Best Practices in Children's Mental Health

A Series of Reports Summarizing the Empirical Research and other Pertinent Literature on Selected Topics

Report # 15

Therapeutic Foster Care

Brief Update and Summary
October, 2005

Produced by the University of Kansas
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Best Practices in Therapeutic Foster Care

Summary of previous literature review and update

Since the 1970s, Therapeutic Foster Care (TFC), also known as "treatment foster care," "family-based treatment," or "specialized foster care," has emerged as an alternative form of care for children and youth with serious emotional and behavioral disorders (SED). Although programs and empirical studies vary widely, ***there is some evidence that TFC can be an effective form of out of home care, and can serve as a less costly, family-based alternative to residential group treatment*** for children and youth with SED. Though TFC was initially thought of as a short-term, transitional placement, it appears that TFC today is ***usually a longer-term placement for many children and youth who frequently remain in TFC for more than one year***.

TFC programs ***vary considerably in their individual intervention approaches*** (including behavior management, social learning, eco-systems, problem-solving, and psychodynamic). Some studies suggest that the main benefit of TFC placements over residential group care may be the higher level of adult supervision and higher levels of positive peer interactions.

TFC programs typically share ***seven main features***:
(1) Care is provided within a family setting,
(2) the program targets children with special needs otherwise placed in more restrictive settings,
(3) the program is committed to individualized and community-based treatment, (4) foster care providers are especially trained and members of the treatment team,
(5) providers usually care for no more than one or two TFC children and receive ongoing support and training,
(6) caseworkers' caseloads are limited to 10-15 children, and
(7) TFC families are reimbursed at higher rates than general foster care.

The ***Foster Family-based Treatment Association (FFTA),*** an organization of more than 300 TFC agencies in the US and Canada, has put forth standards for TFC programs. Though research has not yet been able to establish clear empirical support linking standards and positive outcomes, FFTA standards are currently used to guide TFC programs in 20 states, including Kansas. FFTA standards, and the programs reviewed require 20-30 hours of pre-service training for TFC families, and annual training of at least 24 hours. TFC families are thought of as essential and professional members of the treatment team. TFC parents serve as advocates for the child in the community, receive 24/7 crisis support, ongoing supervision (at least once a week, usually more often), respite care, partake in support groups. Contact and continued involvement with biological families is an espoused value of TFC programs but inconsistently implemented.

Existing TFC programs target a great variety of populations including children referred from child welfare agencies, those leaving psychiatric hospitals, youth with aggressive behavior disorders, including chronic and violent juvenile offenders, pre-school age children identified for early intervention, as well as children and youth with developmental and medical disabilities. The majority of children served in studies were male, Caucasian adolescents. Research has only begun to address the psychosocial and demographic characteristics of TFC populations but findings indicate that TFC children appear similar to residential group care populations. Findings of gender differences call for more attention and modifications of current TFC programs and training to better meet the needs of girls. Girls in TFC tend to have significantly more histories of trauma (especially sexual abuse), higher rates of attempted suicide and run away behaviors. Girls' TFC placements also disrupt more often which may be related to differences in girls' relational patterns with TFC parents.

While outcome studies indicate largely positive effects of TFC on the restrictiveness and stability of placements, placement disruption and the need for re-placing children is still a common occurrence in TFC. Disruption rates range from 38% up to 70%, with most disruptions occurring within the first six months.

Characteristics of best current practices in TFC suggest that a promising TFC program

(1) defines and follows standards of care such as those provided by the FFTA;
(2) consistently implements and monitors a specific and defined model for TFC that includes behavioral management, social learning, an eco-systemic approach and/or a strengths approach that minimizes restrictive parenting techniques;
(3) places no more than one or two TFC children to a family;
(4) assigns no more than 12 cases to a caseworker;
(5) provides caseworkers with 24/7 back-up supports;
(6) recruits foster parents through a variety of sources, including the pool of general foster care providers, word-of-mouth, and creative advertisements;
(7) recruits foster parents who bring high levels of commitment, flexibility, and financial and emotional stability;
(8) enhances the "fit" between foster families and foster children by attending to and matching needs, strengths, cultural, religious and other preferences;
(9) provides a maximum of honest information about the child's strengths and needs to the TFC family prior to placement;
(10) provides foster parents with at least 20 hours of pre-service training and at least 24 annual hours of ongoing training. At its best, training is individualized to the specific needs and strengths of the foster family;
(11) provides supports for foster families including 24/7 crisis intervention, respite care, close (at least weekly) in-home supervision, parent support groups, and assistance in helping foster parents address their own needs and those of their own biological children;
(12) considers and treats foster parents as full professional members of the treatment team;
(13) trains and supports foster parents to negotiate other systems in the community (schools, MH systems, clubs, etc.) and serve as advocates for the child;
(14) emphasizes the role of and frequently involves biological families in the TFC process
(15) provides assistance for foster families to consistently engage with biological families;

(16) provides for aftercare for TFC families and biological families;
(17) allows for career opportunities for TFC parents within the program;
(18) provides resources for independent and transitional living for older TFC youth
(19) consistently gathers and reviews data on children, TFC families, biological families, and the various components of the TFC process and outcomes.
(20) frequently seeks the input of TFC families, biological families, children and professionals.

Update on Literature Review (October 2005):

A recent literature search for new studies on TFC confirms earlier results and adds some new aspects:

A study in North Carolina (Farmer et al., 2004) tracked youths residential status for 12 months prior and 12 months following placement in TFC. Results confirm that TFC is not used as a short-term transitional model. At the end of the 12 months follow up period the most restrictive institutional placement rates remained low but placements in group homes rose to a rate similar to the time before entering TFC. Authors suggest that TFC in usual practice is not always guided by EBP models and future efforts need to address the viability of reunification as a goal of TFC, as well as the increased disruptions of TFC placements associated with older age and higher externalizing behaviors.

A study of characteristics of 119 largely female TFC youth (Hussey & Guo, 2005) indicates neglect as the most common form of abuse experienced by this population, and a history multiple placements. Internalizing behavior scores and scores of critical pathology (such as hallucinations etc.) improved significantly over time in TFC while externalizing scores did not change significantly. Authors conclude that for a subset of youth (particularly those with high externalizing behaviors) adjunct programming may be needed to assist TFC providers.

A small study of TFC for youth who are sexual offenders (Ownbey, et al., 2001) concludes that TFC is effective for these children but requires extended (2.5 years or

more) stays to reduce propensity to reoffend. The authors emphasize that the program was able to maintain children outside of secure facilities only through "energetic" training and support of caregivers, including detailed and comprehensive safety planning.

A study (Breeland-Noble, et al. 2004) comparing the use of psychotropic medications for youths in TFC and those in group homes indicates that group home youths were significantly more likely to take any medications and tended to take more medications than their counterparts in TFC. TFC youth were significantly less likely to take antipsychotics and mood stabilizers (but were similar in their use of other types of medications) even if clinical characteristics and demographic factors were taken into account. The authors speculate that group homes may be more likely to follow a medical model approach while TFC settings focus on family-driven, socializing approach.

A qualitative study of the experience of TFC mothers (Wells, et al. 2004) concludes that concepts of "therapeutic alliance" and "expressed emotion" be afforded more attention to guide research and practice in TFC because foster mothers had no one predominant way of experiencing their role and express their role in highly relational terms.

Gregory and Phillips (1997) describe an afro-centered TFC model developed by the Progressive Life Center, a nonprofit private African-American mental health center in the Washington D.C. area. Services are delivered within a African influenced spiritual and cultural framework and include parent training, rites of passage, in-home family therapy, planned and unplanned respite care, preservice and ongoing training, a foster parent support group, 24-hour crisis intervention and multifamily retreats. The program goal is to return clients to their biological families or a permanent living arrangement within 18 to 24 months of placement. A foster parent advisory board serves as a liaison to TFC parents. The description reports positive outcomes for clients but does not provide study details.

The original literature review is available as Report # 8"Best Practices in Therapeutic Foster Care: Review of National Literature and Local Practices" (October 2003) and can be found at http://www.socwel.ku.edu/occ/cmh/projects.html
or can be requested by contacting Uta M. Walter at the School of Social Welfare, University of Kansas, 785-864-3748 or utaw@ku.edu

#	Author(s) & Date	Type of Article	Key Variables/Components	Main Conclusions	Notes
1	Breeland-Noble, A., Elbogen, E. et al. (2004). Use of psychotropic medications by youths in therapeutic foster care and group homes, *Psychiatric Services, 55 (*6), 706-708.	Briefly examines data on use of psychotropic medications provided by NIMH study (1999-2001 data collection in North Carolina) in group homes vs. TFC.	Sample: 304 (n) youth, 184 in TFC, 120 in group homes. Settings were similar as two ethnic makeup (around 42% African-American; age around 14 years, and CBCL scores). But group homes served significantly fewer girls (74% as opposed to 87% in TFC). Compares rates of psychopharmacology and polypharmacology by setting and controls for demographic and clinical factors. Includes CBCL, CASA (services assessment), brief psychiatric rating scale	During four focal months, 67% of TFC and 77% of group home residents used at least on psychotropic medication, group home youths were significantly more likely to take any medications and tended to take more medications. Regardless of setting, more likely use of medications was associated with younger age (under 13), being white, or having higher externalizing scores (or combined externalizing/internalizing scores). Type of setting was not associated with use of multiple meds but TFC youth were significantly less likely to take antipsychotics and mood stabilizers (but not other types of meds) even if clinical characteristics and demographic factors were taken into account. Authors speculate that group homes may be more likely to follow a medical model approach while TFC settings focus on family-driven, socializing approach.	medication
2	Diaz, A., Edwards, S. et al (2004). Foster Children with special needs: the Children's Aid Society Experience, *The Mount Sinai Journal of Medicine, 71* (3), 166-169.	Briefly describes two models of foster care for special needs children by the Children's Aid Society: Medical foster care for infants, and TFC for children with severe emotional and behavioral difficulties.	TFC: designed for children (80% of participants are between ages of 5-11; 20% 12-18) with high degree of difficulties but "potential to function within family unit in the community." TFC parents must be married, with designated respite provider, undergo basic foster care training plus 28 hours of additional training focusing on therapeutic approaches They are assisted by team of sociotherapist, social worker, psychiatrist and art therapist. Social worker provides home visits, sociotherapist provides ongoing training in active listening, communication, negotiation, motivation.	Results are described as successful in that more children in TFC recover than those in other placement. Still some children's placements disrupt and they return to institutional settings.	Similar to other TFC models
3	Farmer, E.M.Z., Wagner, H.R., Burns, B. et al. (2003). Treatment	Study of TFC in residential trajectories for 184 (n) youth with psychiatric	Sample: mean age 13, 74% male, 44% minority status, slightly over 58% in state custody. Measures: Residential status was tracked monthly 12	Results support TFC use as step-down but not as a short-term transitional model: Most often (46%) youth came from group homes or residential facilities (13%) to enter into TFC. For 84% TFC was a less restrictive placement than	

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	Foster Care in a System of Care: Sequences and correlates of residential placements. *Journal of Child and Family Studies, 12*(1), 11-25.	disorders and aggressive behaviors in North Carolina.	months prior and 12 months following placement in TFC CBCL Behavioral and Emotional Rating Scale (BERS)	their previous one. 64% remained in TFC for 12 months post placement, suggesting that TFC is <u>not</u> used as a short-term transitional model. Of those who left TFC within 12 months most appeared to leave due to problems (not successes): 45% went to less restrictive, and 46% to more restrictive settings (8% ran away). The most common post TFC placement was the child's family (43%) a sharp contrast to only 16% who live with their family prior to TFC. Institutional placements dropped from 19% pre-TFC to 8% immediately post-TFC. These gains may be fleeting however: At the end of the 12 months follow up period the most restrictive institutional placement rates remained low but placements in group homes rose to a rate similar to pre-TFC. Authors suggest that TFC in usual practice is not always guided by EBP models (Chamberlain, 2002) and needs to address questions of viability of reunification as a goal of TFC, as well as increased disruptions of TFC placements associated with older age and higher externalizing behaviors.	
4	Gregory, S, D. P., Phillips, F.B. (1997). Of mind, body, and spirit": Therapeutic foster care--An innovative approach to healing from an NTU perspective. *Child Welfare, 76* (1), 127-142	Description of an Afro-centered TFC model by the Progressive Life Center, a nonprofit private African-American MH center in the Washington DC area.	Therapeutic foster care at PLC encompasses various clinical and educational services, including parent training, rites of passage, in-home family therapy, planned and unplanned respite care, preservice and ongoing training, a foster parent support group, 24-hour crisis intervention, a foster parent advisory board, and multifamily retreats. All PLC services are delivered within a African influenced spiritual and cultural framework. The children or adolescents targeted for the therapeutic foster care program must meet two principal eligibility criteria: (1) they must have a serious emotional disturbance that is identified via a DSM-IV	Over 50% of the children enter the program with a pharmaceutical regimen. Within 6 to 12 months after admission, their medication is either reduced or discontinued. Pharmaceutical regimens for children in care have been significantly diminished from 70% at admission to 42% during placement. The most common medicinal intervention with this population is Ritalin. The approach involves a network of support that includes mental health professionals, biological and foster families, community resources and mentors; educators and therapeutic recreation specialists, and medical personnel and clergy. The program goal is to return the clients to their biological families or a permanent living	Afro-centered approach

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			diagnosis; and (2) they must have an I.Q. of at least 72 as measured by the Wechsler Intelligence Scale for Children. Some children diagnosed with developmental disorders may be eligible for the program	arrangement within 18 to 24 months of placement. PLC is designed as a "short-term placement of up to two years." A foster parent advisory board serves as a liaison to TFC parents. Services for the biological family or other caregivers parent training are offered. The average number of child placements is 30 per year. The average number of failed placements is three. Reported evaluation efforts indicate 74% of youths improved significantly emotionally, 37% improved in school academically and 47% stabilized in their school situations, and 53% of the children showed significantly improved behavior. Eighty-three percent of the treatment parents indicated that they received direct clinical services frequently and consistently, while 90% indicated that the clinical intervention was effective. (Note: No detailed research data were reported.)	
5	Hahn, R. Bilukha, O. et al. (2005). The effectiveness of therapeutic foster care for the prevention of violence. *Journal of Preventive Medicine, 28* (1, Suppl. 2), 72-90.	Review and meta-analysis of five (n) studies related to TFC as means to prevent or reduce violence.	Review of studies (mostly about the Oregon model by Chamberlain) evaluated outcomes, and study design and applicability.	Authors conclude that compared to usual group residential treatment there is evidence that TFC is more effective to reduce violence in male adolescents with chronic delinquencies problems. There are questions about the effectiveness (or even possible harmfulness) of current TFC models for a female population. Since only youth considered "safe" to be in the community was treated in TFC studies. Thus there is no evidence if other more severely aggressive youth could benefit from TFC or if TFC could have a preventative effect of younger children with emotional and behavior disorders.	
6	Hussey, D.L. & Guo, S. (2005). Characteristics and Trajectories of treatment foster	Study of characteristics for 119 (n) youth in TFC and behavior change trajectories for a	Sample: 88% African American, 60% female, mean age 9.7 years, 95% Medicaid covered, 22% were also in partial hospital services while in FC usually as part of transitioning from residential/inpatient program to TFC.	Results Child characteristics: most common neglect (41%), physical abuse (18%), sexual abuse (2.5%). Mean age at first out of home placement 5.5 years; mean number of placements: 4.5; history of psychotropic meds: 51%; parental	

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	care youth, *Child Welfare, 84* (4), 485-	subset of 97 (n).	Measures: Based on extensive chart reviews:, demographics, custody status, prenatal exposure to drugs/alcohol, history of abuse, history of placements, caregiver characteristics. Devereux scales of mental disorder scores for subset of children in partial hospital.	history of drug use (76.5%), criminal incarceration (20%); mental illness (16%), homelessness (9%); mean length of stay in TFC 425 days (median: 384). Predictors of change in scores: Higher scores of disturbance (both internalizing and externalizing) were associated with higher numbers of placements. There clear evidence of the harmfulness of placement instability: With each additional placement internalizing scores increased markedly, and to a lesser extent externalizing and pathology scores. While externalizing scores did not change significantly over time, internalizing scores and scores of critical pathology (such as hallucinations etc.) improved significantly. Authors conclude that for a subset of youth (particularly those with high externalizing behaviors) adjunct programming may be needed to assist TFC providers.	
7	Ownbey, M.A., Jones, R.J. et al (2001). Tracking the sexual-behavior specific effects of a foster family treatment program for children with serious sexual behavior problems, *Child and Adolescent Social Work Journal, 18* (6), 417-436.	Study (pre-post) of Professional Parenting Intensive Program for 6 (n) children (mean age 9.5) with serious sexual acting out behaviors that –if they had been youth— would have led to adjudication.	Sample: three male, three female; three Caucasian, three African-American, all removed from parental custody due to abuse/neglect. Intervention: intermediate-term intensive foster care with care givers specifically recruited and trained to address sexual acting out; professional family support (case manager with max of 5 cases), weekly in-home consultation, on-demand crisis consults, 24 hour telephone support, comprehensive safety planning involving many adults in the community, parent support and educational support group meetings, quarterly in-service training. Measures: Specifically designed interview instrument to track type, target, and frequency of each individualized sexual	Results show a substantial variability of scores for acting out incidents and propensity to reoffend. Still there was a clear tendency of quickly containing acting out behaviors indicated by dropping numbers of incidents (only two clients showing relapses after the three months interval). The propensity to reoffend was also assessed as lowering over time but at a much lesser rate than behavioral incidents suggesting a slower rate of internalizing effects of treatment. After two years in the program caregivers assessed children as being half as likely to reoffend as at the entry point. Authors conclude that TFC is effective for these children but requires extended (2.5 years or more) stays to reduce propensity to reoffend. The authors also emphasize that the program was able to maintain children outside of secure facilities only	

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			acting out behaviors as well as propensity for re-offense, retrospectively one year prior to intervention, and in three-months intervals after intervention start provided by two caretakers.	through "energetic" training and support of caregivers, including detailed and comprehensive safety planning.	
8	Wells, K. Farmer, E., et al. (2004). The experience of being a treatment foster mother, *Qualitative Social Work, 3* (2), 117-138.	Qualitative study of 43 treatment foster mothers. Part of a larger Treatment Foster Care in a System of Care Study (See Farmer et al., 2003)	Inductive iterative (five minute free speech) interviews with foster mothers asked to characterize their experience and the child they care for. All mothers were currently caring for an adolescent (12 or older) and had done so for at least 1 months prior to the interview. Sample of interviewees had mean age of 48 years, 51% white, 44% African-American, 46.5 % some post-secondary education, 35% H.S. education, 70% married, 28% divorced/windowed; 23 taking care of boys, 20 taking care of girls. The youth in TFC was 65% white, 35% African-American; 40% had been in TFC for 7-11 months, another 28% for more than 24 months; the most prominent diagnosis (68%) was Conduct Disorder.	Six main theme categories in mothers' responses: Strategic: a positive stance toward youth with analytical/neutral approach to youth's psychological problems. Struggle: characterized by constant struggle to contain youth's behavior, constant vigilance. Satisfaction: sense of relief and reward, strong positive relationship to youth. Mothering: characterized by strong positive relationship to youth paired with notable commitment to provide a home, making youth part of own family. Rejection: characterized a relationship in which mother felt rejected by youth and often characterized youth's problems in distant, callous way. Other: responses that could not be fit clearly into above categories, mixtures of categories. There was no one predominant category meaning that the idealized professional version of TFC providers (closest described by the "strategic" category), is not easily implemented in the context of standard practice. Because mothers expressed their experience and role in highly relational terms authors suggests that concepts of "therapeutic alliance" and "expressed emotion" be afforded more attention to guide research and practice in TFC.	