform a more culturally relevant TFC Model.

### **Recommendations for Therapy**

LSSI staff had recommendations about therapy in TFC. One participant in an LSSI staff focus group said that all TFC therapists should meet for peer learning groups, so that they could learn from each other's experiences. Another LSSI staff person suggested adding an opportunity for youth, TFC parents and aftercare families to meet (as in the "child and family together" meeting model). In addition, one LSSI staff person stated that therapists should do home visit observations. And one LSSI leader recommending using only the C (Child) Model of TFC, which is for ages 6–11, as there were some challenges implementing TFC with older youth.

### **Recommendations for Aftercare Planning and Support**

LSSI staff focus group participants suggested changes to aftercare. When discussing aftercare, five participants (LSSI leaders and LSSI staff) mentioned that one of the challenges of the TFC Model is that it does not require the aftercare family to follow the Model. In addition, the TFC Model does not contain treatment components for aftercare. A few LSSI leaders disagreed with this statement. When we asked for recommendations for TFC, one LSSI staff person recommended that TFC continue in aftercare for continuity, while two staff recommended aftercare family therapy.

I understand that obviously [the aftercare home] is not TFC licensed and trained. But if the Model at least had some expectation that. . . the aftercare home has to commit to meeting with the family therapist at least X amount of times. So that the family therapist can at least talk to them about the Model, let them know this is what your child has been doing in the TFC home, here's how you could implement it. And then it's obviously going to be up to that aftercare home if they implement it, but I feel that it's a disservice that there isn't any kind of expectation that the aftercare home even knows a thing about the Model. – LSSI staff 305

In addition, an LSSI staff person suggested establishing an aftercare home for youth prior to entering the TFC program. Focus group participants in all three groups said that a stable aftercare home is crucial to achieving successful youth outcomes in TFC, yet it was a challenge to find stable aftercare. Thus, establishing an aftercare home for youth before entering TFC could address this issue.

# DISCUSSION

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This implementation study was designed to better understand whether the TFC Pilot was implemented as planned, as well as the facilitators of and barriers to the TFC program implementation. The study team also collected, analyzed, and reported recommendations and implications for further program development.

## Research Question 1: Was the TFC Pilot implemented as planned?

The TFC Pilot demonstrated many successes. Youth engagement was one success; the TFC Model helped youth by providing trauma-informed support. Participants shared success stories about youth who participated in the TFC Pilot. In addition, TFC parents' role was a success. They built and maintained relationships with the TFC team and licensing team. TFC parents also received ongoing support and were respected members of the TFC team. The TFC Pilot had several implementation challenges. Recruiting TFC homes was often challenging. The TFC Model has high expectations for TFC parents, which may have made it more difficult to find parents who met the criteria. In addition to recruiting TFC parents, recruiting and building the TFC program staff was challenging. Finding youth who fit in the TFC program was a challenge as well. For youth who participated in TFC, one observation from all three focus groups was that TFC is not for everyone. They reported more successes among younger TFC youth. The limited flexibility of the TFC Model may have contributed to a poorer fit of the Model for some youth. Finding a stable aftercare home was one of the major challenges. In addition, because the Model does not require the aftercare family to follow the Model and does not contain treatment components for aftercare, this can cause any positive effects of TFC to dissipate once the youth are in the aftercare home.

## Research Question 2: Can the TFC Model be implemented as a community-based alternative to residential treatment?

When focus group participants were asked if and how the TFC Model can be sustained and developed as a community-based alternative to residential treatment, they provided several recommendations for the Model. One suggestion was that trauma-informed work should be built into the TFC Model to understand youth behavior and needs. Several therapy suggestions were made, such as involving the child and family (TFC parents and aftercare families) together in sessions. Finally, participants recommended early identification of the aftercare home, which would allow for training and continuing to learn and develop skills. As one LSSI leader commented, "Aftercare planning is critical from the very beginning in order to have successful outcomes." Participants in all three focus groups agreed on some key ingredients needed for successfully implementing TFC. First, team communication, support, and continuity are critical for implementing, sustaining, and scaling TFC. Also, TFC parents and aftercare families have vital roles in the TFC Model and successful outcomes of youth. They need to understand, buy in to, and follow the Model. In addition to the solid TFC staff, parents, and aftercare families, the other key ingredient is the consistent stream of youth referrals. Focus group findings suggest that, with the necessary supports in place and all members of the TFC team communicating and collaborating, TFC has great potential to lead to positive outcomes in youth. Because of the benefits that TFC has demonstrated in this Pilot, according to DCFS leaders and LSSI leaders, several leaders recommended training all caseworkers and agencies in TFC. Themes from this study suggest that TFC could be a viable, community-based alternative to residential programs.

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# APPENDIX A

**Table A-1. Focus Group Codes and Themes (N = 14 focus group participants)**

| Topic   |                              | Theme (number of people who mentioned this theme)  | DCFS leaders | LSSI leaders | LSSI staff |
|---|------------------------------|--|--------------|--------------|------------|
| Overall TFC Implementation                              | Successes/ benefits of Model | TFC Model provides youth with trauma-informed support through aftercare (3)  | X            | X            | X          |
|   |                              | TFC parents and after care families have vital roles in the TFC Model and successful outcomes of youth (3)   | X            | X            | X          |
|   |                              | TFC Model provides foster parents with ongoing support   | <b>X</b>     |              |            |
|   |                              | TFC staff received adequate support and guidance from their supervisors and team   |              |              | X          |
|   |                              | TFC can work regardless of geography   |              |              | X          |
|   |                              | TFC staff seemed satisfied with their jobs and the turnover rate remained low across the provider teams (2)  |              |              | X          |
|   |                              | High levels of commitment of TFC staff; maintained support for youth and TFC parents (2)   | X            |              |            |
|   | TFC Model Challenges         | Discrepancy between DCFS vision and TFC Model  | X            |              |            |
|   |                              | Discrepancy between provider agency and DCFS regarding permanency goal   |              |              | X          |
|   |                              | Discrepancy between BH's initial scope regarding youth recruitment and actual capacity -BH removed capacity requirement (2)                                    | X            |              |            |
|   |                              | TFC Model is not culturally responsive (2)   |              |              | X          |
|   |                              | Different opinions on fidelity:  |              |              |            |
|   |                              | <ul style="list-style-type: none"> <li>Adhering to the TFC Model and not being able to make changes/adjustments to meet youth needs was challenging</li> </ul> | X            |              |            |
|   |                              | <ul style="list-style-type: none"> <li>Stricter fidelity to TFC Model is necessary (2)</li> </ul>  |              |              | X          |
| The pilot lost some TFC provider agencies over time (2) | X                            |  |              |              |            |



| Topic              |   | Theme (number of people who mentioned this theme)   | DCFS leaders | LSSI leaders | LSSI staff |
|--------------------|---|---|--------------|--------------|------------|
|                    |   | TFC providers experienced different challenges at different timepoints: from referral to youth engagement to program completion | X            |              |            |
|                    |   | Lack of TFC team capacity/self-sufficiency in implementing TFC Model (2)  | X            |              |            |
|                    | Structural/systemic issues that affect implementation | Confusion as to which agency is responsible for what  |              |              | X          |
|                    |   | Sustaining the TFC program was challenging and required ongoing support for implementation                                      | X            |              |            |
|                    |   | Staff turnover varied across the TFC teams  | X            |              |            |
|                    |   | Staff turnover caused inconsistent adherence to the Model (3)   | X            |              |            |
|                    |   | Change of administration with different priorities  | X            |              |            |
|                    |   | Covid-19 pandemic made TFC programming/engagement even more challenging (2)   |              |              | X          |
|                    |   | Transportation support is necessary for youth to engage in TFC sessions   |              |              | X          |
|                    |   | Relationship between provider agency and GAL office was challenging but improved overtime                                       |              | X            |            |
| Rollout Challenges | Recruitment   | Figuring out the referral stream was challenging  |              | X            |            |
|                    |   | Finding youth that fit in TFC program was challenging:  | X            | X            |            |
|                    |   | <ul style="list-style-type: none"> <li>Difficulty in TFC hybrid Model (2)</li> </ul>  |              | X            |            |
|                    |   | <ul style="list-style-type: none"> <li>Youth criteria: Limitations of finding youth that met pilot criteria (3)</li> </ul>      | X            | X            |            |
|                    |   | <ul style="list-style-type: none"> <li>Youth criteria: Pressure to place children who did not meet criteria</li> </ul>          | X            |              |            |
|                    |   | <ul style="list-style-type: none"> <li>Different youth criteria among different provider agencies</li> </ul>                    | X            |              |            |
|                    |   | Narrow scope of the TFC Model (i.e., population and fidelity criteria) left out   | X            |              |            |

| Topic              |                     | Theme (number of people who mentioned this theme)  | DCFS leaders | LSSI leaders | LSSI staff |
|--------------------|---------------------|--|--------------|--------------|------------|
|                    |                     | some youth who could have benefited from the TFC program   |              |              |            |
|                    | Understanding Model | Lack of communication and clarity about the TFC Model (6)  | X            | X            |            |
|                    | Staffing            | Recruiting and building the TFC team members (e.g., program staff, foster parents) was challenging (3)   | X            | X            |            |
| TFC foster parents | Role                | Matching children to homes was essential   | X            |              |            |
|                    |                     | TFC Parents need to understand, buy in to, and follow the Model  | X            | X            | X          |
|                    |                     | <ul style="list-style-type: none"> <li>Boundaries</li> </ul>   |              |              | X          |
|                    |                     | <ul style="list-style-type: none"> <li>Buy-in</li> </ul>   |              | X            |            |
|                    |                     | <ul style="list-style-type: none"> <li>Clear expectations</li> </ul>   | X            |              |            |
|                    |                     | <ul style="list-style-type: none"> <li>Practice: Learning and following the TFC Model takes a lot of practice for TFC parents.</li> </ul>                        |              | X            |            |
|                    |                     | <ul style="list-style-type: none"> <li>Building and maintaining relationships with TFC team and licensing team is necessary for retaining TFC parents</li> </ul> |              | X            |            |
|                    |                     | TFC Parent practices for Model to be successful:   | X            | X            | X          |
|                    |                     | <ul style="list-style-type: none"> <li>Engaging in activities</li> </ul>   |              |              | X          |
|                    |                     | <ul style="list-style-type: none"> <li>Involving the child in goals and incentives</li> </ul>  |              |              | X          |
|                    |                     | <ul style="list-style-type: none"> <li>Modeled effective parenting skills</li> </ul>   | X            |              |            |
|                    |                     | <ul style="list-style-type: none"> <li>Understanding trauma</li> </ul>   |              | X            |            |
|                    | Successes/ benefits | Received support (2)   | X            | X            |            |
|                    |                     | Higher pay   | X            |              |            |
|                    |                     | Training   | X            |              |            |
|                    |                     | Respected members of the child welfare team (2)  | X            | X            |            |
|                    | Challenges          | Recruiting TFC homes is vital to sustain the TFC program, which was often challenging (3)  | X            | X            |            |

| Topic |                                    | Theme (number of people who mentioned this theme)  | DCFS leaders  | LSSI leaders | LSSI staff |   |
|-------|------------------------------------|--|---|--------------|------------|---|
|       |                                    | Buy-in and understanding the Model can be a challenge (2)  |   | X            |            |   |
|       |                                    | TFC therapists' roles are unclear to some TFC parents  |   |              | X          |   |
|       |                                    | Individual therapist's lack of contact with foster parents   |   |              | X          |   |
|       |                                    | Model has high expectations for TFC parents (2)  | X   | X            |            |   |
|       |                                    | Model not trauma-informed enough   |   | X            |            |   |
|       |                                    | Duration at treatment home longer than specified by Model  | X   |              |            |   |
| Youth | Successes                          | Youth engagement (4)   | X   |              | X          |   |
|       |                                    | TFC Model helps youth by providing them with...  | X   |              | X          |   |
|       |                                    | <ul style="list-style-type: none"> <li>a home-like/community setting</li> </ul>                          | X   |              |            |   |
|       |                                    | <ul style="list-style-type: none"> <li>trauma-informed support through aftercare</li> </ul>              |   |              | X          |   |
|       |                                    | <ul style="list-style-type: none"> <li>opportunities</li> </ul>  | X   |              |            |   |
|       |                                    | <ul style="list-style-type: none"> <li>incentive system which helped some youth make progress</li> </ul> | X   |              |            |   |
|       |                                    |  | TFC can help youth achieve academic and social-emotional outcomes (2) |              | X          |   |
|       |                                    |  | TFC can help youth achieve permanency goal (3)                        | X            |            |   |
|       | Challenges                         |  | Building rapport with youth (2)                                       |              |            | X |
|       |                                    |  | Addressing youth situation and needs to access resources/supports     |              |            | X |
|       |                                    |  | Identifying aftercare   | X            |            |   |
|       |                                    |  | TFC is not for everyone (6)   | X            | X          | X |
|       |                                    |  | Finding youth that fit in TFC program (3)                             | X            | X          |   |
|       |                                    | Limited flexibility of TFC Model (2)   | X   |              | X          |   |
|       | Variations in TFC youth experience | More successes are observed among younger TFC youth (5)  | X   | X            | X          |   |

| Topic  |            | Theme (number of people who mentioned this theme)  | DCFS leaders | LSSI leaders | LSSI staff |   |
|--|------------|--|--------------|--------------|------------|---|
|  |            | TFC Model cannot meet the needs of Beyond Medical Necessity (BMN) youth (2)  |              | X            | X          |   |
|  |            | TFC works successfully with youth who are new to the child welfare system  |              | X            |            |   |
|  |            | TFC works successfully with youth stepping down from residential care  |              | X            |            |   |
| Aftercare  | Role       | Buy-in and sustaining the TFC Model in aftercare home is necessary for maintaining treatment progress (3)  |              | X            | X          |   |
|  |            | Important to discuss aftercare plans with child  |              |              | X          |   |
|  | Successes  | Early identification of aftercare home allows for training and consistent continuation of learning and skills (2)  | X            |              |            |   |
|  | Challenges | Model does not require aftercare family to follow the Model and does not contain treatment components for aftercare, which can cause any positive effects of TFC to diminish (5) |              |              | X          | X |
|  |            | Finding stable aftercare home is one of the biggest challenges (3), which is vital to successful outcomes of youth   | X            | X            |            | X |
|  |            | Discharge resources are not formalized (2)   | X            |              |            |   |
|  |            | Disruption sometimes occurred when child transferred to aftercare home, did not have process in place  | X            |              |            |   |
|  |            | Court goals can sometimes not align with aftercare plan  | X            |              |            |   |
|  |            | Engaging aftercare families, can get burned out on TFC   |              |              |            | X |
| Family therapy does not include the child from the beginning (2) |            |  |              |              | X          |   |
| Model does not include child-family team meetings                |            |  |              | X            |            |   |
| Therapists cannot testify in court but some wish they could      |            |  |              | X            |            |   |
| Lack of cultural fit of Model/TFC is not culturally responsive   |            |  |              |              | X          |   |

| Topic           |                                    | Theme (number of people who mentioned this theme)   | DCFS leaders | LSSI leaders | LSSI staff |
|-----------------|------------------------------------|---|--------------|--------------|------------|
|                 |                                    | Model does not address parents' own trauma, intergenerational trauma  |              |              | X          |
|                 |                                    | Lack of streamlined support system for transition to aftercare  |              |              | X          |
|                 |                                    | TFC Model was not designed originally for children and youth in the child welfare system; complicated Model                   |              |              | X          |
| Sustaining TFC  |                                    | Buy-in and support from stakeholders/community is necessary for maintaining the TFC program                                   | X            | X            |            |
|                 |                                    | Team communication, support, and continuity are key (7)   | X            | X            | X          |
|                 |                                    | Having the right person in the recruiter role is integral to the program functioning  |              | X            |            |
|                 |                                    | Same obstacles will continue, such as finding children for the program  | X            | X            |            |
| Recommendations | TFC Model                          | Trauma-informed work should be built into TFC Model to understand youth behavior and needs (4)                                | X            |              | X          |
|                 |                                    | Cultural variation (2); More research is necessary to inform more culturally relevant TFC Model                               |              |              | X          |
|                 |                                    | TFC Model should be more culturally relevant for families of color (2)  |              |              | X          |
|                 |                                    | Model should allow provider to decline cases for TFC  | X            |              |            |
|                 | Only use C Model of TFC, ages 6-11 |   |              | X            |            |
|                 | Therapy recommendations            | All TFC therapists should meet (i.e., peer learning groups)   |              |              | X          |
|                 |                                    | Add an opportunity for youth, TFC parents and aftercare families to meet together ("child and family together" meeting Model) |              |              | X          |
|                 |                                    | Therapist should do home visit observations   |              |              | X          |
|                 |                                    | Aftercare family therapy (2)  |              |              | X          |

| Topic |                           | Theme (number of people who mentioned this theme)                                     | DCFS leaders | LSSI leaders | LSSI staff |
|-------|---------------------------|---|--------------|--------------|------------|
|       | Aftercare recommendations | TFC should continue in aftercare for continuity (2)                                   |              |              | X          |
|       |                           | Establish aftercare prior to entering TFC program                                     |              |              | X          |
|       | Scaling TFC               | Train all caseworkers and agencies in TFC (2)   | X            |              | X          |
|       |                           | Implement TFC Model when child comes into placement                                   | X            |              |            |
|       |                           | TFC team needs continuity and support (2)   | X            |              |            |
|       |                           | TFC is a viable alternative to residential programs                                   |              | X            |            |
|       | Child welfare system      | Apply the lower caseloads of TFC to all DCFS (3)                                      |              |              | X          |
|       |                           | Pay all foster parents the TFC rate, at least for a period of time (3)                | X            | X            |            |
|       |                           | Therapy should be immediately available to all children in DCFS like it is in TFC (2) |              |              | X          |
|       |                           | Consider cost-benefit (2)   | X            |              |            |
|       |                           | TFC-level of support for all foster parents   | X            |              |            |
|       |                           | Pre-TFC training on cultural humility and systemic racism                             |              |              | X          |
|       |                           | Need monitoring support in DCFS   | X            |              |            |

X. At least one member of this group endorsed this statement in the focus group and/or member check survey.

X. All members of this group endorsed this statement in the member check survey.

X. At least one member of this group agreed with this statement and at least one member of this group disagreed with this statement in the member check survey.