Chapin Hall Research Brief

Therapeutic Foster Care (TFC) Pilot Outcome Evaluation

This research brief summarizes the outcome evaluation of the 5-year TFC Pilot in Illinois as a less restrictive, evidence-based alternative setting to residential care for children in the child welfare system who need intensive therapeutic interventions.

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Introduction

The Illinois Children and Family Services Act (Illinois Public Act 099-0350) requires that the Illinois Department of Children and Family Services (DCFS) "implement a 5-year pilot program of multi-dimensional treatment foster care (MTFC), 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 5-year Therapeutic Foster Care (TFC) Pilot. Chapin Hall at the University of Chicago (Chapin Hall) is the independent evaluator of the TFC Pilot, implemented between July 1, 2016, and June 30, 2021.

The TFC 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. Over the 5-year TFC Pilot period, DCFS contracted with four community-based 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 three sites or subregions: Cook County, Aurora, and Rockford. 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.,

TFC Model, by Provider

	CH+A	JCFS	LSSI	YOS
TFC evidence-based model				
Together Facing the Challenge		x		
Therapeutic Foster Care Oregon (TFCO)			x	x
Therapeutic Crisis Intervention – Family (TCI-F)	x			
Trauma-informed intervention				
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT): Together Facing the Challenge		x		
Trauma-informed TFCO and therapists trained in TF-CBT			x	x
All staff trained in both TFC evidence-based model and trauma-focused care	x			x
Therapists providing TF-CBT		x		
Subregion (child's legal/home county)				
Aurora (Kane, DuPage, Kendall, Will counties)			x	
Cook County	x	x	x	x
Rockford (Boone, Ogle, Stephenson, Winnebago counties)			x	
Youth's age range (in years)				
6-11	x		x	
12-14	x	x	x	x
15-17	x	x		x
TFC caregiver				
Foster parent		x	x	x
Home of relative or home of parent	x			
Anticipated length of program	Until permanency	6–12 months	6–9 months	6–9 months
Target population				
1. Deflection: Youth who need residential care but are not currently in residential care		x	x	x
2. Step-Down: Youth who need residential care and are currently in residential care		x	x	x
3. Step-Down (CH+A): Youth who are ready to step-down from residential care but are currently in residential care	x			

2007).

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 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 but instead entered residential care (i.e., deflection comparison group), remained in residential care (i.e., step-down comparison group), or stepped down from residential care to home of relative, home of fictive kin, specialized foster care, or adolescent foster care (i.e., step-down [CH+A] comparison group).

Methods

Sample

From the first TFC referral on February 1, 2017 to the end of the Pilot on June 31, 2021, a total of 93 unique youth were referred to, accepted, and placed in TFC offered by the four providers. 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. Over 60% of TFC youth were younger than age 12 or Black, and over 50% were male.

In the same period between February 1, 2017 and June 30, 2021, 116 youth who were referred to but not placed in TFC comprised the comparison groups, provided they also met the comparison group criteria described. 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).

TFC Intervention and Comparison Groups

TFC Target Population/Intervention Group		TFC Comparison
1. Deflection (need residential care but are not in residential care)	TFC youth (*n*=52) • LSSI (*n*=50) • YOS (*n*=2)	Referred to TFC but placed in residential care (*n*=77)
2. Step-Down (need residential care and are in residential care)	TFC youth (*n*=28) • JCFS (*n*=2) • LSSI (*n*=24) • YOS (*n*=2)	Referred to TFC but remained in residential care (*n*=27)
3. Step-Down (CH+A) (in residential care but do not need residential care and are ready to step-down from residential care)	TFC youth at CH+A (*n*=13)	Referred to TFC but discharged from residential care to home of relative, home of fictive kin, specialized foster care, or adolescent foster care (*n*=12)
Total	**93**	**116**

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 Family Focused Treatment Association (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: (1) Number of TFC referrals; (2) Number of TFC referral acceptances; (3) Number of unique youth ever placed in TFC; (4) Number of unique youth who completed/graduated from TFC; (5) Number of unique youth who disrupted/were not in TFC placement; (6) Number of unique youth who were in TFC placement; (7) Number of TFC inquiries from potential foster families; (8) Number of certified TFC homes; and (9) 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: 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; 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; FFTA #12: Consider and treat foster parents as full professional members of the treatment team; FFTA #14: Emphasize the role of and frequently involve biological families in the TFC process; FFTA #16: Provide for aftercare for TFC foster parents and biological families; FFTA #18: Provide resources for independent and transitional living for older TFC-Enrolled youth; FFTA #20: Frequently seek the input of TFC foster parents, biological families, children, and professional; and 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.

CH+A tracks fidelity regarding: (1) Therapeutic Crisis Intervention – Family (TCI-F); (2) Attachment, Self Regulation, and Competency (ARC); and (3) Excellence Academy.

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; and 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. 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:

Proximal Outcome (PO)

PO1: Percentage of youth with one or more substantiated investigation[1]

Intermediate Outcomes (IO)

IO1: Percentage of discharge to home-based care[2]; **IO2:** Percentage of discharge to permanency[3]; and **IO3:** Length of stay[4]

Distal Outcomes (DO)

DO1: Percentage of days in detention[5]; **DO2:** Percentage of days in psychiatric hospital[6]; **DO3:** Percentage of days in runaway[7]; **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 (6 items) from baseline[8] to follow-up[9]; **DO6:** Change in emotional/behavioral needs CANS domain score (13 items) from baseline[8] to follow-up[9]; **DO7:** Change in risk behaviors CANS domain score (10 items) from baseline[8] to follow-up[9]; **DO8:** Change in social functional behaviors CANS domain score (3 items) from baseline[8] to follow-up[9]; and **DO9:** Number of placement moves[10] per day in care.

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[1] Substantiated investigation during TFC (intervention groups) or during residential care (comparison groups), using report date of investigation.

[2] 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).

[3] 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]).

[4] Defined by number of days in TFC (intervention groups) or residential care (comparison groups).

[5] Defined by the placement type of DET (Detention).

[6] Defined by the placement type of HHF (Hospital/Healthcare Facility) or HFP (Hospital Facility Psychiatric).

[7] 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).

[8] Baseline CANS is defined by: (1) 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> (2) 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).

[9] 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.

[10] Placement moves are considered for three placement groups: (1) 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); (2) Independent Living Group: ASD

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.

Findings

What was the TFC Pilot capacity and fidelity to TFC?

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.

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

CH+A and LSSI provided fidelity data to select FFTA standards for the final Pilot period from January 1 to June 30, 2021. 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

(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); and (3) 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. Moves within the same placement group are not considered moves if any of the following conditions are true: (1) Open code is AA (Adoption Assistance); (2) Event = End event & Provider ID = End provider ID or 000000 or is missing; (3) Event = 000 (beginning of a case); or (4) End event = ZZZ (end of a case or CEN [Censored, whereby the case was still open as of June 30, 2021]).

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.

What were the outcome differences between the TFC intervention groups and comparison groups?

The three TFC intervention groups—deflection, step-down, and step-down (CH+A)—were compared to their respective TFC comparison groups on 13 outcomes. 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. By design, the comparison groups were considered "matched" to their respective intervention groups. As expected, the three intervention groups and their respective comparison groups were demographically comparable. 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%, $p<.05$).

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

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the intervention, 13 favored the comparison, and 5 showed no difference between the intervention and comparison.

> The deflection and step-down intervention groups had **a significantly greater percentage of discharges from TFC to family and fictive kin caregivers** than their comparison groups.

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.

Outcome Comparisons

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
Proximal Outcome (PO)				
PO1: Percentage of youth with one or more substantiated investigations	Intervention < Comparison	✓ (n.s.)	⦸ (n.s.)	No difference (n.s.)
Intermediate Outcomes (IO)				
IO1: Percentage of discharge to home-based care	Intervention > Comparison	✓***	✓*	⦸ (n.s.)
IO2: Percentage of discharge to permanency	Intervention > Comparison	✓ (n.s.)	⦸ (n.s.)	✓ (n.s.)
IO3: Length of stay	Intervention < Comparison (deflection and step-down) Intervention > Comparison (CH+A)	✓***	✓ (n.s.)	⦸ (n.s.)
Distal Outcomes (DO)				
During TFC/residential care and within 6 months of TFC/residential care discharge:				
DO1: Percentage of days in detention	Intervention < Comparison	⦸ (n.s.)	✓ (n.s.)	✓ (n.s.)
DO2: Percentage of days in psychiatric hospital	Intervention < Comparison	⦸***	⦸ (n.s.)	✓ (n.s.)
DO3: Percentage of days in runaway	Intervention < Comparison	✓ (n.s.)	✓ (n.s.)	✓ (n.s.)
DO4: 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.)
DO5: 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.)
DO6: 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.)
DO7: 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.)
DO8: 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.)
Within 6 months of TFC/residential care discharge:				
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; $^*p<.05$; $^{**}p<.01$; $^{***}p<.001$.

Implications

Pursuant to Illinois Public Act 099-0350, Chapin Hall conducted an outcome evaluation of the 5-year DCFS TFC Pilot to demonstrate whether TFC can 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.

> 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.

The TFC Pilot, despite receiving over 350 TFC referrals over the 5-year period, initially accepted 38% of the referrals and eventually placed 25% of referred youth into TFC. This suggested that increasing the capacity of TFC would require local adjustments to the eligibility, screening, and engagement with potential homes in concert with the developer of a given TFC model. That over 80% of the TFC Pilot youth received LSSI's TFCO intervention also suggested that some TFC models might be more viable and feasible for implementation than others. By committing to careful tracking of productivity and fidelity, LSSI and CH+A, as the two primary providers of the TFC Pilot, were able to collaborate with DCFS to address specific challeges in the implementation process (e.g., referral, home recruitment, staffing/training, etc.).

The outcome study did not identify clear patterns of TFC's effectiveness across the three target populations: deflection, step-down, and step-down (CH+A). Most differences in outcomes observed between the intervention and comparison groups were not statistically significant. Among the outcome differences that were statistically significant, TFC deflection and TFC step-down contributed to a shorter length of stay (as intended) followed by favorable discharges to home-based care as opposed to residential care. However, some of these TFC youth also experienced a greater percentage of care days in psychiatric hospitals or more placement moves. 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.

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. 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. 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 and greater placement instability, likely due to elevated needs that could otherwise be monitored and managed in residential care. 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. These developments suggest that it would be possible to continue TFC in Illinois.

> 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.**

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Established in 1985, Chapin Hall's areas of research include child welfare systems, community capacity to support children and families, and youth homelessness. For more information about Chapin Hall, visit www.chapinhall.org or @Chapin_Hall.

Acknowledgement and Disclaimer

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