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REPORT

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Building a Case for Change

Foster Parent Support Pilot Study: Final Report

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Partners for Our Children is committed to improving the lives of Washington state foster children through rigorous research, analysis and evidence-based innovation. The organization, founded in 2007, is a collaborative effort of the University of Washington School of Social Work, Washington State Department of Social and Health Services and private funders.

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Contents

Section I: Executive Summary 3

Section II: Introduction 6

Section III: Methods 8

Section IV: Results 13

Section V: Conclusions 29

References 31

Appendix 32

SECTION I: EXECUTIVE SUMMARY

Introduction

The Foster Parent Support Pilot (FPSP) study was designed as the first step in a process to determine whether the Mockingbird Family Model (MFM) would be an efficacious model of providing foster care through the state public child welfare system. Partners for Our Children (POC), in collaboration with the Mockingbird Society and the DSHS Children's Administration, planned to develop new MFM constellations in up to three regions of Washington State in 2008. The intention was to use these new sites to test the ability to duplicate the program model in a consistent manner across locations within the public child welfare system. The goal of the pilot was to examine the potential to conduct a large-scale evaluation to assess the effect of the MFM on placement stability, permanency and the well-being of children and families. The first stage of the Foster Parent Support Pilot Study began in Region 3 in the summer of 2008. The plan was to follow children residing in the participating foster homes for two years in order to monitor outcomes of the children and their foster parents. In January 2009, Region 6 was to commence as the second site for the pilot, followed by a third (to be identified) site/region.

Early Termination of the Pilot Study

Two important findings early on led to a decision to terminate the Foster Parent Support Pilot Study after only one year of data collection which was considerably earlier than originally intended.

> First, in Region 3, despite stellar outreach efforts on the part of the Children's Administration, the percentage of eligible parents willing to attend an information session to hear about the MFM and other types of support for foster parents was much lower than anticipated and indicated to the researchers that the rate of "take up" of the intervention could potentially obviate the possibility of conducting a full scale, statewide evaluation of the Mockingbird Family Model. The decision was made to continue to try to recruit foster parents in Region 3 and also to see what level of interest would be demonstrated in Region 6. In Region 3, recruitment efforts continued through the fall of 2008 but yielded only a small increase in interested foster parents.
>
> Second, just prior to the point of implementation (12/31/08), Region 6 Children's Administration decided that there weren't sufficient resources to support the pilot study in that region. This meant that it wouldn't be possible to assess the comparative "take up" rate in Region 6 and furthermore, it spoke to the limitations of the public child welfare system to expend the resources to launch a full-scale evaluation.

Based on these findings, the POC researchers concluded that a full scale, statewide MFM evaluation study within the public child welfare system would not be feasible. A decision was made to terminate the pilot in Region 3 after one year of data collection. Modifications to the research plan were made in an effort to maximize what could be learned from this effort despite the early termination. For example, an exit survey was added and conducted with all study participants to ask about specific challenges they have faced as foster parents and to learn more about the kinds of support that would be helpful to them. Participants were also asked them about their experience participating in the study. The goal in gathering this type of qualitative information was to gain valuable information to inform POC's general foster parent recruitment and retention mission. Modifications were also made to the original study protocol in order to economize on resources that were no longer going to yield meaningful information because of the very small size of the study sample. For example, the labor intensive and costly efforts to extract CAMIS data on the foster parents and children were not undertaken since they were unlikely to yield meaningful comparative data given the small size of the participating study sample.

Although the Foster Parent Support Pilot study was terminated early, it generated useful information regarding the feasibility of using the MFM as a model for providing public child welfare services in Washington State. The pilot

study also provided insight into the types of support foster parents need. This report presents a detailed description of the pilot study methods and findings from the data collected in Region 3 from July 2008 through October of 2009.

Pilot Study Overview

The Mockingbird Family Model (MFM) is designed to provide support to foster families through the creation of a micro-community, made up of a constellation of foster families and a hub home, headed by an experienced foster parent. This structure is intended to increase foster parents' access to respite care and resources. The goal of this increased support is to minimize placement disruptions and create an environment where foster children will feel safe and secure while also forming supportive relationships with caring adults.

The goals of the MFM Program are:

1. To provide a foster care model and be a catalyst for systems change in the child welfare system.
2. To increase permanency and placement stability of children in foster care by: a) providing a model that addresses gaps in the child welfare system, b) improving the sense of connection and social and emotional well-being of foster children, youth and their caregivers and, c) supporting and stabilizing foster and kinship families so children and youths experience the positive qualities and resources found in naturally thriving families.

The Foster Parent Support Pilot study was aimed at testing the feasibility of evaluating the effectiveness of the MFM in achieving the second MFM program goal listed above.

Evaluation Methods

Foster parents living in geographic proximity to the designated hub home in Region 3 were randomly assigned to participate in either the intervention or comparison group. The intervention group participated in a Mockingbird Family Model (MFM) constellation in addition to being eligible for the typical support services offered to foster parents by the DSHS Children's Administration in the Region. The comparison group received foster family support services typically provided by the Children's Administration in Region 3.

At baseline and every six months, assessments were conducted to measure foster parents' stress, depression and family support. Foster parents were asked to complete standardized assessment measures at six month intervals to assess foster children's social, emotional, and behavioral development and well-being. Qualitative and quantitative data on child placement changes, level of cooperation with caregivers, visits with family, and foster parents use of respite services, participation in other support services and training were collected from all participating foster parents through monthly phone interviews. In addition, qualitative data were gathered in a final exit interview to learn more about the kinds of support that foster parents felt would be most helpful to them.

Results

Between July 2008 and October 2009, 16 foster families and 45 children participated in the study. Of these, six families and 20 children participated in the Mockingbird constellation; ten families and 25 children comprised the comparison group. Children in the foster homes at baseline (n=28) were followed for an average of 8.6 months. Children who entered the homes after the study had started (n=17) were followed for an average of 4.1 months. Foster parents (n=16) were followed for an average of 11.3 months. The gender breakdown of participating children (60% female, 40% male) was the same across both groups. The average age of participating children in both groups was 4.9 years. The majority of foster parent respondents were female (94%), not related to the foster children in their care, and had an average age of 38 years.

Because of the limited sample size, this study did not have the statistical power to meaningfully compare the outcomes of interest in the intervention and comparison group children. Therefore, we simply provide descriptive data indicating the status of the children at the end of the study. Of the28 baseline children, 18% were reunited with their biological family, another 4% were in some other type of permanent placement, 46% were still in the same foster home and 32% were living in another foster home outside of the study. Of the 17 children placed after the study had already started, 6% had been reunified, 6% were in some other permanent placement, 41% were still in the same foster home and 47% were living in another foster home outside of the study at the time the study ended.

Developmental assessments completed on 24 children who were living in the foster home at the time of the six month assessments. Approximately 67% of the children were in the "clinical" range on one or more assessments indicating that they had some sort of physical, social-emotional or behavioral issues and may have a need for more resources and support. Foster parents spoke clearly about their need for better access to physical and mental health care for their foster children.

Foster parents in the intervention group (MFM) reported participating in more formal support specifically targeted toward foster parents than the comparison group. This was primarily a result of the monthly constellation meeting and activities that the intervention group participated in. Foster parents in the intervention and comparison groups received similar levels of respite care. The hub home was the most frequently cited source of respite care for the intervention group. For the comparison group, which did not have a hub home to provide respite care, the most commonly cited provider of respite care was from a known respite provider. Foster parents in the comparison group reported receiving more informal foster parent support such as getting together informally with other foster parents.

Foster parents reported a need for better knowledge of and access to resources, services, and navigation through the child welfare system, as well as one-on-one mentoring from a more experienced peer. The mentoring and support from the MFM hub home seemed to answer this need. Participants in the intervention group suggested that this, rather than the respite care that the MFM hub home offered, was the most supportive to them.

Foster parents cited their spouse or partner, friends, and other foster parents as important sources of support. Social workers were high on foster parents' list of important sources of support. At the same time, foster parents were concerned with social workers' limitations due to high caseloads, the inconsistencies of the involvement of multiple workers throughout a case, and unsatisfactory communication with social workers and DSHS.

Conclusions and Recommendations

There were a variety of barriers that prevented this pilot study from being broadly implemented. The low rate of recruitment and participation and lack of resources from collaborating parties made a full scale, statewide evaluation unfeasible. The Foster Parent Support Pilot Study never reached a sizeable enough sample to be able to comparatively examine outcomes between the intervention and comparison groups. As a result, while the MFM was appreciated by foster parents who were involved in the constellation, it seems that the MFM is not necessarily the only or best way to provide foster parents with what they need and want in terms of support. The knowledge sharing, stability, and community support were clear strengths that foster parents reported receiving from their participation in the MFM, while respite care was reportedly less crucial to them.

Despite these limitations, this study gathered important information, especially regarding foster parent needs that, if met, could provide improved stability and well-being for foster children:

- more direct support or mentoring when dealing with the system and other challenges of being a foster parent,
- more knowledge of and access to resources and services, especially high quality physical and mental health care,
- enhanced communication from caseworkers and DSHS, and
- support and guidance in relationships with foster children's biological families.

Summary

The Mockingbird Family Model (MFM), as it is conceived, does not appear to be a viable, alternative model for providing publicly funded foster care since there was not a high enough rate of participation on the part of foster parents, nor the capacity on the part of the system to mount such a resource intensive model and evaluation. Therefore, while the MFM worked well for the families that were involved, because it cannot be rigorously evaluated on a larger scale, it is not possible to draw any conclusions about the impact of the MFM on the identified outcomes of interest for foster children and families. It is very advantageous that this important knowledge was gained through a pilot study prior to attempts to implement a much more costly, full scale evaluation.

SECTION II: INTRODUCTION

History

The Mockingbird Family Model (MFM) was developed to provide support to foster families through the creation of a micro-community intended to increase access to respite care and resources. The MFM places foster children and youth into a community of six to ten foster and kinship homes in a given neighborhood. At the center of the foster homes is a "hub" foster home operated by experienced foster parents who provide regular, scheduled respite care and who coordinate family meetings, social events, and child and youth activities to support children and caregivers within the cluster or "constellation" of foster /kinship homes. The goal of this increased support has been to minimize placement disruptions and create an environment where foster children will feel safe and secure while also forming supportive relationships with caring adults.

In response to an identified need for additional support to recruit and retain foster parents, the Mockingbird Society procured demonstration funds in 2004 and private funding in 2005 to implement a single constellation of the Mockingbird Family Model. In 2006, the Mockingbird Society collaborated with 4 different host agencies and began implementation of 4 MFM constellations in Region 4. In 2006, Mockingbird Society also established collaboration with the District of Columbia's Department of Human Services to form two additional constellations in Washington, DC.

Early Evaluation of the MFM

The Northwest Institute for Children and Families conducted ongoing evaluation during the early implementation phases of the MFM. Five evaluation reports chronicling the findings from 2004-2006 related to the implementation of the MFM were written and can be found on the Mockingbird Society webpage (http://www.mockingbirdsociety.org/the-mockingbird-family-model/reports-evaluations/). Appropriate to the stage of the intervention, the nature of the evaluation over this period of time was predominantly formative and the findings primarily qualitative. The goals and outcomes of the MFM prior to 2006 were primarily service delivery goals and the earlier evaluations focused on the collection of qualitative data that indicated whether or not those goals had been achieved. In 2006, there was a shift to include a more clearly specified interest in placement stability and activities that would have some bearing on permanency, such as the use of the hub home for visits with the biological family or other caring families that may be related to permanent placement.

Development of MFM Logic Model

Beginning in the fall of 2007, Partners for Our Children (POC) worked with Mockingbird Society to gain a better understanding of the MFM program goals and determine what outcome measures to evaluate. This work involved

extensive discussion with the Mockingbird Society and examination of all program materials, fidelity protocols, evaluation reports, etc., and resulted in the identification of two primary goals for the MFM:

1.) To provide a foster care model and be a catalyst for systems change in the child welfare system.

2.) To increase permanency and placement stability of children in foster care by providing a model that aims to:

- Address gaps in the current foster care system
- Improve the sense of connection and social and emotional well-being of foster children and youths and their caregivers
- Support and stabilize foster and kinship families so children and youths experience the positive qualities and resources found in naturally thriving families.

The logic model, found on the following pages, was developed to further explicate these goals (Appendix A). The next step for this program was to determine the feasibility of evaluating the impact of the MFM on these and other outcomes. This led to the initiation of the Foster Parent Support Pilot Study.

Purpose of Foster Parent Support Pilot Study

In order to determine whether the Mockingbird Family Model (MFM) would be an efficacious model of providing foster care through the state public child welfare system, it was decided that a rigorous outcome evaluation was needed. The first step in this process was to conduct a pilot study to explore whether the Mockingbird Family Model could serve as a statewide model within the public foster care system. As part of this pilot study, Partners for Our Children (POC), in collaboration with the Mockingbird Society and the DSHS Children's Administration, planned to develop new MFM constellations in up to three regions of Washington State in 2008. The intention was to use these new sites to test the ability to duplicate the program model consistently across locations and examine the potential to conduct a large-scale evaluation to assess the changes in well-being of children and families that could be attributed to the MFM. The first stage of the Foster Parent Support Pilot Study began in Region 3. Region 6 was to follow shortly thereafter as the second site for the pilot, followed by a third (unidentified) site/region.

The overall goal of the Foster Parent Support Pilot Study was to determine whether it would be feasible to implement and evaluate the Mockingbird Family Model through regional Children's Administration offices across the state of Washington. The pilot conducted in Region 3 was designed to allow for the testing of methods of implementation and evaluation to determine whether the effects of this model in improving foster children's placement stability, permanency and other related outcomes, could be implemented more broadly in a statewide effort. An issue in determining whether a model can be "taken to scale" involves determining how the model will function across actual practice conditions in the field. Success might depend less on the model itself and more on the contextual conditions into which the model is placed. Therefore, an important question regarding whether or not this intervention model can be taken "to scale" involved determining the ability of it to function well under "randomly assigned" conditions. In this pilot, licensed foster families were randomly assigned either to an intervention group or a comparison group. The intervention group involved participation in the MFM constellation in addition to being eligible for the typical support services provided by the CA office. The comparison group was only eligible to receive the typical support services offered by the CA office.

Region 3 was selected as the first pilot location because there was a sufficiently large concentration of foster homes as well as enthusiasm around implementing the MFM. The study was designed to pilot the process of data collection in order to examine the impact of the MFM on permanency, placement stability and foster child and foster parent wellbeing and other short and long term outcomes indicated in the logic model. In addition to piloting procedures and measures that would be used in a full scale outcome evaluation study, the pilot was designed to help to determine

the proportion of foster and kinship families interested in participating in enhanced support through the MFM as well as answer other questions regarding study logistics.

The following questions on the feasibility of the design, methods and logistics were addressed in the pilot:

1.) Can the MFM be implemented using random assignment of foster families to either a MFM constellation or the typical support services offered to foster families throughout the region's CA office?

2.) What are the facilitators and barriers to broader implementation? Are there systemic and structural facilitators and barriers?

3.) Are a sufficient percentage of foster families in the region interested enough in learning about the MFM? Are they willing to participate in a research study? What factors determine willingness to participate? What is the difference between families that opt to participate and those that opt out?

All study procedures, assessment measures, consent forms, participant incentives and modifications were reviewed and approved by the Washington State Institutional Review Board prior to implementation.

SECTION III: METHODS

Sample

The pilot study in Region 3 involved foster families residing in three zip codes in South Everett: 98203, 98204 and 98208 comprising the geographic region in close enough proximity to be served by the MFM hub home. Drawing on those providing consent to participate, the pilot study sample selection was to involve a rolling random assignment to experimental or comparison conditions. At study start-up, the goal for the first wave of enrollment was to randomly assign five families to the MFM constellation (including the hub home) and ten to the comparison group. A rolling recruitment was recommended in order to allow the constellation to get established. Every two months, two more families were to be added to the constellation and four to the comparison group. The overall goal for the pilot study was to recruit 30 families over a period of six months, ten for the MFM and 20 for the comparison group.

All children ages zero to 17 in the participating foster homes were to be included in the study sample with their social worker's consent for them to participate. The children and foster parents were to be followed for two years from the time the child entered the foster home. Children that were already residing in a study foster home were to be followed for two years from the time that the pilot study began. Assuming that foster homes could have anywhere from one to four children residing in the home, at the end of the follow up period, the expected sample size for the experimental group was ten to 40 children and ten foster parents (depending on the size of the foster family). The expected sample size for the comparison group was 20 to 80 children and 20 foster parents.

As it turned out, the pilot study was conducted from July 2008 until October of 2009 and enrolled 16 foster families and 45 children into the study. Of these 16 families, six families (including the hub home family) were in the intervention group and ten families were in the comparison group. Over the course of the study, a total of 20 children resided in intervention group homes and 25 children resided in comparison group homes.

Recruitment

Upon Washington State Institutional Review Board approval, in May of 2008, Children's Administration (CA) staff from Region 3 compiled a list of all licensed foster parents within the zip codes/geographic region to be served by the Mockingbird Family Model (MFM) hub home. As of June 2008, the list included 48 foster homes.

An invitation letter and flyer were sent to all 48 foster families inviting them to attend an information session to find out about available support for foster parents offered by Olive Crest, and to hear about the MFM and pilot study. As

follow up to the letters, phone calls were made to all families. If families weren't reached on the first phone call, a second call was made. If families didn't answer, a phone message was left reiterating the invitation, event dates and CA contact information.

The foster parent information events were held on an evening during the week and also on a weekend to accommodate families' scheduling needs. A meal and childcare were provided as well as two hours of training credit for caregivers. A Mockingbird Society representative and the following CA staff attended all information/recruitment events: CA Program Coordinator, Child Welfare Services Supervisor, Placement Desk Coordinator, Licensor, Hub Home Parent, and CA-contracted Foster Parent Support Liaison (from Olive Crest). Presentations were made about foster parent support resources offered by CA, the Mockingbird Family Model and the pilot study. After the presentations, interested families were invited to consider consenting to participate in the Foster Parent Support Pilot Study. For those who were interested, the consent process was conducted at that time.

Initially, the pilot study research team anticipated having to randomly select families to participate in the first wave of recruitment. The remaining families would be considered for subsequent waves along with newly licensed families. As it turned out, the response to the invitation was considerably smaller than anticipated. The two initial recruitment events held in July only yielded a total (at the time) of five consenting families. As a result, two additional recruitment events were scheduled in August which resulted in another six families agreeing to participate.

CA staff recorded the reasons for non-participation in these recruitment events. Approximately half of the foster parents were never directly reached or spoken to despite several attempts by CA staff to reach them by phone. Of the ones that CA staff spoke with who said they would not attend, the following reasons were given for their lack of willingness to attend an information session or consider participation: a) too busy *(n=2)*; b) difficult placement had resulted in plan to discontinue foster parenting *(n=1)*; c) moving out of area *(n=1)*; and, d) health issues *(n=1)*.

A second wave of recruitment commenced using the same procedures as in Wave 1. First, all newly licensed families (three) were added to the previous list after removing those from the original list that had moved or explicitly declined participation. A letter and flyer were sent and follow up phone calls made to the 29 families on the current list inviting them to participate in one of two recruitment events scheduled in October and November. CA staff spent approximately 40 hours on recruitment efforts in September and October for these two events. This didn't include announcements made at the CA subcontracted monthly foster parent support group and encouraging already participating families to spread the word. The October recruitment event was cancelled because no foster parents planned to attend. Reasons given for not attending included feedback from some newly licensed foster families who did not want to participate because they didn't want to start anything new at that point as they were busy with new placements and "learning the ropes".

After the October event, outreach continued and although four to five families were expected for the November recruitment event, only one family attended. The family agreed to participate in the study. Subsequent to the November recruitment event, the program coordinator followed up with all the families that had been expected to attend the November event. Based on those efforts, one additional family agreed to participate in the pilot study. A total of four families were added to the study in Wave 2; two that resulted from the Wave 2 recruitment efforts and two from Wave 1 who had delayed their participation until Wave 2.

Table 1 indicates the dates the recruitment events were held and the number of foster parents that attended and consented to participate as a percentage of the 51 foster parents who were eligible and contacted about participation.

Table 1. Foster Parent Support Pilot Study - Recruitment and Enrollment Rates

Date of Recruitment Event	Number of foster families attending	Attendance Cumulative Percent	Number of foster parents eventually consenting to participate	Consent Cumulative Percent
July 9th	2	3.9%	1*	1.9%
July 12th	5	13.7%	4*	9.8%
August 12th	3	19.6%	3	15.7%
August 20th	3	25.5%	3	21.6%
October 22nd - cancelled due to lack of attendance	0	25.5%	0	21.6%
November 18th	1	27.4%	2*	25.5%
December 12th (via home visit by CA staff in week prior)	1	29.4%	2*	29.4%

*One family consented to participate after the study and randomization for Wave 1 had already occurred and one family had withdrawn during Wave 1 because they were planning to move out of the area but subsequently changed their plans. Both families were subsequently randomized with the other Wave 2 recruits.

Enrollment

Including the hub home, a total of 16 foster families agreed to participate in the study after 6 months of recruitment efforts. Baseline randomization and data collection began in two waves, one in August and a second in December of 2008. Once foster parents had consented to participate, but prior to randomization, baseline demographic and psychosocial data were collected.

Randomization

Random assignment of the families to the intervention or comparison group involved a two step process. A random number generator was used to assign a number to each consenting family and a second random selection process was used to select the numbers to be assigned to the intervention group. Families were notified by mail as to which group they were assigned and then instructed regarding next steps for participation in the pilot study. The first wave of recruitment began with 11 consenting families of which four were subsequently randomized to the MFM constellation and seven to the comparison group. The second wave of recruitment resulted in four consenting families. One was randomly assigned to the intervention group and the remaining three to the comparison group. Including the hub home, the total baseline enrollment for Waves 1 and 2 combined was six families in the intervention group and 10 in the comparison group.

Intervention Group: Mockingbird Family Model (MFM) - The foster families randomly assigned to the intervention group participated in a Mockingbird Family Model constellation in addition to being eligible for all the typical support services offered to foster parents by the DSHS Children's Administration in the Region. The hub home foster parent was identified prior to the start of the pilot study and was selected because she was a veteran foster parent with over 20 years of experience. The Mockingbird Society's criteria for selection of a hub home includes strong experience as a licensed foster care provider with excellent communication and leadership skills, the ability to

organize, facilitate and build relationships with adults, children and youths, and conflict resolution and crisis management experience and skills. The MFM constellation received training in late September and was officially launched on October 1st, 2008. The satellite homes comprising the MFM constellation were invited to participate in monthly events and to take advantage of respite care and other services and expertise offered by the hub home.

Comparison Group: Region 3 Foster Family Support Services - The comparison group received foster family support services typically provided by the Children's Administration in Region 3. During the period that the pilot study was being conducted, Region 3 had a contractual agreement with Olive Crest, the objective of which was to recruit and support foster and adoptive parents so they can better support children in out-of-home care. The services were expected to achieve a matching of the cultural and behavioral needs of children in care with appropriate community-based homes. In partnership with the Children's Administration, Olive Crest had identified recruitment, retention and support of foster parents as an area of focus. Typical foster parent support services provided in Region 3 through an agreement with Olive Crest included:

a) Support groups in which a group of foster parents meet together regularly more informally to connect and network with each other,

b.) A buddy system which is the pairing of a veteran foster parent/family with a new foster/parent family and,

c.) A mentoring system which serves as a hand-holding method to provide guidance to foster parents going through the licensing process and to provide ongoing guidance and support once licensed.

Data Collection and Measures

Foster Parent Assessments - Each foster family identified a primary caregiver who would be the respondent for the purposes of the study. Prior to being randomized to the intervention or comparison group, the primary caregiver for each of the foster families was interviewed regarding family demographics, parental depression, social support and parenting stress. The measures used included the Center for Epidemiologic Studies – Depression Scale (CES-D) (Radloff, 1977), the Family Support Scale (FSS) (Dunst et. al., 1988) and the Parental Stress Scale (PSS) (Berry and Jones, 1995). Subsequent to these foster parent assessments, the families received their random assignment to participate in either the MFM constellation or the comparison group. Following baseline data collection, information on foster parent stress, depression and social support were to be collected every six months throughout the course of the study. Foster parents received a cash incentive of $25 each time they completed these assessments. Given that the study ended after one year, these assessments were conducted twice, at baseline and again after foster parents had participated in the study for 6 months.

Monthly Check-In Phone Calls - After families consented to participate in the study, research staff contacted the foster children's social workers to seek permission from them to allow the foster parents to share information about the children. Monthly check-in phone calls with the foster parents began in November of 2008. The monthly check-in phone calls were conducted in order to track new placements, changes in placement and reasons for placement changes over the course of the study, to find out how things were going with the foster child(ren), to identify foster parent support, respite and training resources needed and used, to track foster children's visits with biological family, and cultural connections that had occurred in the past month. On average, approximately 3 calls were made per family each month in order to schedule and complete the monthly check-in survey. In appreciation for their completion of the monthly check-in phone call, foster parents were mailed gift cards each month ranging from $5-$15 depending on the number of foster children in their care.

Child Assessments - The physical, social-emotional and behavioral development of the foster children was assessed after foster parents had participate in the study for six months using a subset of the standardized assessment tools that CA uses for their Child Health and Education Tracking (CHET) screenings. The assessments included the Ages &

Stages Questionnaire (ASQ), the Ages & Stages Questionnaire: Social Emotional (ASQ:SE) (Bricker et. al. 1999) and the Child Behavior Checklist (CBCL). Foster parents completed these assessments for each child in their care. Foster parent were compensated $25 for each child assessment completed. If children scored in the clinical range on any of the assessments the foster parent and the social worker were notified so that a decision could be made about appropriate follow up.

Table 2. Schedule of Assessment Measures

Outcomes	**Measurement Tool/Source**	**Frequency**
Caregiver:		
Increased social support	Family Support Scale	Baseline, Every 6 months
Decreased Stress	Parental Stress Scale	Baseline, Every 6 months
Depression	CES-D	Baseline, Every 6 months
Satisfaction with foster parenting	Parental Stress Scale	Baseline, Every 6 months
Avoidance of placement disruption	Monthly Check-in Survey	Monthly
Respite Care	Monthly Check-in Survey	Monthly
Quality of parent/child interactions	Monthly Check-in Survey	Monthly
Child:		
Development, emotional strengths, social skills and awareness	ASQ, ASQ:SE, CBCL	Every 6 months
Visits with biological families	Monthly Check-in Survey	Monthly
Connections with siblings, peers, community members	Monthly Check-in Survey	Monthly
Runaways and time on the run	Monthly Check-in Survey	Monthly

Children's Administration Management Information System (CAMIS) Data – The original plan for the Foster Parent Support Pilot Study was to request CAMIS from Children's Administration for the children and foster parents participating in the study. Permission from the children's social worker was received to allow the research team to examine child welfare variables for each participating foster child including: child demographic characteristics (age, date of birth, gender, race/ethnicity), CPS accepted referral data (type(s) of alleged abuse and date(s) of referral), findings of the allegations, and placement data (dates of all entries and exits from care, placement type, start and end, permanency outcomes (reunification, adoption, guardianship for all exits), zip code of residence prior to placement and Child Health and Education Tracking data (CHET). In addition, foster parents granted permission to allow the research team to examine data pertaining to their foster parent license including: the type of foster parent license they hold and the ages of children they are licensed to care for, types and dates of training they have received, the length of time they have been licensed as a foster parent, and the number of adults in the home. The intention was to use (CAMIS) data to contrast outcomes of children in the intervention and comparison groups in terms of; children's health and wellbeing, children's placement stability and permanency outcomes while also having the ability to adjust for baseline differences in foster parent experience and resources.

In addition, the intention had been to use de-identified CAMIS data in aggregate to look at non-participating, eligible foster parents to determine whether there were significant differences in the characteristics of those who consented to participate and those that did not consent. These two groups were to have been compared in terms of demographic variables such as age and race/ethnicity as well as variables related to foster parents' licensing characteristics such as length of time as a foster parent, types of care they were licensed to provide and ages of children they were licensed to care for.

As will be explained in greater detail later in this report, CAMIS data were not extracted or analyzed for the Foster Parent Support Pilot study. When it became apparent that a full scale evaluation of the MFM was not going to be feasible for Washington State, a decision was made not to expend the resources that would be required to extricate the CAMIS records for these children and families because they would not have added value or meaning to the findings given that the pilot study only involved one region and had a much smaller than anticipated study sample.

Exit Interview – After it was determined that a full scale evaluation of the MFM would not be possible in Washington State because of insufficient rates of take-up by foster parents and the fact that only one CA site participated, it was clear that there wouldn't be sufficient sample size to make quantitative comparisons between the intervention and comparison groups. As a result, the POC research team, in consultation with CA and the Mockingbird Society, decided to terminate the Foster Parent Support Pilot Study after one year of data collection. In an effort to learn as much as possible from the study, the research team decided to concentrate on qualitative data collection and an exit interview was designed to capture, in greater depth, the qualitative experience and needs of foster parents participating in the study. At the end of the study, all 15 participating foster parents were interviewed by phone using a semi-structured interview instrument in October, 2009. In appreciation for their time completing the exit interview, foster parents were sent a $75 gift card.

SECTION IV: RESULTS

Feasibility of Full Scale Evaluation of Mockingbird Family Model

It became clear early on in conducting the Foster Parent Support Pilot Study that a full scale, statewide, experimental evaluation of the Mockingbird Family Model would not be feasible given; the take-up rate of eligible foster parents was very low despite extensive recruitment efforts on the part of Region 3 Children's Administration, and only one region was able to actively participate in the pilot study. As a result, the study was terminated early and procedures were modified to include a larger qualitative component of the study in order to maximize what was learned from the effort. The findings from the quantitative and qualitative components of the pilot study follow.

Description of Participants and Their Study Involvement

Foster Parents – A total of 16 foster families (including the hub home family) participated in the study, 12 in Wave 1 and four in Wave 2. Except for one family that moved out of state after participating in the study for four months, all families were followed until October of 2009, the end point of data collection for the study. The first wave of 12 families (with the exception of the family that moved) participated in the study for all 13 months. The second wave of participants was involved for an average of 8.5 months. With the two waves combined, the intervention group participated for an average of 12.2 months and the comparison group an average of 10.8 months. Over the course of the study, foster parents were contacted monthly for continuous follow up and data collection. Wave 1 participants began to be contacted in November, 2008 for monthly check-ins, and those in Wave 2 began in March, 2009. A total of 116 monthly check-ins were conducted over the year, with an average of 7.25 check-ins per foster parent. In the intervention group, foster parents participated in 47 monthly check-ins, with an average of 7.8 per person. Foster parents in the comparison group participated in 69 check-ins with an average of 6.9 per person. Due to foster

parents' busy schedules and other logistical conflicts, it took approximately three calls to each foster parent every month to schedule and complete each check-in. Table 3 describes the participating foster parents and provides information about their involvement in the study.

Table 3. Foster Parent Support Pilot Study
Description of Foster Parents Participants and Study Involvement

Foster Parents (N=16)	**Intervention**	**Comparison Group**	**TOTAL**
Sample Size (N)	N = 6	N = 10	N = 16
Age (mean years)	37.2	38.9	38.2
Gender (%)			
Female	83	100	94
Male	17	0	6
Hispanic Ethnicity (%)	17	0	6
Race (%)			
White	83.3	70.0	75.0
African American	0.0	10.0	6.3
Asian/Pacific Islander	0.0	0.0	0.0
American Indian/Alaska Native	0.0	0.0	0.0
Mixed Race (African Am+ Native Am, White + Alaska Native)	0.0	20.0	12.5
Other (Mexican American)	16.7	0.0	6.3
Number of Adults (≥18) in the Home (mean)	2.2	2.3	2.25
Number of Children (<18) in the Home (mean)	4.0	2.9	3.3
Number of Biological, Adopted, or Guardian Children in the Home (mean)	2.2	1.2	1.6
Number of Foster Children in the Home (mean)	1.8	1.7	1.75
Average Length of Time in Study (months)	12.2	10.8	11.3
Average number of monthly check-in calls November 2008-August 2009 (range)	7.8 (5-10)	6.9 (1-10)	7.25 (1-10)

Foster Children – At baseline (the time when foster parents enrolled in the study which includes both waves of enrollment), there were 11 children in the intervention group and 17 children in the comparison group. These children were followed for an average of 8.6 months with 10.4 months for the intervention group and 7.5 months for the comparison group. An additional 17 children entered the study at various subsequent points over the course of the study. There were nine children who entered the intervention group homes and 8 children who entered comparison group homes at times other than baseline. These children were followed for an average of 4.1 months with 3.6 months of follow up for the intervention group and 4.6 months of follow up for the comparison group. A total of 45 foster children lived in the participating foster homes during the course of the study. Table 4 provides basic descriptive information about the foster children in the study.

Table 4. Description of Foster Children
(Includes both children in homes at baseline and those entering homes after baseline)

Foster Children (N=45)	**Intervention**	**Comparison**	**TOTAL**
Sample Size (N)	N = 20 (44.4%)	N = 25 (55.6%)	N = 45 (100%)
Baseline Sample	11	17	28
Enrolled After Baseline	9	8	17
Age (mean years, [range])	4.9 [1 wk-14.5 yrs]	4.9 [2 wks–16 yrs]	4.9 [1 wk-16 yrs]
Gender (%)			
Female	60	60	60
Male	40	40	40
Hispanic Ethnicity (%)	20	16	17.8
Race (%)			
White	55	32	42.2
African American	10	8	8.9
Asian/Pacific Islander	0	12	6.7
American Indian/Alaska Native	20	0	8.8
Mixed Race (African Am + Native Am, White + Native Am)	0	36	20
Other (Mexican, El Salvadoran)	15	12	13.3
Living with siblings in foster home (% yes)	25	60	44.4
Have siblings living elsewhere (% yes)	80	64	73.3
Foster parent is a relative (% yes)	0	4	2

Follow Up of Foster Children

During the monthly check-in phone calls foster parents were asked whether children had had visits with their siblings and other family members, how they were doing in terms of cooperation with the foster parent, how well they were getting along with others and whether they had participated in activities that supported their cultural identity. Monthly check-in calls were used as a means to track placement changes and issues that the foster family may have been dealing with in terms of the placement. Quantitative data from these monthly check-in calls are presented in the following tables. Other qualitative data are organized by themes and presented later in the report.

Table 5 provides follow up information for children participating in the study at baseline (n=28). On average, these children had been in foster care for a year prior to their placement in the pilot study home. They'd been in their current pilot study home an average of 41 weeks prior to the start of the study. The mean time in foster care and in the current study home prior to the start of the study was considerably less for the intervention group. This is primarily because; despite random assignment of the study homes to the intervention and comparison groups, all of

the homes that had infants at the start of the study happened to be assigned to the intervention group. (Data not shown.) It also happened that random assignment resulted in the comparison group containing more groups of siblings living together than the intervention group.

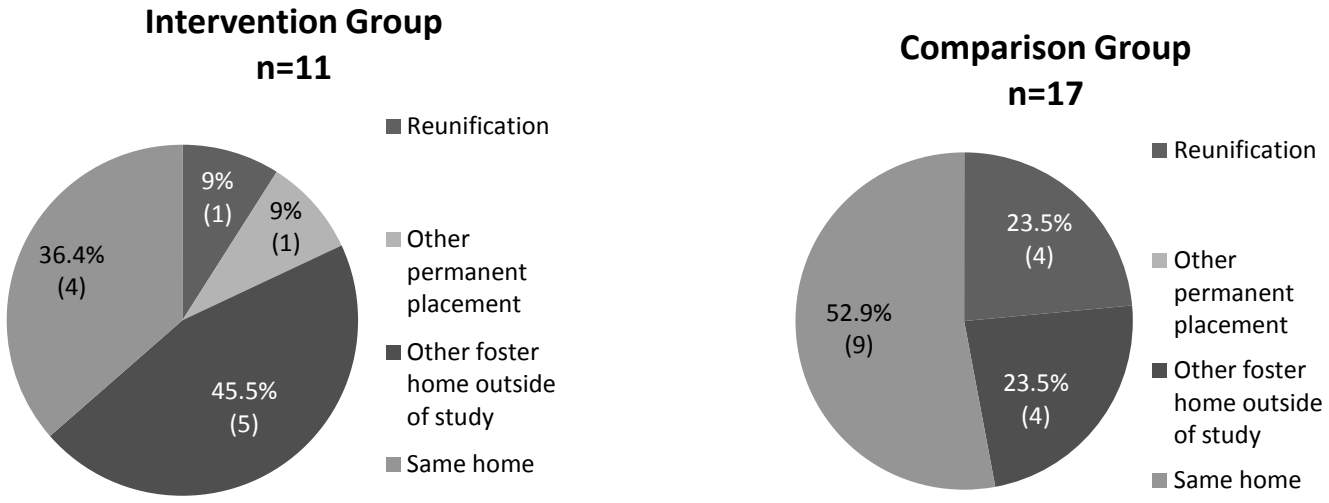
Children who were in the pilot study homes at baseline participated for an average of approximately nine months, with children in the intervention group participating for an average 10.36 months and those in the comparison group an average of 7.5 months. At the end of their participation in the study, approximately 18% of all baseline children were reunited with their biological family and another 4% were in some other type of permanent placement. Of the baseline sample, nearly half were in the same foster home and about a third were in another foster home outside of the study. Given that the period of follow up for children participating in the study was significantly shortened, these outcome data are, at best, preliminary.

Table 5. Foster Children's Follow Up - Baseline Sample Only

Foster Children (N=28) - Includes both Wave 1 and Wave 2	**Intervention**	**Comparison**	**TOTAL**
Sample Size (N)	N = 11	N = 17	N = 28
Mean time in care prior to living in study home (months)	7.4	15.3	12.1
Mean time in current (study) foster home at time of baseline enrollment (weeks)	26.1	51.2	41.4
Average length of time in study (months)	10.4	7.5	8.6
Average number of monthly check- ins/child (mean) (range)	5.7 (1-10)	4.3 (0-10)	4.9 (0-10)
Living with siblings in foster home (%)	27.3	82.4	60.7
Have siblings living elsewhere (%)	72.7	58.8	64.2
Children w/ reported sibling visits (%, Number of children that had any visits with their siblings as proportion of those with siblings outside of home)	75 (6/8)	80 (8/10)	77.8 (14/18)
Children with reported family visits (%)	81.8	100	92.0
Disposition at end of involvement with study (%)			
Reunited with family of origin	9	23.5	17.9
In some other permanent placement	9	0	3.6
Still in same foster home	36.4	52.9	46.4
Living in another foster home within study	0	0	0
Living in another foster home outside of study	45.5	23.5	32.2

Figure 1 illustrates placement status of baseline children at the time that the study ended. Due to the small number of participants in the study, meaningful comparisons between the two groups cannot be made. This information does, however, provide a sense of the movement of foster children in and out of the study and where most children went.

Figure 1. Disposition of Baseline Children at End of Study



Of the children in the intervention group at baseline, one child (9%) was reunified, one went to another permanent placement, five (45.5%) went to another foster home outside of the study, and four (36.4%) remained in the same home until the end of the study. In the baseline comparison group, four children (23.5%) were reunified with family of origin, four went to another foster home outside of the study, and nine (52.9%) remained in the same home until the end of the study.

Figure 1a. indicates the reasons foster children moved out of their foster homes during the study. Problematic behavior issues were cited by foster parents as the main reason placement changes were made (23.5%). Other reasons for placement change included the evolution of the child's case resulting in a need for different placement plans (17.6%), the placement not being a good match for the child or the family (11.8%), the child needing a more permanent placement (11.8%), efforts to keep siblings together (11.8%), safety concerns (6%), and the foster home being over capacity (6%).

Figure 1a. Reasons for Placement Changes Other Than Reunification or Adoption (N=17)

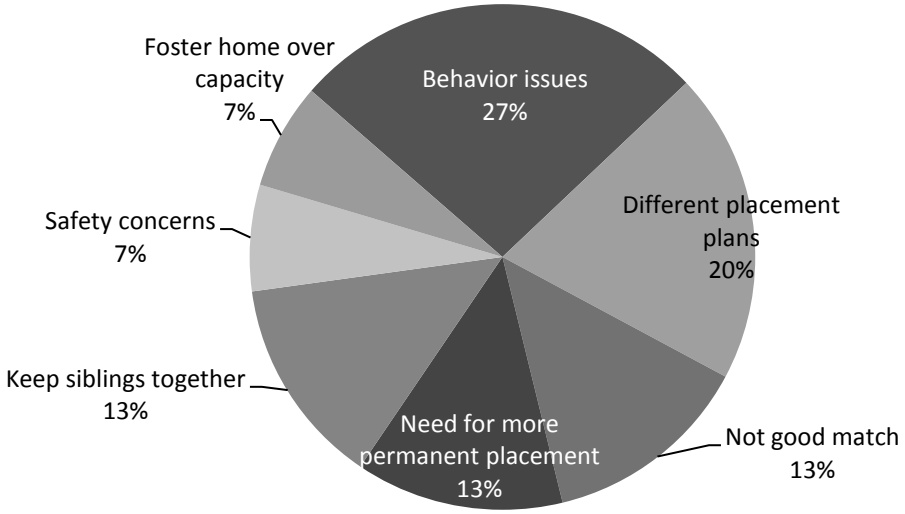


Table 6 provides follow up information for children (n=17) who entered the pilot study homes after the initial enrollment periods. Because these children were followed for a much shorter and varied amount of time, the follow up data for them is presented separately. On average, these children had been in foster care for about six months prior to entering the pilot study foster homes. They spent an average of four months in the pilot study homes. They were more evenly distributed than the baseline groups with respect to being placed with their siblings in the foster homes. At the end of their involvement with the study, 6% had been reunited with their biological family and 6% were in some other type of permanent placement. Forty one percent were in the same foster home and 47% were in another foster home outside of the study.

Table 6. Foster Children's Study Participation – Children Placed After Baseline

Foster Children (N=17)	**Intervention**	**Comparison**	**TOTAL**
Sample Size (N)	N = 9	N = 8	N = 17
Mean time in care prior to living in study home (months)	8.2	3.6	6.2
Average length of time in study (months)	3.6	4.6	4.1
Average number of monthly check- ins/child (mean) (range)	2.4 (1-6)	2.6 (1-7)	2.5 (1-7)
Living with siblings in foster home (%)	22.9	12.5	17.6
Have siblings living elsewhere (%)	88.9	75	82.4
Children w/ reported sibling visits (%, Number of children that had any visits with their siblings as proportion of those with siblings outside of home)	87.5 (7/8)	50 (3/6)	71.4 (10/14)
Children with reported family visits (%)	88.9	87.5	88.2
Disposition at end of involvement with study (%)			
Reunited with family of origin	11.1	0	5.9
In some other permanent placement	0	12.5	5.9
Still in same foster home	33.3	50	41.2
Living in another foster home within study	0	0	0
Living in another foster home outside of study	55.6	37.5	47.1

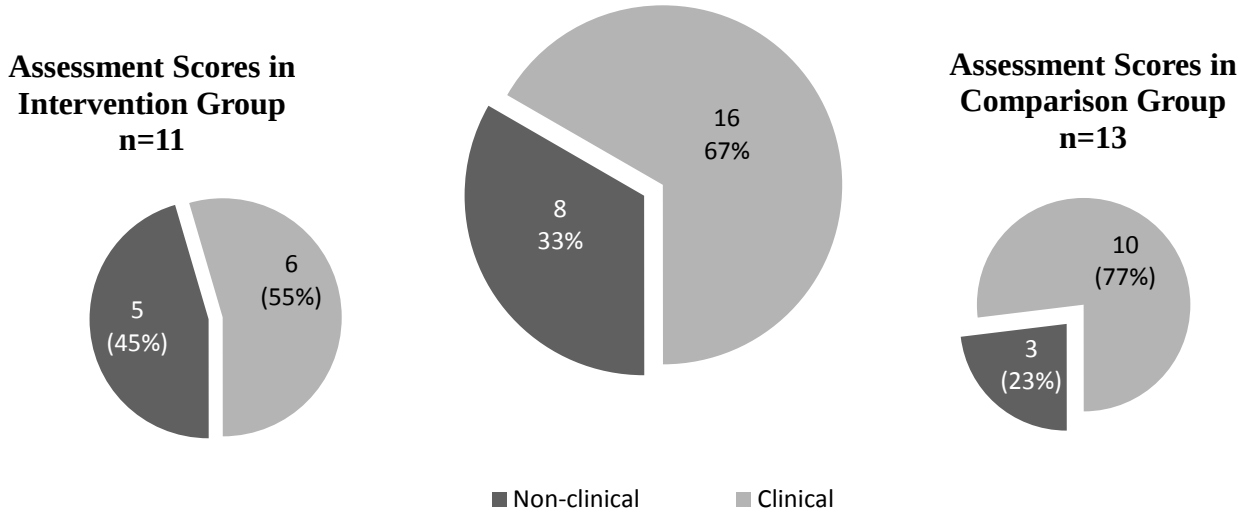
Assessments

Foster Children – The children's physical, social-emotional and behavioral development was assessed using the Ages & Stages Questionnaire (ASQ), the Ages & Stages Questionnaire: Social Emotional (ASQ:SE)and the Child Behavior Checklist (CBCL). Foster parents completed one or more of these standardized assessments according to the age of each foster child in their care. For Wave 1 families, assessments were given in February and March, 2009. For Wave 2 families, they were given in June and July. Because children moved consistently throughout the study,

the assessments were given only to the foster children who were living in each home at those specific times. As a result, 24 children (53%) were assessed out of the total of 45 participating children.

Challenges with health and behavior issues were reflected in the results from these assessments. Figure 2 shows the results of these assessments. A total of sixteen out of the 24 children tested (66.6%) received scores in the clinical range on the CBCL, ASQ, and/or the ASQ:SE. Seventy seven percent of children assessed in the comparison group and 55% of those in the intervention group received a clinical score on one or more assessments. The high percentage of children scoring in the clinical range on these assessments is concerning and is consistent with broader findings that children in foster care tend to have a higher prevalence of physical, social-emotional and behavioral issues (Stahmer et. al. 2005; Burns et. al. 2004; Leslie et. al. 2000). The foster parents and the child's social worker were notified when a child's scores were in the clinical range on these assessments so that they could determine how to follow up on the findings. In many cases, the foster parents and social workers were already aware of the child's health and behavior concerns.

Figure 2. Child Assessments



Foster Parents - Participating foster parents' levels of parenting stress, depression and social support were assessed prior to randomization and again six months later. Wave 1 participants were given the assessment in August, 2008 and again in February/March, 2009, and Wave 2 participants were given the assessment in December, 2008/January, 2009 and June/July, 2009. The results of those assessments are shown in Table 7. The parental stress scores were not elevated for this group of foster parents and were consistent with those reported for parents with children who do not have clinical problems compared to a group of parents with children receiving services for emotional and/or behavioral problems (Berry and Jones 1995).

The CES-D, depression screening measure indicates that as a group, there is low depression risk. There were a few foster parents whose depression scores exceeded the clinical screening cut-off for depression. In addition, for both groups the mean depression scores were higher at the six month follow-up assessment compared to those at baseline. Because the study ended prematurely, it is not clear whether if this was a result a true increase in depression risk or a result of cyclical seasonal variation that has been reported among non-depressed people (Harmatz et. al. 2000).

Depression is typically higher during the winter months and for the majority of foster parents the second assessment was conducted during the winter months.

The Family Support Survey was used to determine the different sources of support that foster families found helpful. Foster parents were asked to identify any additional sources of support that they found useful that were not already specified on the survey. There were a number of different sources of support that foster parent reported were helpful. The most commonly noted sources of helpful support were:

- Spouse/Partner
- Friends
- Professional helpers (social workers, therapists, teachers, etc.)
- Family or child's physician
- Other foster parents/Other parents
- Foster children's social worker

Table 7. Foster Parent Support Pilot Study
Parental Assessments – Baseline and First Follow-Up (Six Months)

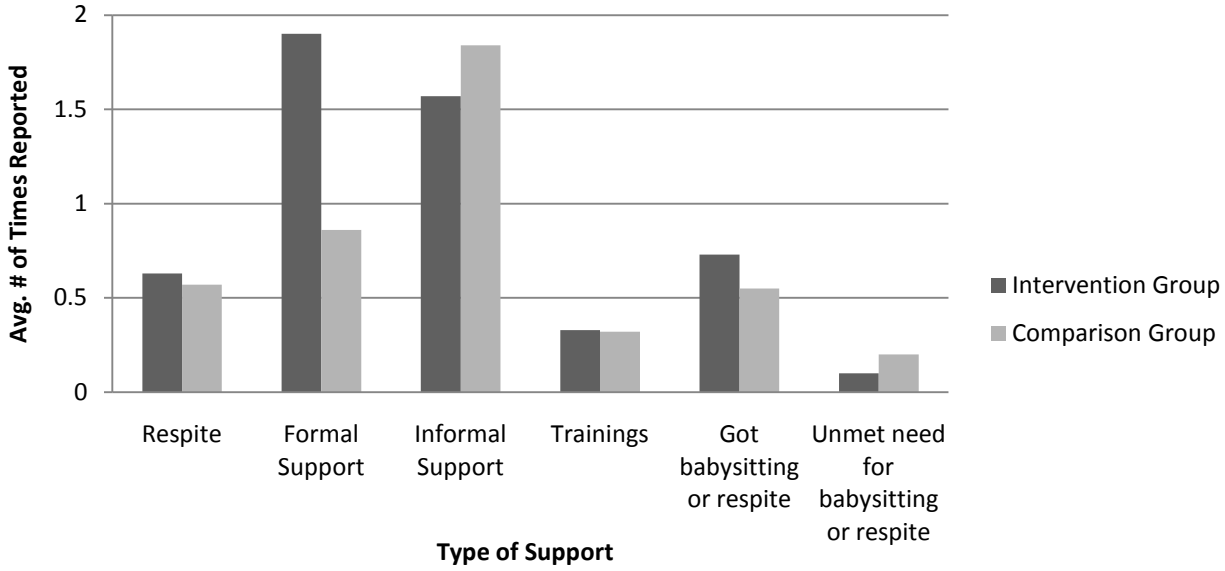
Foster Parents (N=16)	**Intervention**		**Comparison Group**		**TOTAL**	
	Baseline	Six Months	Baseline	Six Months	Baseline	Six Months
	N = 6	N = 6	N = 10	N=9	N = 16	N=15
Parent Stress Scale (Mean Total Score)	38.0	38.8	33.8	35.6	35.4	36.9
CESD – Depression Inventory : Mean Total	9.5	11.8	6.6	10.2	7.7	10.9
Percent Scoring 16 or higher	16.7	33.3	10.0	22.2	12.5	26.7
Sources of Family Support (% Reported Helpful)						
Parents	50	50	50	44.4	50	46.7
Spouse or partner's parents	33.3	33.3	20	11.1	25	20.0
Relatives/kin (other than parents)	66.7	50	50	44.4	56.3	46.7
Spouse or partner's relatives/ kin	50	33.3	10	0	25	13.3
Spouse or partner	100	100	90	88.9	93.8	93.3
Friends	83.3	100	90	88.9	87.5	93.3
Spouse or partner's friends	66.7	83.3	40	22.2	50	46.7
Your own children	66.7	66.7	70	66.7	68.8	66.7
Other parents	100	66.7	80	77.8	87.5	73.3
Co-workers	33.3	16.7	10	22.2	18.8	20.0
Parent groups	50	66.7	44.4	22.2	46.7	40.0
Social groups/clubs	16.7	33.3	44.4	44.4	33.3	40.0
Church members/ minister/religious community	50	50	70	33.3	62.5	40.0
Your family or child's physician	100	83.3	80	44.4	87.5	60.0
Early childhood intervention programs	0	50	22.2	11.1	13.3	26.7
School/day care center	83.3	66.7	60	55.6	68.8	60.0
Professional helpers (social workers, therapists, teachers, etc.)	66.7	100	60	66.7	62.5	80.0
Professional agencies (public health, social services, mental health, etc)	50	33.3	40	22.2	43.8	26.7
Cultural/ethnic/tribal community	33.3	0	0	0	13.3	0
Neighbors	83.3	50	30	11.1	50	26.7
Other foster parents	66.7	83.3	66.7	55.6	66.7	66.7
Foster children's social worker	75	83.3	87.5	44.4	83.3	60.0
Foster parent support group		66.7		33.3		46.7
Mothers of Preschoolers (MOPS)		0		11.1		6.7
Trainings @ DSHS		33.3		33.3		33.3
Meetings		83.3		22.2		46.7
CA Licensor		50		22.2		33.3
Other social worker		50		11.1		26.7
Transporters		33.3		44.4		40.0
Siblings' foster parents		33.3		11.1		20.0
CA Placement Coordinator		83.3		22.2		46.7

On the monthly check-in survey, foster parents were also asked about the types of formal and informal support, training, and respite care that they had received or participated in over the past month. The average amount of these different types of foster parent support that were used or needed per month are shown in Figure 3.

On average, foster parents in the intervention and comparison groups received respite care approximately 0.6 times per month. Foster parents in both groups reported that they needed respite care. Difficulty obtaining respite care was an issue that was reported by almost every foster parent in the study regardless of which group they were in.

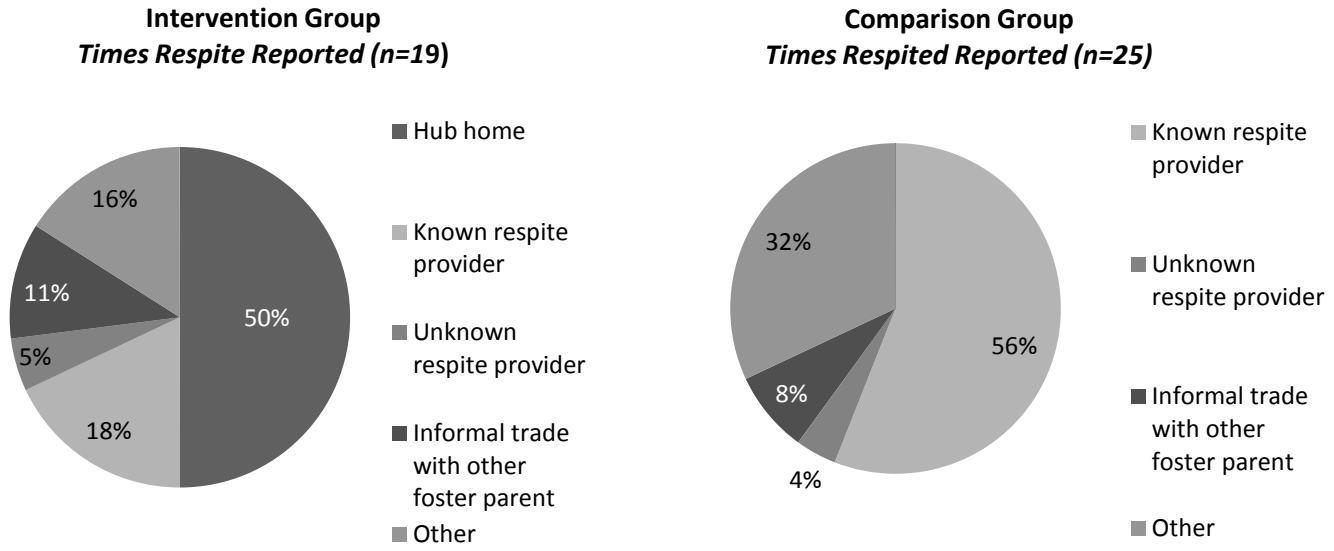
The intervention group parents reported participation in nearly two formal support activities per month while the comparison group reported less than one formal support activity per month. Formal support included support specifically targeted toward foster parents such as the monthly foster parent support group and, for those in the intervention group, the monthly Mockingbird constellation meetings. It is likely the greater frequency of formal support that the intervention group parents reported was because more formal foster parent support activities were provided through the Mockingbird intervention. Foster parents reported receiving informal support, on average, one and a half to just under two times per month. The amount of other types of support and trainings were similar for the intervention and comparison groups.

Figure 3. Average Amount of Foster Parent Support Used or Needed Per Month



Over six months of monthly check-in phone calls, intervention group parents reported receiving respite care 19 times. Foster parents in the comparison group reported a total of 25 episodes of respite care over a six month period. Figure 4 shows the sources of respite care for those foster parents that used respite care. In the intervention group, 50% of the respite care was provided by the hub home, followed by 18% provided by some other known respite provider, 16% by an unspecified provider, 11% through an informal trade with another foster parent and 5% by an unknown respite provider. Foster parents in the comparison group did not have access to the hub home and relied most (56%) on known respite providers followed by 32% provided by some other known respite provider, 8% through an informal trade with another foster parent, and 4% provided by an unknown respite provider.

Figure 4. Sources of Respite Care for Respite Reported Over 6 Months



Monthly Check-In Qualitative Themes

In addition to gathering quantitative data on the movement of foster children and the use of various supports, the monthly check-ins were also designed to collect qualitative information on the experiences of foster parents and children in the following areas:

- Quality of interactions between foster parents and foster children
- Quality of children's interaction with peers
- Children's connection with biological family while in foster care
- Children's connection with racial/cultural/ethnic background
- Placement stability
- Factors affecting placement stability

Quality of interactions between foster parents and foster children - Foster parents were asked to rate how cooperative their foster children were with them. Responses varied greatly depending on the respondent, the status of their foster child, and when the monthly check-in was being conducted. On average, most foster parents rated their foster children as being 'mostly cooperative' or 'somewhat cooperative' when asked on a regular basis. Lower ratings of cooperativeness often corresponded with problematic behaviors and a lack of services available to foster parents to handle them.

Quality of children's interaction with peers - Foster parents were also asked to rate their foster children's ability to get along with other children. Additionally, they were asked about children's ability to regularly attend school and other activities. Responses to these questions also varied greatly on the respondent and their foster child's status. Generally, however, foster parents reported that their foster children got along with other children 'always', 'most of the time', or 'some of the time'. A vast majority of foster parents with school age foster children reported that they were able to attend school or activities regularly. Lower ratings on these scales were often due to medical or mental health issues that were obstacles to healthy interactions or regular participation in activities.

Children's connection with biological family while in foster care - As mentioned previously, the vast majority (92%) of foster children who entered the study at baseline were reported to have had visits with biological family members other than siblings during the study. While visits with biological family were important for foster children, several foster parents reported simultaneously observing negative effects of visitations with biological parents. They described behavior problems and stress due to the emotional nature of the visits.

Children's connection with racial/cultural/ethnic background - To get a sense of whether children's connection with their cultural background was supported while in foster care, the monthly check-in included a question about whether children had participated in any activities that reflected their racial, cultural, or ethnic identity. This included attending support groups and informal get-togethers, religious services, and extracurricular activities. Participation in Special Olympics, for example, was considered a cultural activity by a foster parent whose foster children have disabilities, as it represented a specific place where their foster children felt a sense of community and belonging. While there was some confusion on the part of some foster parents about how to define these activities, most foster parents reported that their foster children had participated in these activities throughout the study.

Placement stability - Based on information gathered in the monthly check-ins (entry date, exit date, status), length of stay and disposition were tracked for each foster child. During the course of the study, more than half of the foster children transitioned outs of the foster home involved in the study, creating a consistent flow of children in and out of participating foster homes.

Many foster parents recognized negative emotional and psychological effects of this lack of permanency and cited a desire to find a more permanent placement for their foster children as a reason for these children having left their home. Several foster parents entered the process of adopting their foster children during the study, but for the most part foster parent participants reported intentions to remain temporary foster care placements.

Factors affecting placement stability - Seeking increased permanency was one of many reasons foster parents cited for considering or initiating placement changes for their foster children. Many foster parents reported having considered a placement change due to unanticipated circumstances (such as increasingly severe behaviors, medical issues, changes in case status, inappropriate placement for child or family, etc.) Delays or failure to respond on the part of DSHS was frequently cited as a major factor in placement changes. Most foster parents felt they would need more services than they currently had or more timely access to services than was provided in order to adequately care for the needs of their foster children. In some cases, foster parents reported that they had received incomplete or erroneous information from caseworkers which did not adequately prepare them for the foster child's behavior or status within the foster care system (e.g., custody issues with biological parents) and therefore felt that they could not meet the child's needs.

In some cases, placement changes were averted due to services (day care, therapy) being provided. Several foster parents in the intervention group reported that mediation and assistance from the Mockingbird hub home parent was instrumental in preserving placements. These forms of support were explored further in the final exit interview that was completed with all participating foster parents and are presented below.

Exit Interview Qualitative Themes

The exit interview was designed to capture, in greater depth, the qualitative experience and needs of foster parents participating in the study.

Sources and Mechanisms of Support for Foster Parents - Participants cited varied sources and mechanisms of support that assist them in being foster parents. The most frequently named sources of support were:

- Social workers
- Friends
- Mockingbird
- Other foster parents
- Spouse/partner
- Family
- Foster Parent Support Group

Mentoring - Many foster parents expressed a need for one on one mentoring from a more experienced peer who could provide trust, knowledge, inspiration, and help accessing resources and respite. Access to this type of mentorship was cited as a form of support that could help them to provide better care for their foster children, keep children in their homes longer, and increase foster parent retention.

This need suggests that one of the primary benefits of a hub home type structure is the hub home foster parents' knowledge, parenting advice, and expertise in navigating the foster care system. Throughout the study, foster parents spoke directly to the value of the Mockingbird Family Model in providing these supports.

Support group - Having a group of people with whom to share experiences and feel a sense of camaraderie was extremely valuable to foster parents. These groups also provided useful trainings and other information, but the main benefit cited by the foster parents in this study was a space to vent and feel that they were not alone in their experiences. For many foster parents, friends and extended family also provided this type of support.

Social workers - In the exit interview, foster parents named social workers most frequently as a major source of support, and indicated that having a good social worker was crucial to having a good experience as a foster parent. Praise of social workers came with significant caveats, however, most of which were related to social workers' high caseloads and being overworked. Many said they do not get adequate communication or responsiveness due to the sheer volume of cases social workers have to follow. These foster parents made it clear that such experiences have negative effects on placement permanency and foster parent retention. Foster parents spoke of the importance of clear, timely communication from social workers for them to be able to most effectively meet the needs of the children in their care.

> *"The majority of the social workers do their best. They're underpaid and overworked and I think most of them step up and try to do what they can. If you're supposed to have a maximum of 18 cases and you have 41 cases, the squeaky wheel gets the grease. She's a really good social worker but she's acting in crisis mode all the time."*

Another issue several foster parents raised was the discontinuity they experienced among social workers. Not only would different social workers give them different information, but they reported that it was not uncommon to be assigned several different social workers throughout a case.

> *"It seems like once the child is in long-term placement they switch the social worker. You just start building a rapport, and then you start from scratch. That's happened with all the foster children I've had in my home."*

Anecdotes from foster parents suggested that such practices often lead to confusion and increased disorganization and usually have negative effects on stability, for both foster children and for foster parents.

Knowledge of and Access to Resources and Services - One of the most frequent responses from foster parents was that they did not feel they had adequate knowledge of and access to needed resources. Most foster parents interviewed expressed concerns and frustrations about finding services for children with special medical or

behavioral needs, emergency care, or respite. They reported that the process for applying for many services, including respite care, is unclear and unnecessarily bogged down with paperwork. The information they do have was for the most part self-learned, not provided by DSHS or other formal sources. Additionally, most said that in the event of an emergency they would go first to their family or informal networks, and that DSHS had not informed them of who to contact or what to do in an emergency.

> *"The department changed the form [for respite], or we weren't told how to fill out the form correctly, so we've submitted two or three times to have the respite paid for and it hasn't been done…. You just have to fill it out right the first time without help or instruction or anything. The social workers don't know how to fill them out either. "*

These reports suggest a need for clearer communication of resources and service providers to foster parents, as well as facilitated access to those providers. All three types of support mentioned above – mentoring, support groups, and social workers – can help clarify the processes through which resources are acquired. Foster parents reported that it is extremely valuable to have a point person who is available to suggest resources, help navigate the processes and paperwork, and be an advocate for foster parents if necessary.

Foster parents also acknowledged the effects of other systemic challenges on their families and their ability to care for foster children.

> *"In general it would be nice to get a lot more services for kids that they need. It ebbs and flows. Two years ago there were plenty of services. Now in the budget crunch it turns into a nightmare."*

> *"The state has no money, so the kids suffer…If the government would give the foster care system money instead of taking it away, giving kids the care they need instead of giving the minimal. I can see why they burn out so fast."*

Physical and Mental Health Care Access - Several foster parents expressed concern with the quality of physical and mental health care their foster children received. Foster children experience a higher than average incidence of clinical behavioral or mental health diagnoses; in this study, 66.6% of foster children tested for emotional and behavioral development received scores in the clinical range. Access to relevant services is therefore of particular concern, and an expressed need for more comprehensive care is not surprising.

As a result of limited health coverage for foster children, they have observed stark differences between the health care their own children receive and the care foster children receive.

> *"I would like better mental health care [for foster children]. Compass [Mental Health] is not very good; it's a bare minimum policy. The kids have moved around therapists a lot; it's not good for kids, but that's their policy…. What my adopted son gets through private insurance is night and day from what the foster kids get. It borders on criminal what the foster kids get."*

Several foster parents in this study cited foster children's untreated or unsupported behavioral issues as being major factors in decisions to request that the children be removed. In some cases, late-arriving support was able to preserve the placement; in others, the foster parents ultimately felt they were not able to meet the children's needs and the children were unable to stay.

Communication **-** Almost all foster parents cited a need for enhanced communication from caseworkers and DSHS. This included simply being kept in the loop about court dates, visitations, progress of a child's case, etc. It also extended beyond frequency of communication to accuracy of information.

Several foster parents reported having received incorrect information from caseworkers about a child or a case that would make them more likely to accept a child in their home. In most cases these placements did not end well for the children or the foster parents, as the foster parents were not prepared to support the child's needs.

Some foster parents also claimed they couldn't get help or services from DSHS until the situation became extreme, for example they asked that the child be removed from their home, the child's behavior became dangerous, or they found a resource within DSHS (e.g., IEP advocate) that could have been more expediently identified by a caseworker and could have helped the foster child get the resources they needed earlier.

> *"In terms of behavior problems, [the caseworkers] were skirting around special preschool, but it was never offered until I asked for him to be placed somewhere else. That could have made his placement more permanent. I could see a change in the two weeks he was going there."*

Finally, foster parents repeated many times that they did not receive adequate communication about services that could be helpful and did not know where to go to get specific types of assistance. In these cases, input from a more experienced foster parent could be invaluable. Indeed, several foster parents contrasted their abilities to meet these challenges before and after taking part in the Mockingbird constellation, indicating a marked improvement once they had contact with the hub home foster parent.

> *"It's a matter of awareness of support. It came once we were in Mockingbird. It should come from DSHS - making foster parents more aware of the foster parent hotline and those types of services."*

Child Care and Respite - Child care of all kinds emerged as an issue of particular importance in this study. For many foster parents, a lack of accessible child care was a common impediment to being able to work regular hours, and attend trainings, support groups, and other events.

For many, the child care options for foster families reflect the lack of communication and information that they have noted in other areas. As a result of the lack of availability of providers, complicated paperwork processes, the system's failure to pay providers, and other previously mentioned difficulties, many foster parents turned to their support networks of friends and family to provide respite, child care, and babysitting when they needed it, rather than to formal services offered by DSHS.

> *"You're on your own on finding somebody to do the respite care. I never went through the whole process because it's been too daunting. You have to find someone, the social worker has to approve the house, they have to check the license for capacity, level of child, etc., and then approve the time so that the other family can get paid and it just seems too daunting if you have an emergency or something comes up quick. If they had a pre-approved list [of providers who have] gone through all that, their info is on file, and you can call and get a yes or no and have the paperwork follow after instead of before".*

> *"Child care is being cut, which makes it impossible for me to work."*

Several foster parents suggested a kind of combination child care and respite model that would provide short term respite during the day on a drop-in basis – similar to a drop in day care. A main motivation for such a model is the current difficulty finding available respite, as well as the time-consuming approval process that does not allow for short notice needs.

> *"It would have been easier if we had had someone who could watch her for a couple of hours, not a full respite day. It wasn't clear if respite for two hours used up a full day. Barriers [included] knowing who could provide it. I didn't know who could provide short notice, short term care. It would have been great to have a drop in center."*

Training - Most foster parents expressed a desire for more trainings on evenings and weekends, to accommodate work schedules, as well as more local trainings so as to be accessible to the Everett area.

One foster parent identified a need for more care providers (e.g., foster parents, teachers, day care providers, etc.) to be more informed about relevant topics such as attachment disorder. It is possible that trainings on topics that foster parents suggested have been offered, but the information has not been sufficiently accessible.

Relationships with Biological Families - Most foster parents in the study had experienced a variety of types of relationships with their foster children's biological families, ranging from having no contact to being very close. Many parents said they disagreed with the biological parents' parenting styles. Some expressed distrust and/or disappointment in them. Several parents expressed concern that caseworkers or other DSHS representatives present at visitations were not sufficiently supervising the biological parents' interactions with the children, allowing the parents to give the children false information or bias them against the foster parents.

Some reported having ongoing contact with the biological parents, communicating through such means as exchanging photographs, phone calls, inviting them to birthday parties and other events, or becoming a formal part of their support network. Several parents had entered into this last type of relationship with specific parents so that if they ever needed help or if their children ever re-entered the system, they would be available to try to provide some consistency for the children.

Experience Participating in the Mockingbird Family Model - Every foster parent who participated in the Mockingbird constellation in this study said they would recommend the Mockingbird Family Model (MFM) to other foster parents.

> *"[Mockingbird] needs to be open to everyone. Every single foster parent should get matched up with someone when they start."*

While a few foster parents focused on the facilitated access to respite provided by the MFM, all of the foster parents mentioned the importance of having an experienced mentor and a sense of community.
The findings from the exit interview and throughout the study suggest that the MFM provides much more than respite for many foster parents, and indeed, respite may not be a top priority for foster parents in this constellation. For several foster parents, the hub home foster parent made it directly possible for them to keep foster children that they were on the verge of requesting be removed from their homes. In two particular cases, the foster children eventually were reunified with their biological families or are in the process of being adopted.

> *" [We got] the support we needed [from Mockingbird]. At one point I said the child had to go, I couldn't deal with her behaviors and we got the call that we were part of the MFM and [the hub home foster parent] was able to help us. From her working with me we ended up keeping that child until she went home."*

Foster parents also had some suggestions for further improvement of the Mockingbird Family Model. These suggestions included:

- holding some meetings without children present for more focused meetings
- assigning a hub home that has fewer children or is less busy than other families
- create constellations with multiple families with similar special needs
- allow respite from any of the constellation members to come from a separate allotment than state-provided respite
- get constellation foster parents involved in information gathering for fellow foster parents

Experience Participating in the Foster Parent Support Pilot Study - Foster parents reported having had a positive experience participating in the Foster Parent Support Pilot Study, and all were interested in receiving information about the study's findings.

Experience Being a Foster Parent - All of the foster parents reflected on fostering as a difficult but very rewarding experience. While they expressed intense frustration with the system and described some of the profound parenting challenges they often met, they were spurred on and inspired by the experience of making a difference in the lives of children. As previously noted, during the course of the study, several foster parents entered the process of adopting their foster children. However, most part foster parent participants reported that they intended to continue to function as temporary foster care placements.

SECTION V: CONCLUSIONS

The pilot study was designed to determine whether it would be feasible to pilot all the procedures and measures that would be used in a full scale outcome evaluation study of the Mockingbird Family Model, as well as to answer other questions regarding study logistics. Because of the limited number of foster parents willing to attend an information session to consider participation, the sample size was extremely small and meant that there was not sufficient statistical power to meaningfully compare the outcomes of interest in the intervention and comparison groups.

The qualitative data collected from the small number of foster parents participating in the pilot study suggested that for this constellation the most expensive aspects of the model (respite care) were not the aspects that foster parents felt they most benefitted from. Having a veteran foster parent as an ally and mentor was most frequently cited as a beneficial aspect of participation in the constellation.

Use of Random Assignment with the MFM

From the pilot study it was learned that foster families were willing to be randomly assigned to either an intervention (MFM constellation) or comparison group (receive only the typical support services offered to foster families throughout the region's CA office). However, not enough eligible foster parents were willing to attend an information session to learn about support options and hear about the study to consider whether or not they would like to participate. Foster families who did attend an information session and learned about the Foster Parent Support Pilot Study were willing to be randomized to intervention or comparison conditions. The issue of feasibility does not lie with willingness to be randomized, there simply were not enough foster parents willing to come forward and consider participation to make it feasible to conduct a full scale, statewide evaluation.

Facilitators and Barriers to Broader Implementation

A very critical piece of information that was learned from this study was that not enough families were willing to attend an information session to learn about the MFM and participation in a pilot study to make it feasible to implement a full scale, statewide evaluation through the public child welfare system. After considerable recruitment efforts during the first two months (Wave 1) only 25% of eligible families attended an information session. With considerable additional effort over subsequent months, an additional 4% of eligible families agreed to participate in the information session for a cumulative participation rate of 29%. Although all families who attended the information sessions ultimately agreed to be randomized to the intervention or comparison groups, the rate of take up was too low which indicates that a full scale evaluation would be feasible to conduct nor able to demonstrate an impact of the MFM on the permanence and placement stability of foster children. It was hoped that Region 6 would yield a greater interest. However, after receiving Washington State Institutional Review Board approval to

commence the pilot site in Region 6, the region decided that, due to budget constraints, they could not participate in the pilot study. Therefore, it was concluded within 8 months of starting the pilot study that a full scale, statewide evaluation would not be feasible.

Other Key Findings

- Foster parent need more direct support or mentoring when dealing with challenging situations or just navigating the system. Experienced peers, support groups and social workers are recognized sources of support in this regard but there is a need for much more of this type of support.
- Intervention group foster parents reported finding the Mockingbird Family Model to be very helpful. The mentoring and assistance they received from the hub home parent was the primary source of their satisfaction and the respite care offered was not their highest priority.
- High percentage of children had clinical findings on child assessments
- Need for more knowledge of and access to resources and services, especially high quality physical and mental health care.
- Foster parents report a need for enhanced communication from caseworkers and DSHS (being kept in the loop about child's case, court dates, visitations, increased accuracy information, information about available services).
- Lack of accessible child care and difficulties with processes and communications have negative impact on foster parents' ability to work and take part in trainings.
- Need for support and guidance in relationships with foster children's biological family.

Summary

The Mockingbird Family Model (MFM), as it is conceived, does not appear to be a viable alternative model for providing publicly funded foster care since there was not a high enough rate of participation on the part of foster parents, nor the capacity on the part of the system to mount such a resource intensive model and evaluation. Therefore, while the MFM worked well for the families that were involved, because it cannot be rigorously evaluated on a larger scale, it is not possible to draw any conclusions about the impact of the MFM on the identified outcomes of interest for foster children and families. It is very advantageous that this important knowledge was gained through a pilot study prior to attempts to implement a much more costly, full scale evaluation.

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APPENDIX A. MOCKINGBIRD FAMILY MODEL – LOGIC MODEL

Goal 1: To provide a foster care model and be a catalyst for systems change in the child welfare system.

- Facilitate planning, collaboration, communication and shared decision-making across agencies and departments involved in serving children and families through the Mockingbird Family Home Model.

Resources	Activities	Outputs	Short Term Outcomes	Long Term Outcomes
Mockingbird Society: Planning Facilitator - With systems change eventually moves to HOST agency • Statewide Coordinator • Resource Coordinator - Keeps system moving, understands model, problem-solves, etc. **Host Agency:** • Program Manager - Convenes and leads planning team • Planning Team - Licensing - Placement Coordinator - CWS Supervisor - Area Administrator - Social Workers - Family to Family Coordinator - Caregiver Recruitment (PA?) in some geographies	• Introduce Mockingbird Family Model • Engage senior management of potential host agency • Engage middle management • Engage direct service staff • Determine organizational readiness • Determine organizational commitment to adopt model • Register with MBS • Negotiate MOU between Host Agency and MBS • Convene cross-departmental planning team • Conduct planning meetings • Shared and intentional decision-making • Consideration of sibling placement • Consideration of needs of constellation - Foster family requirements/supports needed - Retention needs for caregivers - Requirements of children and youths in care and supports needed - Educational needs - Other needs (medical, mental health visitation, behavioral)	• Signed Memorandum of Agreement between Host Agency and Mockingbird Society • Interdisciplinary Team formed • Implementation plan developed • Development of constellation • Program fidelity to MFM model • Formation of micro-communities	• Enhanced cross-team communication • Enhanced cross agency/department integrated planning for children and youths • Enhanced cross agency/department integrated decision making • Fewer gaps in services to children, youths and families	**System Changes that better serve children and youths:** • The Mockingbird Family Model is the way foster care is structured within the Children's Administration • Dedicated social worker supervising children/youths for each Constellation • Child Welfare System collaborates with Host Agencies and Hub Homes to convene shared planning meetings within MFM Constellations • Host Agency takes on Planning Facilitator role • Increased collaboration and the formation of micro-communities to support partnering between the Child Welfare System, Host Agencies, Constellations and community organizations • MBS no longer integral to MFM system running smoothly

APPENDIX A. MOCKINGBIRD FAMILY MODEL – LOGIC MODEL

Goal 2: To increase permanency and placement stability of children in foster care by providing a model that aims to:

- Address gaps in the current foster care system.
- Improve the sense of connection and social and emotional well-being of foster children and youths and their caregivers.
- Support and stabilize foster and kinship families so children and youths experience the positive qualities and resources found in naturally thriving families.

Resources	Activities	Outputs	Short Term Outcomes	Long Term Outcomes
Mockingbird Family Model: • Licensed Hub Home - 2 beds • MFM oriented6-8 other Foster Homes • May also include - Kinship Home - Biological Home - Adoptive Home - Chosen Home • **Host Agency** - Case management services for children in placements - Recruitment of foster caregiver - Training of foster caregiver - Info/placement history on kids - MFM activity funds	**Mockingbird Society** - MOU with Host Agency to replicate MFM - Conduct orientation for Host Agency staff - Conduct orientation for Constellation members (Host Agency staff, Hub and Satellite Homes) - Value supported and communicated of cultural competence and anti-bias practices by MBS **Host Agency** **Recruit Hub and other foster care homes** - Contract (1099 relationship) with Hub - Provide/coordinate training for Hub Home **Biological family connections supported:** - Sibling connections	• # of respite visits/month • # of HUB home events • # and types of contact visits with biological family • # and types of contact with caring adults - Hub adults - Other constellation adults - Adults in community-at- large - Professionals • # and types of contacts with peers • Training attended • Assessment/ professional support received	**Caregiver Wellbeing:** • Increased retention rate • Decreased isolation • Increased social support • Decreased stress • Increased safety • Renewed commitment to foster parenting • Increase in informal and formal social support • Placement disruption averted due to back-up support, respite, peer support to caregiver • Increased use of effective parenting strategies • Increased satisfaction with/sense of competency in parenting • Increased access to training • Increased skills	**Increased placement stability:** • Decrease in # of foster care placements • Decrease in runaways • Decreased length of time 'on the run' **Increased rates of permanency:** • Adoption • Reunification • Connection with a family member • Reduced overall length of stay in foster care **Foster Parent Retention:** • Greater satisfaction with support for fostering **Foster Parent**

- Computer and internet connection for the Hub Home - Mental Health Resources • **Mockingbird Society** - Resource Coordinator: - Facilitates planning process, trouble shoots implementation issues and coordinates Community Resources - Monitoring of program fidelity - Documentation/data collection systems	prioritized via placement proximity - Visits with family **Connections with Community professional and support services for children such as:** - Assessment of children's placement needs to facilitate care planning or matching with foster family - FCAP - Medical assessments - Education assessments - Mental health counseling **Hub Home Support to Caregivers:** • Support during transitions/ crisis, help with re-entry, stabilization within constellation • Concrete, moral, peer support/ camaraderie • Respite care/back-up care • Provide information to foster caregivers about needs of children • Transportation • Peer mentoring and coaching • Facilitation of problem solving and conflict resolution		**Child Wellbeing:** • Increased "sense of belonging" • Increased emotional strength, skills, awareness • Increased social skills • Increased safety/decrease in # of founded caregiver CPS referrals • Decreased stress • Increased bonding and attachment • Children/youth have increased contact with caring adults • Stronger connections with siblings, peers, community members • Reduction of conflicts • Reduce # placement disruptions • Increase in needs being met • Increased access to professional/support services	**Recruitment:** **Improved Relationships for Youth/Children:** • Increased skill/capacity for developing/ maintaining trusting relationships with: - Adults - Family - Peers Increased self confidence Increase in social skills

	• Identification and/or coordination of community resources for the constellation **Cultural connections supported:** - Events held/attended to celebrate cultural differences, facilitate cross cultural learning and dialogue - Expose children/youths to culturally appropriate role models **Biological family connections supported:** - Extended family welcomed into constellation/micro community - Visits with family when approved by Host Agency **Connections with Community professional and support services for children such as:** • Tutoring • Homework support • Other therapeutic services • Dental services **Community/Social/Recreational Support:** • Community activities			