What does the Research Tell us about Services for Children in Therapeutic/ Treatment Foster Care with Behavioral Health Issues?

Report of the SAMHSA, CMS and ACYF
Technical Expert Panel, September 27-28, 2012

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Executive Summary

Introduction

In September 2012, the Substance Abuse and Mental Health Services Administration (SAMHSA), the Centers for Medicare & Medicaid Services (CMS), and the Administration on Children, Youth, and Families (ACYF) held a technical expert panel to identify what the research tells us about services for children in therapeutic/treatment foster care (TFC)[1] with behavioral health issues (see Appendix A for meeting agenda). A non-Department of Health and Human Services[2] 16-member panel of researchers representing the fields of mental health, child welfare, measurement and evaluation, social work, and psychology came together to provide policymakers with a responsible assessment of currently available information on this topic (see Appendix B for participant list).

Information that informed the panel included findings from *Assessing the Evidence Base* (see Appendix E), the results of a systematic review of the literature; a 1.5-day session with presentations by investigators working in areas relevant to the meeting questions; and discussion with meeting attendees. On the basis of the scientific evidence presented and robust dialogue, technical expert panel members reached consensus through a modified Delphi process (see Appendix C). The panel consensus reflects the panel's assessment of the information available at the time of the meeting. Thus, it provides a point-in-time analysis of the state of knowledge on the issue.

Statement of the Problem

Children's Mental Health. "Mental health problems in children and adolescents have created a 'health crisis'[3] in this country. Studies indicate an alarmingly high prevalence rate, with approximately 1 in 5 children having a diagnosable mental disorder and 1 in 10 youth having a serious emotional or behavioral disorder that is severe enough to cause substantial impairment in functioning at home, at school, or in the community (Friedman et al., 1996)."[4]

"Prevalence estimates indicate that young people with serious emotional disorders (SED) are at heightened risk for substance use disorders. Among youth who receive mental health services almost 43 percent of recipients were diagnosed with a co-occurring substance use disorder. The reverse is also true. In samples from SAMHSA-funded treatment studies, 62 percent of the male

[1] Note: Although the meeting title was "What Does the Research Tell Us About Services for Children in Therapeutic/Treatment Foster Care with Behavioral Health Issues?" the term treatment foster care (TFC) will be used to refer to the service in this report.

[2] One presenter was a staff member from the Department of Health and Human Services; however, he did not participate in consensus statement development.

[3] U.S. Public Health Service. (2000). *Report of the Surgeon General's conference on children's mental health: A national action agenda*. Washington, DC: U.S. Department of Health and Human Services.

[4] Huang, L., Stroul, B., Friedman, R., Mrazek, P., Friesen, B., Pires, S., & Mayberg, S. (2005). Transforming mental health care for children and their families. *American Psychologist, 60*(6), 615–627. (p. 615).

and 83 percent of female adolescents who received substance abuse treatment also had an emotional or behavioral disorder."[5]

"For many youth in the juvenile justice system, their mental health needs are significantly complicated by the presence of a co-occurring substance use disorder. In fact, among those youth with a mental health diagnosis, almost 61 percent also met criteria for a substance use disorder."[6]

"Children and adolescents at risk for emotional and behavioral problems are likely to have experienced: (1) significant early traumas, such as loss of major people in their lives or exposure to violence; (2): impaired functioning at home, in school, and or in the neighborhood; (3) a negative concept of self; (4) co-occurring disorders (i.e., combinations of behavioral, attention-deficit/hyperactivity, anxiety, depressive, and substance abuse disorders); and (5) being bounced from one service system to another, including education, health, child welfare, juvenile justice and mental health."[7] "Children with serious emotional disturbance have many challenges that require multiple interventions to be successful."[8]

In conjunction with high prevalence rates, there is an extremely high level of unmet treatment need. "It is estimated that about 75 percent of children with emotional and behavioral disorders do not receive specialty mental health services."[9]

Yet, as Huang stated in 2005, "…despite these levels of prevalence and unmet need and the serious impact of mental health problems on the functioning of our children, our nation has failed to develop a comprehensive, systematic approach to this crisis in children's mental health."[10]

History. A glance at history may provide a context for efforts to improve the mental health system, in general, and to improve care for children and youth with mental health problems.

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[5] Walter, U.M., Logan, A., & Petr, C. (2005). Co-occurring disorders of substance abuse and SED in children and adolescents. *Best practices in children's mental health: A series of reports summarizing the empirical research and other pertinent literature on selected topics.* Lawrence, KS: University of Kansas.

[6] National Center for Mental Health and Juvenile Justice. (2005). *Blueprint for change: A comprehensive model for the identification and treatment of youth with mental health needs in contact with the juvenile justice system.* Office of Juvenile Justice and Delinquency Prevention.

[7] Burns, B. J. (2002). Reasons for hope for children and families: A perspective and overview. In B. Burns & K. Hoagwood (Eds.). *Community treatment for youth: Evidence-based interventions for severe emotional and behavioral disorders*. New York: Oxford University Press. p. 3.

[8] English, M.J. (2002). Policy implications relevant to implementing evidence-based treatment. In Burns, B.J., & Hoagwood, K. (Eds.), *Community treatment of youth: Evidence-based interventions for severe emotional and behavioral disorders.* New York: Oxford University Press. p. 305.

[9] National Institute of Mental Health [NIMH]. (2001). *Blueprint for change: Research on child and adolescent mental health*. Rockville, MD: U.S. Department of Health and Human Services, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

[10] Huang, L., Stroul, B., Friedman, R., Mrazek, P., Friesen, B., Pires, S., & Mayberg, S. (2005). Transforming mental health care for children and their families. *American Psychologist, 60*(6), 615–627. (p. 616).

In his 1963 address to the 88th Congress, President Kennedy called for movement away from institutionalizing people with mental illness. He proposed "… a national mental health program to assist in the inauguration of a wholly new emphasis and approach to care for the mentally ill. Central to a new mental health program is comprehensive community care. We need a new type of health care facility; one which will return mental health care to the mainstream of American medicine, and at the same time upgrade mental health services."[11]

"[President Kennedy] emphasized the notion of community involvement and community ownership of the program. In addition, these mental health centers were to be comprehensive, providing services not only to the severely mentally ill, but also to children, families, and adults suffering from the effects of stress. These programs were to be comprehensive, coordinated, of high quality, and available to anyone in the population. In essence, where this country had failed to establish a comprehensive national health service or national health insurance system, the President was now proposing exactly that for mental health systems."[12] With this effort, Kennedy launched the era of the community mental health center, and deinstitutionalization became a priority for the mental health system.

"In 1969, the Joint Commission on Mental Health of Children conducted an extensive study of the quality of the children's mental health system. The commission concluded that services for children were seriously inadequate. This was true across the socioeconomic spectrum for children rich or poor, rural or urban. The finding that only a fraction of children in need were being served was of particular concern."[13]

In the 1970s "legal issues also accelerated deinstitutionalization, as concerns over individuals' civil rights and the conditions in institutions led courts to hand down rulings that both limited when individuals could be institutionalized against their will and set minimum requirements for their care and treatment when they were admitted. These judicial orders put constraints on the use of institutions and emphasized that care must be furnished in the least restrictive setting."[14]

Knitzer's investigation of the lack of public responsibility for children in need of mental health services in 1982[15] found that state mental health agencies placed a very low priority on services for children. "Less than half of the states had a staff member assigned to direct children's mental health services. Only a fraction of the children in need were served and many were ineffectively

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[11] Kennedy, J.F. (1963). *Special message to the Congress on mental illness and mental retardation*. Retrieved from John F. Kennedy Presidential Library and Museum website: http://www.jfklibrary.org/Asset-Viewer/Archives/JFKPOF-052-012.aspx.

[12] Cutler, D.L., Bevilacqua J., & McFarland, B.H. (2003). Four decades of community mental health: A symphony in four movements. *Community Mental Health Journal, 39*(5), 381–398.

[13] Duchnowski, A.J., Kutash, K., & Friedman, R.M. (2002). Community-based interventions in a system of care and outcomes framework. In Burns, B.J., & Hoagwood, K. (Eds.), *Community treatment for youth: Evidence-based interventions for severe emotional and behavioral disorders.* New York: Oxford University Press, p. 17.

[14] Koyanagi, C. (2007). *Learning from history: Deinstitutionalization of people with mental illness as precursor to long-term care reform*. Menlo Park, CA: Kaiser Commission on Medicaid and the Uninsured, p. 5.

[15] Knitzer, J. & Olson, L. (1982). Unclaimed children: The failure of public responsibility to children and adolescents in need of mental health services. Washington, DC: Children's Defense Fund.

served in restrictive settings."[16] She concluded that "very little had changed since the report of the Joint Commission in 1969."[17]

Interest in community mental health care revived under the Carter Administration, with First Lady Rosalynn Carter's longstanding involvement in mental health advocacy. "The 1978 President's Commission on Mental Health issued recommendations that were codified in the Mental Health Systems Act of 1980, creating a comprehensive federal-state approach to mental health services. The Carter Commission recommendations embodied the spirit of the community mental health services movement, addressing not only improvements in services offered in the community but also the need to bolster natural, informal social supports."[18] The election of 1980 ushered in a new administration. Most of the Mental Health Systems Act was rescinded by the Omnibus Budget Reconciliation Act of 1981. The remnant was significantly revamped.

Influenced by Knitzer's earlier findings, in 1984 the National Institute of Mental Health launched the Child and Adolescent Service System Program (CASSP). CASSP had "the objective of helping states and communities build capacity to develop systems of care targeted to children with serious and complex needs who were involved with multiple service sectors, for example, mental health, special education, child welfare, and juvenile justice."[19] CASSP "explicitly promoted the policy direction of identifying children with serious emotional disturbances as the priority population, and before long, most states designated this group" as such.[20] "The intent of this focus was not to neglect or diminish the importance of preventive efforts but to redirect public mental health systems away from serving children with mild problems that did not significantly interfere with their functioning and toward serving those who had severe problems that interfered with their functioning and who were a particular challenge and expense to service systems."[21]

"An early accomplishment of the CASSP was the refining of the concept of a system of care to serve as a framework for reform."[22] In 1986, Stroul & Friedman defined a system of care as "a comprehensive spectrum of mental health and other services and supports organized into a coordinated network to meet the complex and changing needs of children and their families."[23] "It included a set of core values and principles to guide service delivery to children and families.

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[16] Duchnowski, A.J., Kutash, K., & Friedman, R.M. (2002). Community-based interventions in a system of care and outcomes framework. In Burns, B.J., & Hoagwood, K. (Eds.), Community treatment for youth: Evidence-based interventions for severe emotional and behavioral disorders. New York: Oxford University Press, p. 18

[17] Ibid.

[18] The Bazelon Center for Mental Health Law. (2009). Still waiting…the unfulfilled promise of Olmstead. Washington, DC: The Bazelon Center for Mental Health Law, p. 5.

[19] Huang, L., Stroul, B., Friedman, R., Mrazek, P., Friesen, B., Pires, S., & Mayberg, S. (2005). Transforming mental health care for children and their families. American Psychologist, 60(6), 615–627. (p. 616).

[20] Ibid.

[21] Ibid.

[22] Ibid.

[23] Stroul, B., & Friedman, R. (1986). *A system of care for children and youth with severe emotional disturbances*. Washington, DC: Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health.

The core values specified that services should be community based, child centered, family focused and culturally appropriate. Key principles specified that services should (a) be comprehensive, with a broad array of services and supports; (b) be individualized to each child and family; (c) be provided in the least restrictive, appropriate setting; (d) be coordinated at both the system and service delivery levels; (e) include early intervention efforts; and (f) engage families and youth as full partners."[24] "A major goal of the system of care model is to increase the availability of intensive treatment interventions in community-based settings, in contrast to being limited to restrictive residential centers as the only option for such treatment."[25]

"As Duchnowski and colleagues correctly point out, evolution of the system of care model has effected three key shifts in the way services are delivered: (1) change in the location of services from institutions to family-based care, (2) changes in the manner of service delivery from office-based to community care; and (3) change from a 'pathological family' perspective to a strengths-based approach that capitalizes on the resilience of children and the supportive capacities of their families. Each of these shifts has dramatic policy implications."[26]

In 1993, the newly created SAMHSA Center for Mental Health Services initiated the Comprehensive Community Mental Health Services for Children and Their Families program known as the Child Mental Health Initiative (CMHI). The purpose of this program was to support states, political subdivisions within states, the District of Columbia, territories, Native American tribes, and tribal organizations. The program helped develop integrated home and community-based services and supports for children and youth with serious emotional disturbances[27] and their families by encouraging the development and expansion of effective and enduring systems of care.

The CMHI defined a "system of care" as an organizational philosophy and framework that involves collaboration across agencies, families, and youth for the purpose of improving access and expanding the array of coordinated community-based, culturally and linguistically competent services and supports for children and youth with a serious emotional disturbance and

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[24] Huang, L., Stroul, B., Friedman, R., Mrazek, P., Friesen, B., Pires, S., & Mayberg, S. (2005). Transforming mental health care for children and their families. *American Psychologist, 60*(6), 615–627. (p. 616).

[25] Duchnowski, A.J., Kutash, K., & Friedman, R.M. (2002). Community-based interventions in a system of care and outcomes framework. In Burns, B.J., & Hoagwood, K. (Eds.), *Community treatment for youth: Evidence-based interventions for severe emotional and behavioral disorders.* New York: Oxford University Press, p. 30

[26] English, M.J. (2002). Policy implications relevant to implementing evidence-based treatment. In Burns, B.J., & Hoagwood, K. (Eds.), *Community treatment of youth: Evidence-based interventions for severe emotional and behavioral disorders.* New York: Oxford University Press. p. 305.

[27] The CMHI defined serious emotional disturbances as the following: "Children with serious emotional disturbance are persons from birth to age 18 who currently, or at any time during the past year have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-III-R, that resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, or community activities." (Federal Register, 1993).

their families.[28]

While the system of care philosophy was taking root within the mental health field, there were also changes happening in Medicaid. In 1989, the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) provisions in Medicaid were amended to require that all states screen eligible children "as medically necessary, to determine the existence of certain physical or mental illnesses or conditions" and provide "other necessary health care, diagnostic services, treatment, and other measures described in section 1905(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan."[29]

Subsequently, lawsuits brought under Medicaid authorities established that appropriate treatment was most often community-based. Settlements such as *J.K. v. Eden* (2001) in Arizona and *Rosie D. v. Romney* (2006) in Massachusetts emphasized maintaining youth with mental health conditions in the community. As a result, states had to be proactive in developing robust community-based service systems to meet the requirements of the court orders. The more recent *J.K. v. Humble* (2009) suit was brought because, among other services, Arizona had not created the intensive community-based services that children with serious mental health conditions require under the original *J.K. v. Eden* suit. A 2012 decision denying the state's Motion to Terminate Jurisdiction in the *J.K.* case indicates that the requirements are not yet met.

In 1999, the need for community-based services was strengthened through the Supreme Court case *Olmstead v. L.C.*, which established two basic legal principles. First, the unjustified institutionalization of people, who would otherwise prefer to live in the community, is a violation of the Americans with Disabilities Act (ADA). The Court also ruled that states are legally required to remedy discriminatory practices through "reasonable modifications" of their state programs.[30]

Under the ADA, a person cannot be discriminated against because of a disability. In *Olmstead*, the Supreme Court held that "unjustified isolation of individuals with disabilities" in institutions should be considered a form of discrimination. These cases are "unjustified" if the person in question wishes to live in the community, and treatment professionals have stated that the individual is capable of living in the community with "reasonable modifications" to state programs. Justice Ginsburg, writing for the majority, concluded that such isolation could be considered discrimination because it "perpetuates unwarranted assumptions" about the ability of institutionalized individuals to "participate in community life. Second, confinement in an institution severely diminishes the everyday life activities of individuals" by denying or making

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[28] Duchnowski, A.J., Kutash, K., & Friedman, R.M. (2002). Community-based interventions in a system of care and outcomes framework. In Burns, B.J., & Hoagwood, K. (Eds.), *Community treatment for youth: Evidence-based interventions for severe emotional and behavioral disorders.* New York: Oxford University Press, p. 19

[29] Social Security Act § 1905(r) 42 U.S.C. §§1396d(a)(4)(B) and 1396(r).

[30] Rosenbaum, S. & Teitelbaum, J. (2004). *Olmstead at five: Assessing the impact*. Menlo Park, CA: Kaiser Commission on Medicaid and the Uninsured. p. 3.

difficult the opportunity for individuals to maintain family and social relationships, or to engage in work and cultural enrichment.[31]

Although this suit was brought on behalf of two adult women, a 2000 report by the Bazelon Center for Mental Health Law noted that "…this reasoning is perhaps even more applicable to children. Needlessly segregating children contributes to the stigma that they are bad children…cuts off their ability to participate in family outings and cultural and educational opportunities…[and] hampers family relationships, which are critical to mental health and development."[32]

In 2001, Sturm et al. found that "there has been a documented shift to outpatient care over the past 15 years, based on an analysis of mental health service use and expenditures but significant service gaps in the continuum of care for children and their families remain."[33]

To address these gaps in one state, California plaintiffs brought the *Katie A. v. Bonta* (subsequently *Katie A., et al. v Douglas, et al.*) lawsuit under the authorities of both EPSDT and the ADA for the class of youth who: "(a) …are in foster care or are at imminent risk of foster care placement, and (b) have a mental illness or condition that has been documented or, had an assessment already been conducted, would have been documented, and (c) need individualized mental health services, including but not limited to professionally acceptable assessments, behavioral support and case management services, family support, therapeutic foster care, and other medically necessary services in the home or in a home-like setting, to treat or ameliorate their illness or condition."[34]

The suit charged the California Departments of Health Care Services and Social Services with neglecting to provide "appropriate mental health services in the community, while instead relying on services provided in restrictive, congregate, and institutional placements, in violation of the Medicaid Act and the ADA."[35]

In a 2011 settlement, California agreed to provide home- and community-based mental health services to Medicaid eligible children in the foster care system, or at risk of entering the foster care system, in order to help them avoid institutional care.

The Agreement requires the defendants to, among other things, support the development and delivery of an array of coordinated, community-based mental health services and develop a

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[31] Olmstead v. L.C. (98-536) 527 U.S. 581 (1999) 138 F.3d 893.

[32] The Bazelon Center for Mental Health Law. (2001). Merging system of care principles with civil rights law: Olmstead planning for children with serious emotional disturbance. Washington, DC: The Bazelon Center for Mental Health Law. p. 3.

[33] Sturm, R., Ringel, J., Stein. B., & Kapur, K. (2001). Mental health care for youth: Who gets it? How much does it cost? Who pays? Where does the money go? Arlington, VA: Rand. (RB-4541)

[34] Katie A., et al. V. Douglas, et. al., CV-02-05662 AHM (SHX); Comments of the United States in Support of Final Approval of the Proposed Settlement Agreement. 2011.

[35] Ibid., Pls.' First Am. Compl. ("Compl."), ECF. No. 33, ¶¶ 47, 76, 80-87.

process "to identify class members and link them firmly to services."[36] The defendants were ordered to develop and disseminate a Medi-Cal documentation manual designed to inform and instruct providers on the provision of Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS) and Therapeutic Foster Care (TFC).

The Agreement stipulated that TFC services:

a) place a child singly, or at most in pairs, with a foster parent who is carefully selected, trained, and supervised and matched with the child's needs;
b) create, through a team approach, an individualized treatment plan that builds on the child's strengths;
c) empower the therapeutic foster parent to act as a central agent in implementing the child's treatment plan;
d) provide intensive oversight of the child's treatment, often through daily contact with the foster parent;
e) make available an array of therapeutic interventions to the child, the child's family, and the foster family (including behavioral support services, crisis planning and intervention, coaching and education for the foster parent and child's family, and medication monitoring) … ; and
f) enable the child to successfully transition from therapeutic foster care to placement with the child's family or alternative placement by continuing to provide therapeutic interventions.[37]

Although work could proceed on the ICC and IHBS, the Agreement had to set up a negotiation committee to address TFC design and financing issues. This action in California is indicative of the confusion around TFC nationwide, which is described in the following section.

Therapeutic or Treatment Foster Care. To respond to the growing emphasis to serve individuals with mental health problems in the community, TFC evolved in the 1970s "through a synthesis of the best qualities of mental health residential treatment programs and child welfare foster care programs (Bryan and Snodgrass, 1990)"[38] as an alternative to institutionalizing children with severe emotional and behavioral disorders.[39] TFC evolved as a multidisciplinary

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[36] Katie A., et al. V. Douglas, et. al., CV-02-05662 AHM (SHX); Comments of the United States in Support of Final Approval of the Proposed Settlement Agreement. 2011. Pls.' First Am. Compl. ("Compl."), ECF. No. 33, ¶¶ 47, 76, 80-87.

[37] Ibid., ¶¶ 20(a)-(g), (i)).

[38] Bereika, G. M. (Fall 1992). Treatment Foster Care: Its role in the service system. *Position Papers from the Foster Family-Based Treatment Association*, 9–13. Retrieved from http://www.ffta.org/publications/position_papersfinal.pdf

[39] Meadowcroft, P., Thomlison, B., & Chamberlain, P. (1994) Treatment foster care services: A research agenda for child welfare. *Child Welfare*, *73*(5), 565–581. (p. 565).

approach to providing care within a broader system of social services (e.g., mental health, child welfare, special education, juvenile justice).[40]

TFC serves youth across the age range. The service may be used to address an array of problems, including youth with behavioral health diagnoses such as internalizing and/or externalizing mental health conditions and/or substance use disorders.[41,42]

Youth may enter TFC from three different child-serving systems and for many different clinical reasons. They may be involved in the child welfare system or the juvenile justice system, or they may simply need a certain level of mental health care. These three child-serving systems share a common goal of protection and treatment, but they have historically served populations with differing issues.

"While each of these systems has historically focused on meeting different aspects of children's needs, increasingly they share common concerns regarding the emotional and behavioral disturbances of the children and youth in their care. In the child welfare system, as a link began to be realized between the early life trauma of abuse and neglect and later problems in adjustment and functioning, the need for a more therapeutic level of foster family care was acknowledged."[43]

"Although in the early years of the founding of the juvenile court much attention was paid to the psychological functioning of juvenile offenders, emphasis on incarceration and punishment took precedence as juvenile services evolved."[44]

"Only in the last decade or two has there been a resurgence in recognition of the extensive mental health needs of delinquent youth with an accompanying search for therapeutic models of care, particularly for incarcerated youth ready for release back into their home communities."[45]

"Finally, as managed care programs have increasingly restricted funding for in-patient psychiatric hospitalization as well as for long-term residential care of children and youth with severe emotional and behavioral disturbances, the children's mental health system has also

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[40] Meadowcroft, P., Thomlison, B., & Chamberlain, P. (1994) Treatment foster care services: A research agenda for child welfare. *Child Welfare*, *73*(5), 565–581.

[41] Although not the focus of this meeting, it should be noted that TFC may also be used to care for medically fragile or developmentally disabled children.

[42] Administration for Children and Families. (n.d.) *Treatment foster care.* Washington, DC: U.S. Department of Health and Human Services. Retrieved April 23, 2013 from https://www.childwelfare.gov/outofhome/foster_care/treat_foster.cfm.

[43] Dore, M.M., & Mullin, D. (1996). Treatment family foster care: Its history and current role in the foster care continuum. *Families in Society: The Journal of Contemporary Social Services*, *87*(4), 475–482. (pp. 475–476).

[44] Ibid.

[45] Ibid.

sought cost-effective community-based treatment alternatives for youth with special mental health needs."[46]

"Children in TFC have often experienced multiple failed placements prior to referral to TFC, often four or more prior placements, and typically have higher rates of severe emotional and behavioral problems and trauma histories than children referred for regular foster care (Burns et al., 1999; Kerker & Dore, 2006; Baker & Curtis, 2006; Fisher et al., 2009; Hussey & Guo, 2005; Smith et al., 2006)."[47]

"TFC is now one of the most widely used forms of out-of-home placement for children and adolescents with severe emotional and behavioral disorders and is considered to be the least restrictive form of residential care (Kutash & Rivera, 1996; Stroul 1989). An estimated 1200 youth in the United States receive TFC at any one time, representing over 6 million "client days" at a cost of one-half billion dollars per year (Farmer, Burns, Chamberlain, & Dubs, 2001)."[48]

Yet, little is known about TFC. The federal Adoption and Foster Care Analysis and Reporting System (AFCARS) does not separate information about youth in TFC from other foster care youth in the data, so there is no way to know the number of youth, or other variables specific to those in TFC.

The Foster Family-based Treatment Association (FFTA) *Program Standards for Treatment Foster Care* (1991, p.16) define treatment foster care as "…the coordinated provision of services and use of procedures designed to produce a planned outcome in a person's behavior, attitude or general condition based on a thorough assessment of possible contributing factors. Treatment typically involves the teaching of adaptive, prosocial skills and responses which equip young persons and their families with the means to deal effectively with conditions or situations which have created the need for treatment."[49]

However, Farmer et al. found that "[al]though the standards promulgated by FFTA were an effort to establish uniformity in the definition of treatment foster family care, there is currently a wide range of approaches to providing this form of foster care."[50]

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[46] Dore, M.M., & Mullin, D. (1996). Treatment family foster care: Its history and current role in the foster care continuum. *Families in Society: The Journal of Contemporary Social Services*, *87*(4), 475–482. (pp. 475–476).

[47] Bruton, J. (2012, September). Assessing the evidence base: Treatment foster care. (Literature Review). Briefing paper presented at the Technical Expert Panel Meeting, *What Does the Research Tell Us about Services for Children in Therapeutic/Treatment Foster Care with Behavioral Health Issues?*

[48] Chamberlain, P. (2002). Treatment foster care. In B. Burns & K. Hoagwood (Eds.). *Community treatment of youth: Evidence-based interventions for severe emotional and behavioral disorders*. New York: Oxford University Press. p. 117.

[49] Berlin, J. Allen, M., & Robinson, G. (Summer, 1994). Family-centered, community-based services in treatment foster care. *Position Papers from the Foster Family-Based Treatment Association*, 16–21. Retrieved from http://www.ffta.org/publications/position_papersfinal.pdf

[50] Farmer, E.M.Z. et al. (2002). Assessing conformity to standards for treatment foster care. *Journal of Emotional and Behavioral Disorders*, 10, 213-222.

Redding concurred saying, "while there is a well-articulated treatment family foster care program model promulgated by the FFTA, and certain features are generally common across programs, the clinical application of TFC varies across agencies, particularly in the structure and intensity of services, population served (child welfare, mental health, juvenile justice), and staff and foster parent characteristics."[51]

"Treatment foster care is known by a variety of names, including therapeutic foster care, foster family-based treatment, individualized residential treatment, and others."[52] "The very name of the model – treatment foster care – contributes to the confusion by suggesting that it is simply a type of family foster care. These two models share certain obvious similarities, including a common belief about the benefit and the power of family-based care… [but] the differences between the models far outweigh the similarities, and warrant a recognition that they are not simply variations on a theme."[53]

"There have been attempts in the literature to differentiate TFC from family foster care. These have been important contributions to the literature. However, they have sought to achieve differentiation by comparing the two models on variables shared by both (e.g., caseload size, frequency of home visits, average number of children in a home). These are important differences, but the use of the shared variables as the bases of the comparison has perhaps unintentionally contributed to the idea that TFC is a variation of family foster care, rather than a distinct model."[54]

"…[A] lack of clarity still exists about the differences between TFC and family foster care, and between TFC and other treatment modalities, such as residential treatment facilities and other group care models. Is TFC simply an improved model of family foster care? Are there similarities between TFC and therapeutic group homes or residential treatment facilities? How does the function of TFC in the service system compare with that of family foster care and residential treatment facilities?"[55]

State variations in definitions of TFC. Researchers at the Boston University School of Social Work recently completed a 50-state and District of Columbia survey of all current foster care programs, policies, and financing with an emphasis on TFC. Topics covered in questions asked included: service definition, eligibility criteria, assessment tools for eligibility, standards of care, regulatory definitions and Medicaid billing practices.[56]

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[51] Redding, R. et al. (2000). Predictors of placement outcomes in treatment foster care: Implications for foster parent selection and service delivery. *Journal of Child and Family Services*, 9(4), 425-447

[52] Bereika, G. M. (Fall 1992). Treatment Foster Care: Its role in the service system. *Position Papers from the Foster Family-Based Treatment Association*, 9–13. Retrieved from http://www.ffta.org/publications/position_papersfinal.pdf. p. 9.

[53] Ibid., p. 10.

[54] Ibid.

[55] Ibid.

[56] Boston University School of Social Work.*The 50 State Chartbook on Foster Care.* Online. Retrieved from http://www.bu.edu/ssw/usfostercare.

States were asked about their definitions of TFC. The survey indicated that states have different names for their TFC programs. Some states (including Arkansas, Connecticut, and Indiana) use the term therapeutic foster care, whereas others (including Minnesota and California) call the service treatment foster care. Several states (including Idaho, Iowa, and Washington) use both terms to label their TFC programs. New Mexico and Wisconsin have three different levels of therapeutic foster care. TFC has also been called elevated needs, specialized foster care, specialized treatment care, TFC with enhanced services, and Therapeutic Foster Boarding Home Care. Six out of 50 states and the District of Columbia do not have names for their TFC programs.[57]

Twenty states did not respond to the question about whether they have eligibility criteria for TFC. Of the remaining 30 states and the District of Columbia, California and South Dakota do not have criteria for determining TFC eligibility. The states vary in the criteria they use to determine whether a child needs TFC. Some states have criteria such as mental health of the child, number of failed placements, or medical necessity to determine eligibility. For example, to be placed into TFC in Alabama, the child needs to have a DSM-IV diagnosis on Axis 1 accompanied by a behavior that would require the treatment and the structure provided by TFC.

Washington uses medical necessity as the criteria for TFC. In California the determination of TFC eligibility is made by a local child welfare supervisor and a judge. In South Dakota, Child Protection Services staff members fill out applications provided by the child placement agencies that provide TFC to determine if the level of care is appropriate for the child.[58]

Twenty-six states and the District of Columbia did not respond to the question on whether standards of care differ for TFC from traditional foster care. Of the 24 states that responded, Alaska and Tennessee said that standards of care did not differ for TFC. Arkansas gave a detailed response on how the standards differed for TFC: TFC parents are specially trained and more intensively supervised and supported to help them care for children with more complex needs. In New York, TFC social workers have lower case loads, and educational specialists provide communication with local school systems to help resolve educational problems. Foster parents also receive additional support from child care workers. Extensive and specialized training is provided to foster families and staff.[59]

Twenty-two states and the District of Columbia did not respond to the question on regulatory definitions for TFC. Eight states that did respond, including Alabama, Alaska, Delaware, Georgia, North Dakota, Oklahoma, South Dakota, and Wisconsin, did not have a regulatory definition.

The survey also asked states about Medicaid billing for TFC. Fifteen states did not respond to the question. Among the 11 states that said that they did not have Medicaid billing for TFC, the

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[57] Ibid.

[58] Ibid.

[59] Boston University School of Social Work.*The 50 State Chartbook on Foster Care.* Online. Retrieved from http://www.bu.edu/ssw/usfostercare.

reasons varied. Nevada does not bill for TFC directly, but related services are billed individually following a CMS directive and State Plan Amendment in 2009. The Medicaid billing in South Dakota was discontinued in July 2010. The South Dakota Department of Social Services has $26 million from the state legislature to contract placements for children who qualify. The same providers have other services billed to Medicaid with prior authorization under the rehabilitation option. Although the survey identified other important funding sources, including Title IV-B and Title IV-E, it did not collect billing data from these funding sources at the service-type level.

The states that have Medicaid billing for TFC have varied requirements. Florida provides for Medicaid billing for licensed clinical supervisors, licensed foster homes, parents who receive additional training, crisis intervention, and intensive institutional care. In Texas, services provided through STARHealth, such as therapy, psychiatric evaluations, psychological evaluations, and management, are billed through Medicaid. Wisconsin does not have Medicaid billing for TFC in the state plan, but it allows for payment through a 1915(c) Home and Community-Based Services waiver.[60]

The results of the Boston University survey indicate a need to study and clarify TFC. "The lack of clarity that exists between TFC and family foster care and between TFC and other models of residential treatment manifests itself in request for proposals issued by states, counties and provinces, in licensing regulations, and in the widely disparate rates paid for TFC through the United States and Canada."[61] "Greater clarity (with TFC) will help ensure that children are served in the most appropriate and least restrictive setting that can address their needs." It "…will [also] help states, counties and provinces use their limited resources effectively, by ensuring that children are served in the least restrictive and least costly program model that is appropriate to meet their complex and varied needs."[62]

Research on TFC. Unfortunately, there is a lack of literature, randomized controlled trials, and rigorous evidence-based studies of TFC programs. "Although a significant body of research over the past 25 years has documented the mental health needs of youth in foster care (Heflinger et al., 2000), less is known about those in treatment foster care settings particularly how they may differ from children in regular foster care settings, including the long-term foster care settings more likely to encompass treatment foster care youth. Youth in treatment foster care are hard to identify and investigate as a distinct subgroup, given the varieties of samples and methods used in the published research and the lack of clarity regarding the meaning of long-term treatment, specialized, and therapeutic foster care (Reddy & Pfeiffer, 1997)."[63]

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[60] Ibid.

[61] Bereika, G. M. (Fall 1992). Treatment Foster Care: Its role in the service system. *Position Papers from the Foster Family-Based Treatment Association*, 9–13. Retrieved from http://www.ffta.org/publications/position_papersfinal.pdf. p. 10.

[62] Bereika, G. M. (Fall 1992). Treatment Foster Care: Its role in the service system. *Position Papers from the Foster Family-Based Treatment Association*, 9–13. Retrieved from http://www.ffta.org/publications/position_papersfinal.pdf. p. 10.

[63] Reddy, L. A. & Pfeiffer, S. I. (1997). Effectiveness of Treatment Foster Care with children and adolescents: A review of outcome studies. *Journal of the American Academy of Child & Adolescent Psychiatry*, 36, pp. 581-588.

Two specific TFC programs, Multidimensional Treatment Foster Care (MTFC) and Together Facing the Challenge, have been researched. MTFC was developed in 1983, based on earlier studies to treat "serious and chronic juvenile defenders.[64] MTFC is a specific evidence-based treatment model that works to "decrease problem behavior and to increase developmentally appropriate normative and prosocial behavior in children and adolescents who are in need of out-of-home placement."[65] "Youth are referred into MTFC through a variety of places including juvenile justice, foster care, and mental health systems."[66]

MTFC focuses on treatment foster parent recruitment and screening, intensive preservice treatment foster parent training, treatment fidelity, positive reinforcement, daily structure, close supervision of both youth and treatment foster parents, coordination of services with strong case management interaction, a view of treatment foster parents as professionals, intensive services, consistency of discipline, a team approach, clinical services, respite care, work with the youth's family when possible, aftercare services, and the promotion of positive peer relationships.[67] MTFC adapted for use in preschool aged children is called Early Intervention Foster Care (EIFC) or Multidimensional Treatment Foster Care Program for Preschoolers (MTFC-P) and was found to have similarly effective results.[68] MTFC is listed on SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP) and is the most-well known and well-researched model of TFC.[69]

The other well-known model of TFC is Together Facing the Challenge. This program was developed to provide in-service training for existing TFC programs. It is a hybrid intervention that includes ideas and elements from existing TFC agencies, Chamberlain's model, and other sources to fill in gaps that were seen in practice but not filled by MTFC.[70] Together Facing the Challenge is not listed on NREPP, but it is listed on the California Evidence-Based Clearinghouse for Child Welfare.[71]

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[64] TFC Consultants, Inc. (2013). History of MTFC. *Multidimensional treatment foster care: An evidence-based solution for youth with behavioral problems, their families and their communities*. Retrieved from http://www.mtfc.com/history.html

[65] Ibid.

[66] Ibid.

[67] Sprengelmeyer, P. G., & Chamberlain, P. (2001). Treating antisocial and delinquent youth in out-of-home settings. In J. N. Hughes, A. M. La Greca, & J. C. Conoley (Eds.). *Handbook of psychological services for children and adolescents*. New York: Oxford University Press, pp. 285–299.

[68] Fisher, P. A., & Kim, H. K. (2007). Intervention effects on foster preschoolers' attachment-related behaviors from a randomized trial. *Prevention Science, 8,* 161–170.

[69] Bruton, J. (2012, September). Assessing the evidence base: Treatment foster care. (Literature Review). Briefing paper presented at the Technical Expert Panel Meeting, *What Does the Research Tell Us about Services for Children in Therapeutic/Treatment Foster Care with Behavioral Health Issues?*. p. 4

[70] Farmer, E. M. Z., Burns, B. J., & Murray, M. (2009). Enhancing treatment foster care: An approach to improving usual-care practice. *Emotional and Behavioral Disorders in Youth*, *9*(4), 79–84.

[71] The California Evidence-Based Clearinghouse for Child Welfare. *Together facing the challenge*. 2011. Retrieved from http://www.cebc4cw.org/program/together-facing-the-challenge/

Although MTFC and Together Facing the Challenge have some supporting research, there have been numerous challenges to rigorous research in this area. Dore and Mullin (1996) found that research on outcomes for children in TFC is limited in scope and scientific rigor. "Most outcomes research to date has focused on discharge status (restrictiveness of subsequent placements), placement stability (number of disrupted placements and/or moves while in care), program completion, rates of institutionalization, and reentry into care following program discharge (Bryant & Snodgrass, 1992; James & Meezan, 2002), but it is not clear if these outcomes represent improved behavioral or social outcomes (James & Meezan, 2002; Reddy & Pfeiffer, 1997)."[72] It is difficult to rely on past studies of TFC, because often the models of care being studied are not clearly specified.

"Another limitation to current research is that control or comparison groups are seldom used. As a result, findings cannot indicate whether observed changes are due to the treatment foster care program or to other factors."[73] "When comparison groups are utilized, differences between groups are usually not accounted for. For example, children placed in treatment foster care are generally not comparable demographically or in their psychosocial functioning to those placed in regular family care or institutional settings—groups to which they are often compared—so comparisons in outcomes between these groups may not be appropriate."[74]

A review by Turner and MacDonald in 2011 found that, "despite the fact that individual studies typically indicate that TFC is a promising intervention for children with serious emotional and behavioral concerns, mental health diagnoses, and delinquency, the evidence base is weak."[75]

In addition to the challenges facing the researched models, there are many other TFC programs addressing youth with the same behavioral and emotional disorders that have not been researched.

Organizational and financing issues. Very little is known about the effects of organizational factors on the access to or quality of TFC. As previously noted, while the Foster Family-based Treatment Association has promulgated and recently revised national TFC standards, studies find differences in clinical practice, as well as wide variation across a host of implementation issues. These issues include (but are not limited to) disparate agency structures and staffing patterns, parent recruitment and retention practices, staff and parent training, and supervision requirements at the local level. Nationally, the lack of uniform level-of-care criteria for out-of-home mental health care, coupled with variations in federal and state regulations, often makes it difficult to conceptualize TFC as a single service type.

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[72] Dore, M.M., & Mullin, D. (1996). Treatment family foster care: Its history and current role in the foster care continuum. *Families in Society: The Journal of Contemporary Social Services*, *87*(4), 475–482. pp. 475–476.

[73] Dore, M.M., & Mullin, D. (1996). Treatment family foster care: Its history and current role in the foster care continuum. *Families in Society: The Journal of Contemporary Social Services*, *87*(4), 475–482. pp. 475–476.

[74] Ibid.

[75] Turner, W., & Macdonald, G. (2011). Treatment foster care for improving outcomes in children and young people: A systematic review. *Research on Social Work Practice*, *21*(5), 501–527.

In addition, as we have seen, TFC may be administered through at least three different public child-serving agencies: child welfare, juvenile justice, and mental health. In addition, in many cases youth in TFC may have the service paid, at least in part, by yet another public sector agency—Medicaid. Much less is known about the role and responsibility of the Individuals with Disabilities Education Act, the special education law in these cases. Suffice it to say that, in most instances, two or more child-serving agencies may have shared responsibility for many youth in TFC. Historically, this shared responsibility has manifested itself most concretely in often complex financing arrangements supporting service delivery. These historical funding issues may be compounded by upcoming changes to public health care financing, which will affect some youth and their families.

In "Policy Implications Relevant to Implementing Evidence-Based Treatment," English wrote that "multiple public agencies have an obligation to collaborate in delivering services to common clients, both for the convenience of the client and for the efficient use of public resources."[76] Realizing this and the extensive shared responsibility for youth in TFC, on September 27-28, 2012, SAMHSA, CMS, and ACYF convened a technical expert panel to address the clinical, organizational, and financing issues that surround TFC.

The Technical Expert Panel Meeting

The technical expert panel reflected one aspect of the broader partnership among SAMHSA, CMS, and ACYF to improve services for children with behavioral health issues. In this case, the focus was on the population of children and youth in need of a therapeutic, home-based level of mental health care.

The technical expert panel was designed to convene a small group of experts with different perspectives and areas of expertise to identify the population of youth in TFC, appropriate services and supports for youth in TFC, and TFC organizational issues. Technical expert panelists examined the evidence base for the principles supporting TFC, clinical outcomes, and the role of TFC organizational factors in the delivery of the service. The panel employed a modified Delphi consensus process to identify areas of agreement (see Appendix C).

At the meeting, federal officials provided the rationale and context for the meeting. National experts presented research in six areas: identifying what we know about TFC, identifying youth appropriate for TFC, identifying the essential elements of TFC, psychosocial treatment of youth in TFC, outcomes for youth, and organizational issues in TFC.

Technical Expert Panel Consensus: Knowledge and Implementation

Throughout the technical expert panel meeting, presenters and panel members submitted candidate consensus statements by topic area (see Consensus Process, Appendix C) and in

[76] English, M.J. (2002). Policy implications relevant to implementing evidence-based treatment. In Burns, B.J., & Hoagwood, K. (Eds.), *Community treatment of youth: Evidence-based interventions for severe emotional and behavioral disorders.* New York: Oxford University Press. p. 306.

response to three overarching questions:

1. *What Does the Research Tell Us About Therapeutic/Treatment Foster Care?*
2. *What Are Recommendations for the Implementation of What We Know?*
3. *What Are Recommendations for Advancing the Knowledge Base?*

This section synthesizes excerpts from the panel member consensus on the first two questions.[77] Excerpts of the consensus on recommendations for advancing the knowledge base are reported in the following section.[78]

I. What Do We Know About Therapeutic/Treatment Foster Care?

Question 1: What Does the Research Tell Us About Therapeutic/Treatment Foster Care?

Therapeutic/Treatment Foster Care (TFC) is a community-based, less restrictive alternative to more restrictive settings (e.g., group care, psychiatric residential treatment facilities, long-term residential programs). TFC models generally treat seriously emotionally disturbed youth who have a high likelihood of needing more restrictive long-term residential treatment. Many variations of TFC models exist. TFC plays a different role in states' systems of care depending upon its location in the system (e.g., child welfare, juvenile justice, mental health). States license TFC in different systems for different purposes. The design of TFC programs administered by child welfare agencies may differ significantly from the design of TFC programs administered by mental health agencies.

Youth may be in TFC for medical, behavioral, developmental or justice-related reasons. The placement histories of TFC youth are dictated by the systems (e.g., mental health, juvenile justice, child welfare) in which they are served. Currently the purpose of TFC varies depending on how it is used in the continuum of out-of-home care. TFC needs to be available for youth who need that level of care as an initial placement but also may be used as a step down resource for youth leaving residential treatment.

Relationships matter in the lives of youth. TFC serves a range of youth at risk of more intensive placements and poor life outcomes. While youth in regular foster care may also have high mental health service utilization many youth need more structure and services than is provided through regular foster care. Youth in TFC are a high service-need group who have a wide range of presenting problems including significant social, emotional and mental health problems. Youth in TFC have high mental health service utilization and for many youth mental health

[77] Editorial Note: The following section synthesizes the results of two rounds of consensus process voting.

[78] See consensus statement voting results in Appendix D to identify the strength of the agreement for each consensus statement.

concerns persist until adulthood. Transition-age youth and young adults are at high risk for mental health problems. It is important to have a range of treatment models to address youth with diverse mental health needs. Some youth can benefit from regular foster care kinship placements. The TFC model must fit the youth's diagnostic profile and needs.

Placement disruption is a common event in foster care. Many youth come into TFC after experiencing multiple out-of-home placements. Research indicates that the older the age of youth at entrance into foster care, the higher the number of out-of-home placements experienced and that experiencing multiple placements may compound a youth's problems. The majority of TFC research has focused on these youth.

While it is important to provide trauma-informed services for youth in TFC, it is important to discriminate between traumatic responses to maltreatment and other mental health conditions affecting youth in TFC. Addressing trauma/stress symptoms and other behavioral health needs of youth can successfully reduce their risk of adverse child welfare outcomes.

Some models of TFC can be effective. TFC is promising for youth with complex emotional, psychological and behavioral needs. Behavioral health problems in youth may improve through this service.

The research on TFC has concentrated primarily on two models, MTFC and Together Facing the Challenge, both of which are well specified in the existing research. Youth enter MTFC because of behavioral problems or involvement in the juvenile justice system rather than for internalizing problems typically addressed by informed trauma treatment. MTFC has been implemented in child welfare settings, mental health settings, and juvenile justice settings and has indicated effectiveness in producing positive outcomes for youth.

MTFC has been shown to be a cost-effective TFC model; however, the dissemination of the MTFC model is quite limited. Together Facing the Challenge, a modified MTFC model, was developed because it is difficult to implement MTFC in real world settings. Together Facing the Challenge has shown effectiveness in producing positive outcomes for youth.

Both MTFC and Together Facing the Challenge were shown to result in improvements in both youth well-being and permanency outcomes in randomized controlled trials. Youth with serious problems have a better than chance likelihood of improving with either MTFC or Together Facing the Challenge and children with serious problems have a better than chance likelihood of improving with MTFC-preschool.

The research on the MTFC and Together Facing the Challenge models, while well-specified and tested, is not sufficient to provide a full understanding of what is needed, for whom, under what conditions with what outcomes. Most of the research on MTFC and Together Facing the Challenge has been conducted by the developers of the models and many other models of TFC have not been tested. Pilot studies should be conducted before widespread funding and utilization of TFC.

TFC is a treatment setting, yet there is no standard implementation of TFC across child-serving systems or across states. While many TFC agencies are incorporating key components of the

Foster Family-based Treatment Association Standards, there is widespread variation in TFC programs' conformity to those Standards.

There is no uniform set of enrollment criteria for TFC. States license TFC in different systems for different purposes. TFC programs vary in implementation readiness and duration. TFC as widely implemented in the United States does not follow established evidence-based practices. TFC programs also vary in cost.

It is important to clarify the distinction between a TFC practice and a TFC model. There is a need for widespread implementation of evidence-based TFC models. However, few agencies are implementing evidence-based TFC models with fidelity, although fidelity to the model leads to improved outcomes for youth. There is a need to adhere to TFC practice standards. A goal is to move from providing generic interventions to different youth to matching specific interventions to specific youth.

Question 2: What Are Recommendations for the Implementation of What We Know?

There is a need for a clear operational definition of TFC that distinguishes between TFC standards of care and TFC model components. TFC needs to follow clear manuals and protocols.

TFC requires multifaceted interventions. The field needs to determine the services that comprise TFC and develop clear standards of practice. There is a need for federal and state regulations that encourage fidelity to basic standards of TFC, and a clear process to measure adherence to TFC standards of care.

Placement of a youth should be based on needs. In current practice, youth with a wide range of mental health needs may be placed in either regular foster care or in TFC, not based on need but on the availability of foster care placement slots. Information from existing regular foster care and TFC needs to be analyzed to identify differences between the two. The field needs to identify the target population who benefit from the TFC treatment modality, clarify the criteria for admission of young children into TFC and identify the developmental treatment trajectory that youth in TFC are likely to follow. Many states need standardized criteria for TFC enrollment and services.

There is a need to expand the use of best practices in TFC. MTFC is not available for the vast majority of youth who could benefit from it. The field needs greater uptake of evidence-based TFC programs. TFC interventions require fidelity to a model in order to be successfully implemented. It is essential to correct fidelity drift from a TFC model using a continuous quality improvement process.

The Administration on Children, Youth and Families (ACYF) considers well-being as important as safety and permanence. Youth well-being should be considered at intake into the child welfare system however there is a need for an operational definition of youth well-being.

It is important to connect TFC youth to supportive, caring adults. The TFC treatment plan must be individualized, address the specific needs of each youth and include preparation for that youth's transition out of child welfare services. The field must consider youth attachment to

providers in the transition from TFC and assess alternative permanency supports for TFC youth in case planning, including making TFC available to youth as a treatment option for as long as it is needed. Providing ongoing step-down services to maintain treatment gains is beneficial to TFC youth. It is also critical to match the needs of TFC families with appropriate services. TFC families should be reimbursed at higher rates than regular foster care families. TFC caseworkers' caseloads should be limited to 10-15 youth.

Funding restrictions greatly influence the decisions about which youth will have access to evidence-based TFC. There is a need for flexible funding options that promote both youth treatment and youth well-being. Child welfare and juvenile justice systems would save money through greater implementation of evidence-based TFC programs.

II. What Do We Know About Identifying Youth Appropriate for Therapeutic/Treatment Foster Care?

Question 1: What Does the Research Tell Us About Therapeutic/Treatment Foster Care?

Screening instruments, assessment requirements and level of care criteria vary widely in practice and in published research. No one measure meets all needs. Existing assessment measures for youth have limitations; there is a need to improve measures used to assess key youth and family domains. Rather than using a "one size fits all" assessment for youth in foster care, systems serving youth receiving child welfare services should employ an array of assessment tools to appropriately evaluate the domains of social-emotional well-being for youth and evaluate functioning across age groups.

Measures must be developmentally appropriate. Assessment measures should be selected based on an established set of criteria (e.g., reliability, validity, feasibility). It is also critical to evaluate the sensitivity of measures used in making decisions about treatment intensity. Understanding the limitations of measures used to assess the mental health status of children and youth is important.

Youth entering foster care should receive a functional assessment that includes an assessment of psychological, emotional and substance use status to determine the need for placement in TFC or another intensive intervention. A comprehensive functional assessment (i.e., assessment of youth's day-to-day functioning across TFC domains) is important for determining the appropriate service needs and level of care as well as monitoring the youth's progress while receiving services. It is important to assess issues that precipitated TFC placement (e.g., emotional and psychological health, interpersonal functioning, behavior problems, education, physical health care status and time in treatment).

There is a need for actionable data on TFC youth outcomes. Measures used to assess TFC youth outcomes vary in terms of dimensionality, sensitivity, validity, and reliability. Measurement criteria should be established for all measures used in assessing care outcomes. Measures should provide actionable information (i.e., information that assists in treatment planning and policy decisions). Little attention has been given to the psychometric qualities of the measures used in TFC. Standardized measures do not capture the nuances of a youth's psychological status.

Question 2: What Are Recommendations for the Implementation of What We Know?

The field needs to better understand how to identify youth who are appropriate for TFC. Placement and treatment decisions would be improved by having a documented connection between screening and assessment tools and treatment needs.

Measures of youth functioning and symptomatology are one component of the decisionmaking process in determining whether a youth may benefit from TFC. Assessment must include measures of trauma symptoms and experiences. The field also needs measures that are sensitive to racially, ethnically and culturally diverse youth populations using items that are reviewed in terms of cultural sensitivity.

It is important to operationally define a functional assessment. TFC placement decisions should be based on a functional assessment of the youth, and funders should require at least one functional assessment as part of determining assignment to the TFC level of care. Measurement items must encompass the range from mild to serious impairment so that a youth's treatment needs can be accurately identified using measures that assess real world functioning of youth as well as symptomatology.

There is a need for knowledgeable clinicians to interpret standardized assessment data. Both individual items as well as assessment measure sub-scores and total scores can be useful in placement planning. The field knows very little about the quality of measures for specific populations. There is a need for different measures to determine placement for different youth populations. The limitations of measures and tools should be considered in determining the level of care for TFC.

In practice, the placement of some youth in TFC may be a business decision rather than a clinical decision. It is important to sort out the influence of the business component versus the youth's needs when conducting assessments for placement in TFC. Assignment to TFC must be based on the youth's needs independent of the referral source.

A validated assessment tool and regular re-assessments must inform the development and updating of the youth's TFC treatment plan. Staff consensus is not a substitute for sound empirical measurement which should inform all changes in placements. There is a need for multiple measures to be available for TFC providers and clinicians.

The field needs assessment measures that are sensitive to change in youth over time. Measures developed for assessing appropriate level of care at intake should not be assumed to be adequate measures of outcomes. Strengths-based assessments may overlook important considerations in assessing improvement.

Measures that inform practice have greater utility. Funding should not drive the decision to adopt specific measurement instruments. Assessment measures and tools should be free or open source. The field should not employ measures simply because they are included in existing management information systems (MIS). Functional assessments and psycho-diagnostic evaluations of youth in TFC should be reimbursable.

The field needs to develop fidelity measures of TFC model implementation. TFC measures should be scientifically sound and assure that TFC fidelity measures have established validity. Measuring the level of fidelity to TFC models is essential in evaluating TFC's contribution to youth outcomes.

In setting standards for funders, it is important to distinguish case level measures versus program evaluation measures. Child and Family Services Reviews (CFSRs) and other evaluative tools should be adapted to better reflect the needs of sub-populations of youth, especially those youth, such as TFC youth, with high-service needs.

Cost is a component that should be included in evaluating the quality of TFC. The field does not know the cost-effectiveness of TFC services thus there is a need to study the cost-effectiveness of different approaches and models.

III. What Do We Know About the Essential Elements of Therapeutic/Treatment Foster Care?

Question 1: What Does the Research Tell Us About Therapeutic/Treatment Foster Care?

It is important to identify the essential elements of Therapeutic/Treatment Foster Care (TFC). There are some essential elements in TFC that need to be consistent across models. They include:[79]

- demonstrating the TFC agency's ability to support treatment foster parents,
- including TFC parents as members of the treatment team,
- assuring reduced caseloads for staff supporting TFC parents,
- investing in TFC parents,
- assuring the TFC agency's ability to supervise treatment foster parents,
- providing specialized training to TFC parent,
- monitoring the behavior of TFC youth,
- establishing therapeutic alliance between TFC foster parents and the youth in their care,
- providing 24/7 support/coaching to treatment foster parents,
- providing appropriate aftercare resources for youth,
- providing older youth in TFC with preparation and training for adulthood,
- coordinating services for everyone involved in the TFC treatment plan,
- monitoring the use of psychotropic medications for TFC youth,
- assuring that treatment foster parents are able to meet the psychosocial needs of youth in their care,
- supporting and engaging the family to whom the TFC youth will go following TFC,

[79] The following essential elements are listed in rank order according to the consensus voting.

- providing individual mental health treatment for TFC youth,
- conducting service planning for youth in TFC,
- providing academic support for TFC youth,
- providing social skills training for youth in TFC,
- providing 24/7supervision to TFC foster parents,
- scheduling regularly held clinical supervision for TFC staff to assure their effective working relationship with TFC parents,
- maintaining treatment foster homes with professional treatment parents,
- involving birth or biological parent(s) in treatment planning and implementation,
- providing higher reimbursement rates for TFC parents, and
- bundling of TFC services.

TFC models often employ some but not all of the TFC essential elements. Typical TFC practice does not adhere to the principles of the essential elements in MTFC. The essential elements of TFC have not been identified through randomized controlled trials. The field is currently limited in its knowledge of the relationship between race, ethnicity and culture and the essential elements of TFC.

Although not elements per se there are other important considerations. There should be flexibility in the definition of an aftercare resource depending on the TFC youth's permanency plan (e.g., adoption, reunification, independent living, emancipation). Allowing some youth to remain in TFC into early adulthood is essential to achieve lasting treatment outcomes.

It is important to assure that there is a match between youth needs and treatment foster parent ability or placements may fail. Child trauma is an underlying issue for many of the youth who may benefit from TFC. There is a need to assure that therapists working with TFC youth are competent in therapeutic modalities (e.g., individual and family therapy) and are competent in addressing intergenerational trauma through trauma-informed treatment. Higher education institutions must prepare behavioral health students to work in TFC programs. There is a need to identify the credentialing requirements and professional expertise of mental health professionals who work in TFC. Therapists working with TFC youth should also be compensated for delivering care management services. Addressing length of stay is also important. The clinical judgment of the treatment team should determine the appropriateness of length of placement in TFC for youth. Length of stay in TFC may be driven by the TFC model's theory of change. It is essential that TFC models estimate the intended length of stay from the outset. Many funded TFC programs do not have limits on length of stay. TFC may be a long-term placement option.

Question 2: What Are Recommendations for the Implementation of What We Know?

It is important to keep youth in the community in as normal a setting as possible. TFC needs to be designed to serve youth, regardless of custody status. TFC should link with a youth's biological family or other designated post-discharge caregiver; however, eligibility for TFC should not be based on having a pre-determined post-discharge caregiver. The TFC model

should also include genuine engagement of the TFC parents and the youth. TFC should not mix TFC youth with regular foster care youth within the same home.

TFC parents and providers should work with supportive aftercare resources to connect the youth to the community. The Parent Daily Report is a validated assessment tool that can monitor caregiver and youth well-being. In addition to identifying a youth's problematic behaviors the Parent Daily Report should capture what is going well for the TFC youth as well as what is being done to reinforce pro-social behaviors in TFC youth.

There is a need for a more widespread uptake of TFC programs that contain the identified essential elements. Funding must support evidence-based, trauma-informed TFC. It is crucial to sort out how to integrate the TFC resource demands within the context of financial redesign and privatization models that are being developed in various states.

IV. What Do We Know About the Psychosocial Treatment of Youth in Therapeutic/Treatment Foster Care?

Question 1: What Does the Research Tell Us About Therapeutic/Treatment Foster Care?

The field knows little about mental health outcomes for youth currently served by TFC. There is little information about psychosocial treatment of children (age 8 and younger) in TFC. MTFC is the only TFC program that has demonstrated efficacy over a range of important outcomes.

Service coordination alone is unlikely to generate improved youth behavior. Youth in TFC receive services from a wide range of providers and need access to an array of high quality services from the child serving agencies. Psychosocial treatment of TFC youth should also include the biological parents when they are available.

Clinicians must be trained in appropriate evidence-based practices.

Question 2: What Are Recommendations for the Implementation of What We Know?

Youth in TFC should receive behavioral health care that is evidence-based. Mental health therapy should be included as part of any TFC model, should be tailored to the treatment goals of each TFC youth and should be embedded in the TFC model rather than referring TFC youth out for mental health treatment. In TFC, one well-trained, informed staff member on each youth's team should coordinate the mental health treatment, care delivered by all other providers and all ancillary services. The TFC treatment team must have a coordinator who has skill in coaching treatment foster parents to help improve TFC youth's behavior. TFC must be youth-centered and meet the individual needs of each youth.

There is a need to monitor progress for both reduced symptoms and improved youth functioning. When a foster home placement fails, the youth's mental health needs should be reevaluated. Decisions regarding re-placement following a placement disruption should reflect the youth's psychosocial needs. To maintain treatment gains, there is a need to extend access to long-term mental health services for TFC alumni.

Mental health therapists embedded within the TFC team should be funded at the same reimbursement rates as comparable mental health practitioners. Reimbursement approaches need to support the range of auxiliary services that TFC youth need. While there is a need to identify the TFC components billable to health insurance, reimbursing TFC as a bundled service should be considered. Carefully designed TFC has the opportunity for cost-effectiveness.

V. What Do We Know About Outcomes for Youth in Therapeutic/Treatment Foster Care?

Question 1: What Does the Research Tell Us About Therapeutic/Treatment Foster Care?

Existing studies demonstrate positive outcomes for TFC including improving mental health outcomes for youth in this level of care. Short-term outcomes are consistently improved in the efficacy trials for the clearly articulated TFC models for populations tested thus far; however, TFC programs vary in effect sizes for outcomes.

MTFC is an effective model for preventing placement disruptions, with some evidence of fewer placement disruptions for TFC youth versus regular foster care youth. MTFC is most effective for youth with severe behavioral problems.

Randomized controlled trials of MTFC have demonstrated:

- improved child welfare outcomes for TFC youth;
- improved mental health outcomes for TFC youth, including youth with severe behavioral problems, who have better outcomes from MTFC than from regular foster care;
- improved juvenile justice outcomes, including reduced recidivism for males and females in the juvenile justice system for TFC youth;
- improved substance abuse outcomes for TFC youth with one study showing that MTFC youth had significantly lower levels of marijuana or other drug use than group care youth; and
- improved outcomes for crossover youth (i.e., youth who are involved in both the child welfare and the juvenile justice systems).

The MTFC-preschool model provides strong evidence for improving children's behavior, including evidence of changing children's cortisol levels and changing children's executive functioning. Randomized controlled trials of Together Facing the Challenge have demonstrated improved mental health outcomes for TFC youth.

TFC shows greater improvements than regular foster care over time for girls. TFC has the potential to significantly reduce juvenile justice involvement and has been shown to reduce recidivism in females in the juvenile justice system, however, variability in adherence to existing TFC standards affects TFC youth outcomes. There is very little research on substance abuse outcomes in TFC.

Question 2: What Are Recommendations for the Implementation of What We Know?

TFC should be designed to address the needs of youth across the developmental range. The field also needs to focus on services that improve outcomes for transition-age youth in TFC. The field needs to monitor youth well-being on a regular basis following TFC placement. Youth behavioral health functioning should be measured as a TFC outcome.

TFC outcomes have been studied for only a small number of the sub-populations of youth in TFC. The field should be cautious when implementing TFC for youth under-represented in research studies. Variations in child-rearing practices among racial, ethnic and cultural subgroups may have significant effects on the TFC practice model and outcomes for subgroups of youth (e.g., Hmong, Native American).

While therapeutic alliance is an important predictor of change in TFC youth outcomes, other factors in addition to therapeutic alliance may also be important predictors of change in outcomes for TFC youth. It is important to assess TFC youth outcomes in terms of real life activities or life skills that optimize the transition to adulthood. The field needs to collect data on a relevant range of outcomes for youth in TFC. Developing strategies for holding TFC providers accountable to youth-level outcomes is an important priority.

Outcomes for youth in both the juvenile justice and child welfare systems would improve with greater implementation of evidence-based TFC programs. MTFC is more cost-effective than group care. Given its strong evidence base, certification process and manualization, MTFC is an excellent candidate for bundled reimbursement.

VI. What Do We Know About Organizational Issues in Therapeutic/Treatment Foster Care?

Question 1: What Does the Research Tell Us About Therapeutic/Treatment Foster Care?

The field has a limited understanding of TFC organizational issues due to a limited empirical base. TFC agency organizational factors are important in shaping outcomes of youth in TFC. The field needs to attend to how TFC is operationalized in practice.

There is a need for nationwide uniform TFC standards that differentiate regular foster care from TFC. The field needs to develop level of care criteria for clinical decisionmaking. TFC programs and each TFC component need to be manualized to assure treatment fidelity. Variability in adherence to TFC standards affects the identity of TFC.

The field must define the selection criteria for TFC parents/families. The supervision of treatment foster parents must address the youth's needs. Providing on-going training for treatment foster parents after the initial implementation of the TFC model is very important.

Currently reimbursement for TFC is insufficient to provide essential services. Reimbursement levels and designs should be informed by level of care criteria.

Question 2: What Are Recommendations for the Implementation of What We Know?

Implementation of TFC may be affected by both policy and personnel issues. TFC implementation must address organizational factors that determine whether providers maintain fidelity to a TFC model. Developing the human capital resources of both TFC parents and program staff is an important priority. TFC parents see themselves as substitute parents, however, TFC parents should be considered as professionals/employees and be identified using a more appropriate title. TFC regulations on training should reflect the current state of the knowledge base. TFC agency management needs to provide support and coaching sessions to assist staff in effectively working with TFC foster parents, as well as provide systematic training for TFC supervisors.

There is a need to clarify which child serving agency/agencies should be responsible for placing youth in TFC. Both SAMHSA and the Children's Bureau should provide training, technical assistance and on-going support for evidence-based, youth focused mental health interventions. SAMHSA should assure that those interventions are delivered with fidelity to the model.

The field should develop clear measures of best practices in TFC. Currently the number of children in a TFC home is variable. Regulations regarding supervision and number of youth per TFC home need to reflect the current state of the knowledge base. There is a need to develop TFC discharge criteria and a need for quality assurance to monitor TFC model fidelity.

Collaborative partnerships should be developed between researchers and practitioners across TFC models to better understand the TFC theory of change. The field needs to integrate research findings across child-serving agencies to assure effective out-of-home care practices. The field needs a vehicle for disseminating generic information about the implementation of TFC. Interaction with community leaders is essential to developing TFC for racially, ethnically and culturally diverse youth. There is a need for more careful designation of TFC youth in the Statewide Automated Child Welfare Information Systems database.

Effective TFC is expensive. There is a need to clarify how to determine the responsibility for funding a TFC placement. The field needs to accept the cost of implementing TFC well. Reimbursement rates need to reflect the additional requirements of TFC. Without adequate funding, it is impossible to fully implement evidence-based practices. TFC may lend itself to blending funding across two or more child serving agencies.

Technical Expert Panel Consensus: Advancing the Knowledge Base

This section synthesizes excerpts from the technical expert panel consensus on advancing the knowledge base on services for children in therapeutic/treatment foster care with behavioral health issues.

I. What Do We Know About Therapeutic/Treatment Foster Care?

Question 3: What are Recommendations for Advancing the Knowledge Base?

There is a need to study the efficacy and effectiveness of TFC in a number of areas including TFC as an initial out-of-home placement, trauma informed interventions in TFC, and approaches

to step-down care following TFC. There is also a need to study the main causes of TFC placement disruption.

The field needs funding to support short- and long-term research on TFC youth and TFC alumni. There is a need for more research on child welfare system-involved youth in TFC, on the efficacy of TFC for Native American youth and on how TFC works for different racial, ethnic and cultural youth populations in order to implement TFC in real world practice. Researchers should assure racially, ethnically and culturally diverse representative samples of youth in TFC and the disaggregation of outcomes associated with TFC by racially, ethnically and culturally diverse groups of youth. TFC models may require model adaptation for racially, ethnically or culturally diverse populations.

There is a need for more research on the effectiveness of the types of TFC currently in use nationwide and on short and long term outcomes of currently implemented TFC programs. The field lacks research about which youth will do well in TFC, thus there is a need to increase knowledge of who benefits from what models of TFC, under what conditions. There is a need to study how TFC builds resilience in youth. The gap in TFC effectiveness research could be a barrier to TFC implementation.

The field should conduct propensity studies of TFC practices that have evidence of good outcomes in real world settings. It is important to move promising models of TFC with good outcomes in real world settings to rigorous randomized controlled trial testing.

The field lacks research about the impact of the individual components of aggregated TFC models such as MTFC. Researchers should study which components of TFC models predict desirable outcomes for the family of the youth in TFC.

There is a need for studies on specific aspects of TFC including to what extent biological/birth family parent involvement contributes to TFC youth outcomes, prior youth and family service use history and its impact on TFC outcomes, the trajectory of service needs of youth in TFC and post TFC placement, and how outcomes differ for youth who are referred to TFC from different child serving agencies (e.g., child welfare, juvenile justice, mental health).

The field needs rigorous research in order to increase the power of the results and improve generalizability of TFC findings. The field should use both qualitative and quantitative research methods to determine the efficacy of TFC. Randomized controlled trials, the accepted standard of measuring treatment efficacy, should be conducted on manualized TFC models. Research on TFC needs to include variables for the provider and system characteristics that impact the services provided. Randomized controlled trials, comparative effectiveness research and real time program evaluation of TFC models should be used to study TFC across diverse regions of the United States.

Quasi-experimental research when done with methodological rigor can contribute to the knowledge base on TFC. The samples of youth in TFC studies currently represent only specific segment(s) of the out-of-home placement population. Currently MTFC model trials have small numbers in homogenous samples. There is a need for both short term and long term research of TFC youth with larger sample sizes. The field needs to better understand how sample selection

(e.g., youth history, characteristics, connection to community) affects outcomes of youth in TFC research. There is a need to clarify appropriate comparison groups for studies of TFC. The field needs researchers with the ability to successfully implement studies of TFC with representative samples of TFC youth. There is a need to publish research on TFC models.

There is a need for studies of different theoretical approaches to TFC and how well mature TFC programs are implemented with fidelity to the model. The field needs to determine the impact of TFC model fidelity on meeting performance standards and how it impacts outcomes of TFC programs that already show promise as an evidence-based practice. The field should implement the two currently tested TFC models with fidelity checks to ensure each model's ability to produce long-term positive outcomes. There is a need for more research on the fidelity of TFC models with racially, ethnically and culturally diverse populations.

There is a need for information on problem-based interventions for youth in TFC and a need to use practice-based evidence to add context to what is known about TFC. Large private TFC providers' in-house researchers have significant unpublished research that could benefit the field thus they should be included in the conversation about necessary research. There is a need to fund studies of TFC using secondary analysis of administrative data from TFC providers.

Research should be conducted on the business aspects of TFC including causes of turnover of therapists/staff in TFC, the costs of TFC, cost effective ways of providing TFC to youth prior to youth experiencing multiple other placements, as well as an evaluation of cost-effectiveness of TFC.

II. What Do We Know About Identifying Youth Appropriate for Therapeutic/Treatment Foster Care?

Question 3: What are Recommendations for Advancing the Knowledge Base?

There is a need for research to identify best practices for assessing youth entering TFC. The field needs to develop scientifically sound, comprehensive measures to establish criteria for appropriate levels of out-of-home care and to continue refining the psychometric properties of assessment tools to improve referral to appropriate therapeutic interventions. It is also important to study the sensitivity of measures that are used to assess the progress of youth in TFC.

Person or item fit data can be valuable. Measures of therapeutic alliance between TFC caregivers and youth need to be developed and tested. There is a need to develop tools to assess the strengths and needs of the biological families of youth entering TFC. There is also a need to develop better screening to identify TFC parents who will fully participate in the treatment team. Multiple scientifically sound, valid, reliable and comprehensive measures are needed to assess the outcomes of care. There is a need for studies that identify the relative contributions of the TFC system, parents and youth to outcomes

The field needs a consistent measurement approach to assess the fidelity to TFC models. More research is needed on the quality of TFC fidelity measures and on whether existing TFC fidelity measures are generalizable to all TFC treatment sites. Idiosyncratic changes and tweaks to

measures compromise the ability to compare information. There is a need for additional public funding for measure development.

III. What Do We Know About the Essential Elements of Therapeutic/Treatment Foster Care?

Question 3: What are Recommendations for Advancing the Knowledge Base?

There is a need to develop a research framework to study TFC. Existing TFC research is not sufficient to provide a full understanding of the TFC elements that contribute to outcomes. There is a need to study the relative contribution and the direct and indirect contribution of each essential element (e.g., 24/7 support for TFC parents) on outcomes for TFC youth as well as study whether every TFC model must employ all essential elements.

Further research is needed on essential TFC elements that promote effective transitions for TFC youth between levels of care. There is a need to determine the essential elements that must be provided by the TFC parent(s) and to further investigate how race, ethnicity and culture impact the essential elements of TFC care. There is a need for research to determine the needs of young people who remain in TFC until age 26 and how well states address these needs.

Implementation science paradigms must inform the evaluation of TFC implementation. It is important to have input from TFC youth, TFC parents, the biological family and the TFC clinician into the evaluation of TFC. There is a need to determine the impact of length of stay limits in TFC.

Currently research has only studied bundled TFC models. There is a need to clearly define the tested models of TFC in research studies and conduct more research on both the short and long-term effectiveness of TFC, as well as more research on a tiered level model of TFC.

There is a need to study which aftercare resources (e.g., bio/adoptive parent or community caring supportive adults) are most effective for TFC youth under which particular permanency discharge option (e.g., reunification, emancipation). Research linking organizational characteristics, TFC treatment model, other implementation factors and outcomes will help the field better understand which TFC models can be implemented in which settings. The field needs to research solutions to implementation issues related to access to TFC for rural populations.

There is a need to fund TFC implementation studies and conduct research on less costly versions of TFC as well as further research on the use of technology in TFC to improve fidelity monitoring and cost-effectiveness. There is a need for more cost-effectiveness research on TFC especially for non-juvenile justice populations.

IV. What Do We Know About the Psychosocial Treatment of Youth in Therapeutic/Treatment Foster Care?

Question 3: What are Recommendations for Advancing the Knowledge Base?

There is a need for more research on the mental health and other service needs of TFC youth. There is a need to identify specific mental health disorders that can effectively be addressed within the context of TFC and to identify the most effective array of mental health services for youth in TFC. Research in TFC needs to specify the types and amounts of mental health services that youth in TFC study samples are receiving and study patterns of service utilization for young children (birth–3), children (ages 4–12) and for youth (age 13 and older) in TFC. The field needs to study the long-term mental health outcomes of TFC intervention models for youth in state custody. There is a need for more research on the effects of TFC parents' engagement in TFC youth's mental health treatment.

It is necessary to better understand the variations that exist in the TFC models. There is a need to compare TFC to other types of 24-hour care in real world settings and to use common definitions of levels of out-of-home care in this research. There is a need for more research on trauma-informed models of TFC and how trauma-informed treatment affects the developmental trajectory of youth. There is a need to understand the relative contribution of behavioral consultation to TFC foster parents on youth outcomes. Research should inform the minimum education and training levels of staff needed to implement TFC programs with fidelity.

The organization of TFC providers, the Foster Family-based Treatment Association (FFTA) should be involved in evaluating TFC. Their studies could contribute to the knowledge base on evidence-based practice in TFC. Given the limited knowledge on the state of treatment foster care nationally, researchers should explore the possibility of extracting national level data on treatment foster care from the Chapin Hall Multi-State Child Welfare data archive as well as the possibility of extracting national level data on treatment foster care from the National Survey of Child and Adolescent Well-Being.

V. What Do We Know About Outcomes for Youth in Therapeutic/Treatment Foster Care?

Question 3: What are Recommendations for Advancing the Knowledge Base?

The field needs to look beyond safety and permanency and focus on well-being outcomes for youth in TFC. Comparative effectiveness studies should be conducted on evidence-based models of mental health treatment for foster care youth. There is also a need for follow-up studies of mental health outcomes of former TFC youth by gender.

Evaluation of wide scale implementation of evidence-based TFC practices should be conducted to assess outcomes, sustainability, and fidelity to the models. TFC outcomes should be clearly differentiated from outcomes of regular foster care and should be compared with appropriately matched samples of youth in more restrictive treatment settings (e.g., group care, psychiatric residential treatment facilities, residential treatment).

There is a need for research on ways to assess readiness and fit of both youth and TFC parents so that these factors may be examined in relation to outcomes. Alternative permanency supports (e.g., connections to caring, supportive adults) should be a variable in TFC outcome measurement. It is also important to understand the relative contribution of ancillary services (e.g., wraparound, recovery supports, pro-social skills development) on outcomes for TFC youth.

There is a need to study outcomes for youth in kinship TFC versus non-kinship TFC and a need to determine which characteristics of TFC youth mediate/moderate positive outcomes. Additional studies should be conducted on the effects of TFC on youth substance use disorder outcomes as well as on specific TFC outcomes across genders.

The field needs research on the connection between short-term and long-term well-being outcomes for TFC youth and a need to learn more about why TFC services do not work for specific youth. There is a need for concurrent randomized trials and field-based studies on TFC best practice models as well as a need to use varied research designs beyond randomized controlled trials in studying TFC outcomes.

There is a need for more research on how TFC improves outcomes and a need to determine if promising TFC outcomes can be replicated with other diverse populations in diverse geographic locations. There is a need for more research on the applicability of MTFC for Native Americans and a need for longitudinal studies with larger samples of racial, ethnic and cultural minority TFC alumni.

There is a need to study the most effective methods of taking a TFC intervention to scale as well as why TFC implementation fails. Unevaluated models of TFC may have data that could inform the question of TFC efficacy. There are outcomes data available from large TFC providers on outcomes for youth who have completed TFC programs that could inform the understanding of this intervention.

More randomized controlled trials of MTFC should be supported because of the limited sample size and limited outcomes in existing studies. Randomized controlled trials should provide supports to participating agencies to enable them to address random assignment requirements in research.

There is a need for research on cost-savings for child welfare youth in TFC versus other placement settings and a need for cost-effectiveness studies of TFC that incorporate a range of outcomes measures beyond the cost to child-serving agencies (e.g., child welfare, juvenile justice, mental health).

VI. What Do We Know About Organizational Issues in Therapeutic/Treatment Foster Care?

Question 3: What are Recommendations for Advancing the Knowledge Base?

The field needs research on barriers to implementing TFC programs and studies on the influence of business practices on treatment aspects of TFC models. There is also a need for research on the organizational structure needed to sustain TFC, the essential organizational components that influence youth outcomes in TFC and research to determine the appropriate models and reimbursement rates for TFC.

There is a need for more research on the common elements and components of clinical supervision in TFC. The field needs research on what types of out-of-home care are working in practice and how usual care TFC agencies are organized/operating. There is need to study the causes of turnover in TFC families and to identify the common elements of optimal, effective

training and supervision models for TFC parents and providers. The field needs studies to determine the optimal number of youth in a TFC home. There is a need to evaluate TFC models based on the existing evidence base and practice. The field needs to study how to avoid unintended consequences of providing access to TFC only through a specific agency or funding mechanism.

Conclusions

Research and experience demonstrate that 20 percent of American youth have a diagnosable mental disorder and 10 percent have a disorder serious enough to affect functioning at home, school and within the community. Through the evolution of policy and practice over the past fifty years, there has been an increasing emphasis on serving these youth in home or home-like community-based settings. Whether youth first present to the child welfare, juvenile justice, or mental health system, they share a common need for state-of-the-art behavioral health treatment, continuing care, and community supports to maximize their full potential. Yet, even in the face of scientific breakthroughs and a 25-year focused effort to develop comprehensive community-based systems of care, the field is still challenged with questions about the most effective interventions for these youth and their families.

To address an aspect of developing a good and modern treatment and recovery system for youth, SAMHSA, CMS, and ACYF convened a technical expert panel to identify what the research indicates about services for children in TFC with behavioral health issues. Through participation in a panel and consensus process, 16 national content experts identified key findings on TFC, actions to be taken, and the next set of questions to address.

There was consensus in many areas. Although they acknowledged a significant lack of research on all aspects of TFC, participants focused on what is known. Through the consensus process, the panel clearly defined TFC as a community-based, less-restrictive alternative to more restrictive settings such as group care, psychiatric residential treatment facilities, and long-term residential programs. The panel clarified that TFC models generally treat seriously emotionally disturbed youth who have a high likelihood of needing more restrictive, long-term residential treatment. Youth in TFC may enter from the child welfare, juvenile justice, or the mental health systems.

Although there are established TFC models, much informal variation exists in implementation. However, it is possible to identify essential elements of TFC. While assuring adherence to these requirements, TFC models must also include a focus on best practices for culturally-relevant care for racially, ethnically, linguistically, sexually, and culturally diverse populations. TFC models must also be able to address challenges to youth, including traumatic life events and placement disruption.

Participants concurred that there is a need for level-of-care criteria for all out-of-home mental health care, including TFC, and for an array of accurate, sensitive measures to screen and assess youth in order to inform level-of-care placement decisions.

The group also agreed that organizational and financing issues significantly influence the TFC delivery. Standards should be enforced at state and federal levels. Provider agencies should

ensure the ability to train and clinically supervise agency staff and TFC parents. There is a need for federal and state child-serving agencies to clarify both oversight and responsibility for financing TFC. The cost effectiveness of TFC should be examined by comparing it to more restrictive mental health placements rather than to regular foster care.

Although there was significant agreement on these and many other issues, the panel generated a robust research agenda responding to the pervasive theme of inadequate research and evaluation of TFC. Participants agreed on the need for extensive research to provide more insight into developing specific level-of-care criteria for out-of-home mental health care and to identify which youth benefit most from TFC and under which conditions.

Additional studies are needed on evidence-based TFC models, testing them with different populations and in varied geographic settings. Promising practices should be rigorously examined to move the field forward, incorporating the most recent knowledge in science and technology. All research on TFC must produce actionable data that can be used to examine the influence of clinical and organizational factors on youth outcomes in order to inform future TFC implementation. Health services research should identify organizational factors and financial arrangements that optimize TFC.

Throughout the consensus process, participants stressed using what is currently known about TFC—assuring accountability for best practices and providing adequate on-going support, while continuing to encourage more clarity about TFC by reviewing administrative practices and expanding the knowledge base. The combination of the panel's best thinking and extensive experience has provided insight into an aspect of the development of a good and modern treatment and recovery system for youth with behavioral health issues.

Introduction

In September 2012, the Substance Abuse and Mental Health Services Administration (SAMHSA), the Centers for Medicare & Medicaid Services (CMS) and the Administration on Children, Youth and Families (ACYF) held a technical expert panel to identify what the research tells us about services for children in therapeutic/treatment foster care (TFC)[1] with behavioral health issues (see Appendix A for meeting agenda). A non-Department of Health and Human Services[2] 16-member panel of researchers representing the fields of mental health, child welfare, measurement and evaluation, social work and psychology came together to provide policymakers with a responsible assessment of currently available information on services for children in therapeutic/treatment foster care with behavioral health issues (see Appendix B for participant list).

Information that informed the panel included findings from *Assessing the Evidence Base* (see Appendix E), the results of a systematic review of the literature; a 1.5-day session with presentations by investigators working in areas relevant to the meeting questions; and discussion with meeting attendees. On the basis of the scientific evidence presented and robust dialogue, technical expert panel members reached consensus through a modified Delphi process (see Appendix C). This report presents a statement of the issues, summarizes meeting presentations and identifies technical expert panel consensus, which reflects the panel's assessment of the information available at the time of the meeting. Thus, it provides a point-in-time analysis of the state of knowledge on the issue. The findings offer a roadmap for system enhancement now and a compass for future direction.

Statement of the Issues

Children's Mental Health. "Mental health problems in children and adolescents have created a "health crisis"[3] in this country. Studies indicate an alarmingly high prevalence rate, with approximately 1 in 5 children having a diagnosable mental disorder and 1 in 10 youth having a serious emotional or behavioral disorder that is severe enough to cause substantial impairment in functioning at home, at school, or in the community (Friedman, Katz-Leavy, Manderscheid, & Sondheimer, 1996)."[4]

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[1] Note: While the meeting title was "What Does the Research Tell Us About Services for Children in Therapeutic/Treatment Foster Care with Behavioral Health Issues?" the term treatment foster care or TFC will be used to refer to the service in this report.

[2] One presenter was Department of Health and Human Services staff; however, he did not participate in consensus statement development.

[3] U.S. Public Health Service. (2000). *Report of the Surgeon General's conference on children's mental health: A national action agenda*. Washington, DC: U.S. Department of Health and Human Services.

[4] Huang, L. et al. (2005). Transforming mental health care for children and their families. *American Psychologist*, 40, p. 615

"Prevalence estimates indicate that young people with serious emotional disorders (SED) are at heightened risk for substance abuse disorders. Among youth who receive mental health services almost 43 percent of recipients were diagnosed with a co-occurring disorder. The reverse is also true. In samples from SAMHSA treatment studies, 62 percent of the male and 83 percent of female adolescents who received substance abuse treatment also had an emotional or behavioral disorder."[5]

"For many youth in the juvenile justice system, their mental health needs are significantly complicated by the presence of a co-occurring substance use disorder. In fact, among those youth with a mental health diagnosis, 60.8 percent also met criteria for a substance use disorder."[6]

"Children and adolescents at risk for emotional and behavioral problems are likely to have experienced: (1) significant early traumas, such as loss of major people in their lives or exposure to violence; (2): impaired function at home, in school, and or in the neighborhood; (3) a negative concept of self; (4) co-occurring disorders (i.e., combinations of behavioral, attention-deficit/hyperactivity, anxiety, depressive, and substance abuse disorders); and (5) being bounced from one service system to another, including education, health, child welfare, juvenile justice and mental health."[7] "Children with serious emotional disturbance have many challenges that require multiple interventions to be successful."[8]

In conjunction with high prevalence rates, there is an extremely high level of unmet need. "It is estimated that about 75 percent of children with emotional and behavioral disorders do not receive specialty mental health services."[9]

Yet as Huang stated in 2005, "…despite these levels of prevalence and unmet need and the serious impact of mental health problems on the functioning of our children, our nation has failed to develop a comprehensive, systematic approach to this crisis in children's mental health."[10]

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[5] Walter, U.M. et al. (2005). Co-Occurring disorders of substance abuse and SED in children and adolescents. *Best practices in children's mental health: A series of reports summarizing the empirical research and other pertinent literature on selected topics*. Lawrence, KS: University of Kansas.

[6] National Center for Mental Health and Juvenile Justice. (2005). *Blueprint for change: A comprehensive model for the identification and treatment of youth with mental health needs in contact with the juvenile justice system.* Office of Juvenile Justice and Delinquency Prevention.

[7] Burns, B. J. (2002). Reasons for hope for children and families: A perspective and overview. In B. Burns & K. Hoagwood (Eds.). *Community treatment for youth: Evidence-based interventions for severe emotional and behavioral disorders*. New York: Oxford University Press. p. 3

[8] English, M.J. (2002). Policy implications relevant to implementing evidence-based treatment. In Burns, B.J., & Hoagwood, K. (Eds.), *Community treatment of youth: Evidence-based interventions for severe emotional and behavioral disorders.* New York: Oxford University Press. p. 305

[9] National Institute of Mental Health [NIMH]. (2001). *Blueprint for change: Research on child and adolescent mental health*. Rockville, MD: U.S. Department of Health and Human Services, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

[10] Huang, L. et al. (2005). Transforming mental health care for children and their families. *American Psychologist*, 40, p. 616

History. A glance at history may provide a context for efforts to improve the mental health system, in general, and to improve care for children and youth with mental health problems.

In his 1963 address to the 88th Congress, President Kennedy called for movement away from institutionalizing the mentally ill. He proposed "… a national mental health program to assist in the inauguration of a wholly new emphasis and approach to care for the mentally ill. Central to a new mental health program is comprehensive community care. We need a new type of health care facility; one which will return mental health care to the mainstream of American medicine, and at the same time upgrade mental health services."[11]

"[President Kennedy] emphasized the notion of community involvement and community ownership of the program. In addition, these mental health centers were to be comprehensive, providing services not only to the severely mentally ill, but also to children, families, and adults suffering from the effects of stress. These programs were to be comprehensive, coordinated, of high quality, and available to anyone in the population. In essence, where this country had failed to establish a comprehensive national health service or national health insurance system, the President was now proposing exactly that for mental health systems."[12] With this effort, Kennedy launched the era of the community mental health center, and deinstitutionalization became a priority for the mental health system.

"In 1969, the Joint Commission on Mental Health of Children conducted an extensive study of the quality of the children's mental health system. The commission concluded that services for children were seriously inadequate. This was true across the socioeconomic spectrum for children rich or poor, rural or urban. The finding that only a fraction of children in need were being served was of particular concern."[13]

In the 1970s "legal issues also accelerated deinstitutionalization, as concerns over individuals' civil rights and the conditions in institutions led courts to hand down rulings that both limited when individuals could be institutionalized against their will and set minimum requirements for their care and treatment when they were admitted. These judicial orders put constraints on the use of institutions and emphasized that care must be furnished in the least restrictive setting."[14]

Knitzer's investigation of the lack of public responsibility for children in need of mental health services in 1982[15] found that state mental health agencies placed a very low priority on services

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[11] Kennedy, J.F. (1963). Special Message to the Congress on Mental Illness and Mental Retardation. Online by Gerhard Peters and John T. Woolley. *The American Presidency Project.*

[12] Cutler, David et al. "Four Decades of Community Mental Health: a Symphony in Four Movements." Community Mental Health Journal, Vol. 39, No. 5, October 2003. Pg. 384-385

[13] Duchnowski, A.J. et al. (2001). Community-based interventions in a system of care and outcomes framework." In Burns, B.J., & Hoagwood, K. (Eds.), *Community Treatment of Youth: Evidence-Based Interventions for Severe Emotional and Behavioral Disorders.* New York: Oxford University Press, p. 17

[14] Koyanagi, C. (2007). *Learning from history: Deinstitutionalization of people with mental illness as precursor to long term care reform*. Menlo Park, CA: Kaiser Commission on Medicaid and the Uninsured, p. 5

[15] Knitzer, J. & Olson, L. (1982). *Unclaimed Children: The Failure of Public Responsibility to Children and Adolescents in Need of Mental Health Services.* Washington, DC: Children's Defense Fund

for children. "Less than half of the states had a staff member assigned to direct children's mental health services. Only a fraction of the children in need were served and many were ineffectively served in restrictive settings."[16] She concluded that "very little had changed since the report of the Joint Commission in 1969."[17]

Interest in community mental health care revived under the Carter Administration, with First Lady Rosalynn Carter's longstanding involvement in mental health advocacy. "The 1978 President's Commission on Mental Health issued recommendations that were codified in the Mental Health Systems Act of 1980, creating a comprehensive federal-state approach to mental health services. The Carter Commission recommendations embodied the spirit of the community mental health services movement, addressing not only improvements in services offered in the community but also the need to bolster natural, informal social supports."[18] The election of 1980 ushered in a new administration. Most of the Mental Health Systems Act was rescinded by the Omnibus Budget Reconciliation Act of 1981. The remnant was significantly revamped.

Influenced by Knitzer's earlier findings, in 1984 the National Institute of Mental Health launched the Child and Adolescent Service System Program (CASSP). CASSP had "the objective of helping states and communities build capacity to develop systems of care targeted to children with serious and complex needs who were involved with multiple service sectors, for example, mental health, special education, child welfare, and juvenile justice."[19] CASSP "explicitly promoted the policy direction of identifying children with serious emotional disturbances as the priority population, and before long, most states designated this group" as such.[20] "The intent of this focus was not to neglect or diminish the importance of preventive efforts but to redirect public mental health systems away from serving children with mild problems that did not significantly interfere with their functioning and toward serving those who had severe problems that interfered with their functioning and who were a particular challenge and expense to service systems."[21]

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[16] Duchnowski, A.J. et al. (2001). Community-based interventions in a system of care and outcomes framework." In Burns, B.J., & Hoagwood, K. (Eds.), *Community Treatment of Youth: Evidence-Based Interventions for Severe Emotional and Behavioral Disorders.* New York: Oxford University Press, p. 18

[17] Duchnowski, A.J. et al. (2001). Community-based interventions in a system of care and outcomes framework." In Burns, B.J., & Hoagwood, K. (Eds.), *Community Treatment of Youth: Evidence-Based Interventions for Severe Emotional and Behavioral Disorders.* New York: Oxford University Press, p. 18

[18] The Bazelon Center for Mental Health Law. (2009). Still waiting…the unfulfilled promise of Olmstead. Washington, DC: The Bazelon Center for Mental Health Law, p. 5

[19] Huang, L. et al. (2005). Transforming mental health care for children and their families. *American Psychologist,* 40, p. 616

[20] Huang, L. et al. (2005). Transforming mental health care for children and their families. *American Psychologist,* 40, p. 616

[21] Huang, L. et al. (2005). Transforming mental health care for children and their families. *American Psychologist,* 40, p. 616

"An early accomplishment of the CASSP was the refining of the concept of a system of care to serve as a framework for reform."[22] In 1986 Stroul & Friedman defined a system of care as "a comprehensive spectrum of mental health and other services and supports organized into a coordinated network to meet the complex and changing needs of children and their families."[23] "It included a set of core values and principles to guide service delivery to children and families. The core values specified that services should be community based, child centered, family focused, and culturally appropriate. Key principles specified that services should (a) be comprehensive, with a broad array of services and supports; (b) be individualized to each child and family; (c) be provided in the least restrictive, appropriate setting; (d) be coordinated at both the system and service delivery levels; (e) include early intervention efforts; and (f) engage families and youth as full partners."[24] "A major goal of the system-of-care model is to increase the availability of intensive treatment interventions in community-based settings, in contrast to being limited to restrictive residential centers as the only option for such treatment."[25]

"As Duchnowski and colleagues correctly point out, evolution of the system of care model has effected three key shifts in the way services are delivered: (1) change in the location of services from institutions to family-based care, (2) changes in the manner of service delivery from office-based to community care; and (3) change from a 'pathological family' perspective to a strengths-based approach that capitalizes on the resilience of children and the supportive capacities of their families. Each of these shifts has dramatic policy implications."[26]

In 1993, SAMHSA's Center for Mental Health Services initiated the Comprehensive Community Mental Health Services for Children and Their Families program, known as the Child Mental Health Initiative (CMHI). The purpose of this program was to support states, political subdivisions within states, the District of Columbia, territories, Native American tribes, and tribal organizations. The program helped develop integrated home and community-based services and supports for children and youth with serious emotional disturbances[27] and their

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[22] Huang, L. et al. (2005). Transforming mental health care for children and their families. *American Psychologist*, 40, p. 616

[23] Stroul, B., & Friedman, R. (1986). *A system of care for children and youth with severe emotional disturbances*. Washington, DC: Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health

[24] Huang, L. et al. (2005). Transforming mental health care for children and their families. *American Psychologist*, 40, p. 616

[25] Duchnowski, A.J. et al. (2001). Community-based interventions in a system of care and outcomes framework." In Burns, B.J., & Hoagwood, K. (Eds.), *Community Treatment of Youth: Evidence-Based Interventions for Severe Emotional and Behavioral Disorders.* New York: Oxford University Press, p. 30

[26] English, M.J. (2002). Policy implications relevant to implementing evidence-based treatment. In Burns, B.J., & Hoagwood, K. (Eds.), *Community treatment of youth: Evidence-based interventions for severe emotional and behavioral disorders.* New York: Oxford University Press. p. 305

[27] The CMHI defined serious emotional disturbances as the following: "Children with serious emotional disturbance are persons from birth to age 18 who currently, or at any time during the past year have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-III-R, that resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, or community activities." (Federal Register, 1993)

families by encouraging the development and expansion of effective and enduring systems of care.

The CMHI defined a "system of care" as an organizational philosophy and framework that involves collaboration across agencies, families, and youth for the purpose of improving access and expanding the array of coordinated community-based, culturally and linguistically competent services and supports for children and youth with a serious emotional disturbance and their families.[28]

While the system of care philosophy was taking root within the mental health field, there were also changes to Medicaid. In 1989 the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) provisions in Medicaid were amended to require that all states screen eligible children "as medically necessary, to determine the existence of certain physical or mental illnesses or conditions" and provide "other necessary health care, diagnostic services, treatment, and other measures described in section 1905(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan."[29]

Subsequently, lawsuits brought under Medicaid authorities established that appropriate treatment was most often community-based. Settlements such as *J.K. v. Eden* (2001) in Arizona and *Rosie D. v. Romney* (2006) in Massachusetts emphasized maintaining youth with mental health conditions in the community. As a result, states had to be proactive in developing robust community-based service systems to meet the requirements of the court orders. The more recent *J.K. v. Humble* (2009) suit was brought because, among other services, Arizona had not created the intensive community-based services that children with serious mental health conditions require under the original *J.K. v. Eden* suit. The 2012 decision denying the state's Motion to Terminate Jurisdiction in the *J.K.* case indicates that the requirements are not yet met.

In 1999, the need for community-based services was strengthened through the Supreme Court case *Olmstead v. L.C.*, which established two basic legal principles. First, the unjustified institutionalization of people, who would otherwise prefer to live in the community, is a violation of the Americans with Disabilities Act (ADA). The Court also ruled that States are legally required to remedy discriminatory practices through "reasonable modifications" of their state programs.[30]

Under the ADA, a person cannot be discriminated against because of a disability. In *Olmstead*, the Supreme Court held that that "unjustified isolation of individuals with disabilities" in institutions should be considered a form of discrimination. These cases are "unjustified" if the person in question wishes to live in the community, and treatment professionals have stated that

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[28] Duchnowski, A.J. et al. (2001). Community-based interventions in a system of care and outcomes framework." In Burns, B.J., & Hoagwood, K. (Eds.), *Community Treatment of Youth: Evidence-Based Interventions for Severe Emotional and Behavioral Disorders.* New York: Oxford University Press, p. 19

[29] Social Security Act § 1905(r) 42 U.S.C. §§1396d(a)(4)(B) and 1396(r)

[30] Rosenbaum, S. &Teitelbaum, J. (2004). *Olmstead at five: Assessing the impact*. Menlo Park, CA: Kaiser Commission on Medicaid and the Uninsured. p. 3

the individual is capable of living in the community with "reasonable modifications" to state programs. Justice Ginsburg, writing for the majority, concluded that such isolation could be considered discrimination because it "perpetuates unwarranted assumptions" about the ability of institutionalized individuals to participate in community life. Second, it "severely diminishes the everyday life activities of individuals" by denying or making difficult the opportunity for individuals to maintain family and social relationships, or to engage in work and cultural enrichment.[31]

Although this suit was brought on behalf of two adult women, a 2000 report by the Bazelon Center for Mental Health Law noted that "this reasoning is perhaps even more applicable to children. Needlessly segregating children contributes to the stigma that they are bad children… cuts off their ability to participate in family outings and cultural and educational opportunities… [and] hampers family relationships, which are critical to mental health and development."[32]

In 2001, Sturm et al. found that "[t]here has been a documented shift to outpatient care over the past 15 years, based on an analysis of mental health service use and expenditures but significant service gaps in the continuum of care for children and their families remain."[33]

To address these gaps in one state, California plaintiffs brought the *Katie A. v. Bonta* (subsequently *Katie A., et al. v Douglas, et al.*) lawsuit under the authorities of both EPSDT and the ADA for the class of youth who: "(a) …are in foster care or are at imminent risk of foster care placement, (b) have a mental illness or condition that has been documented or, had an assessment already been conducted, would have been documented, and (c) need individualized mental health services, including but not limited to professionally acceptable assessments, behavioral support and case management services, family support, therapeutic foster care, and other medically necessary services in the home or in a home-like setting, to treat or ameliorate their illness or condition."[34]

The suit charged the California Departments of Health Care Services and Social Services with neglecting to provide appropriate mental health services in the community, while instead relying on services provided in restrictive, congregate, and institutional placements, in violation of the Medicaid Act and the ADA."[35]

In a 2011 settlement, California agreed to provide home- and community-based mental health

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[31] Olmstead v. L.C. (98-536) 527 U.S. 581 (1999) 138 F.3d 893.

[32] The Bazelon Center for Mental Health Law. (2001). Merging system of care principles with civil rights law: Olmstead planning for children with serious emotional disturbance. Washington, DC: The Bazelon Center for Mental Health Law. p. 3.

[33] Huang, L. et al. (2005). Transforming mental health care for children and their families. *American Psychologist,* 40, p. 619

[34] Katie A., et al. V. Douglas, et. al., CV-02-05662 AHM (SHX); Comments of the United States in Support of Final Approval of the Proposed Settlement Agreement. 2011.

[35] Katie A., et al. V. Douglas, et al., CV-02-05662 AHM (SHX); Comments of the United States in Support of Final Approval of the Proposed Settlement Agreement. 2011. Pls.' First Am. Compl. ("Compl."), ECF. No. 33, ¶¶ 47, 76, 80-87.

services to Medicaid eligible children in the foster care system, or at risk of entering the foster care system, in order to help them avoid institutional care.

The Agreement requires the defendants to, among other things, support the development and delivery of an array of coordinated, community-based mental health services and develop a process "to identify class members and link them firmly to services."[36] The defendants were ordered to develop and disseminate a Medi-Cal documentation manual designed to inform and instruct providers on the provision of Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS) and Therapeutic Foster Care (TFC).

The Agreement stipulated that TFC services:

a) place a child singly, or at most in pairs, with a foster parent who is carefully selected, trained, and supervised and matched with the child's needs;
b) create, through a team approach, an individualized treatment plan that builds on the child's strengths;
c) empower the therapeutic foster parent to act as a central agent in implementing the child's treatment plan;
d) provide intensive oversight of the child's treatment, often through daily contact with the foster parent;
e) make available an array of therapeutic interventions to the child, the child's family, and the foster family (including behavioral support services, crisis planning and intervention, coaching and education for the foster parent and child's family, and medication monitoring) … ; and
f) enable the child to successfully transition from therapeutic foster care to placement with the child's family or alternative placement by continuing to provide therapeutic interventions.[37]

Although work could proceed on ICC and IHBS, the Agreement had to set up a negotiation committee to address TFC design and financing issues. This action in California is indicative of the confusion around TFC nationwide, which is described in the following section.

Therapeutic or Treatment Foster Care. To respond to the growing emphasis to serve individuals with mental health problems in the community, TFC evolved in the 1970s "through a synthesis of the best qualities of mental health residential treatment programs and child welfare foster care programs (Bryan and Snodgrass, 1990)"[38] as an alternative to institutionalizing

[36] Katie A., et al. V. Douglas, et al., CV-02-05662 AHM (SHX); Comments of the United States in Support of Final Approval of the Proposed Settlement Agreement. 2011. Pls.' First Am. Compl. ("Compl."), ECF. No. 33, 47, 76, 80-87.

[37] Katie A., et al. V. Douglas, et al., CV-02-05662 AHM (SHX); Comments of the United States in Support of Final Approval of the Proposed Settlement Agreement. 2011. 20(a)-(g), (i)).

[38] Bereika, G. (Fall 1992). Treatment Foster Care: Its role in the service system. *Focus* (*Foster Family-based Treatment Association newsletter*). p. 10

children with severe emotional and behavioral disorders.[39] TFC evolved as a multidisciplinary approach to providing care within a broader system of social services (e.g., mental health, child welfare, special education, juvenile justice).[40]

TFC serves youth across the age range. The service may be used to address an array of problems, including youth with behavioral health diagnoses such as internalizing and/or externalizing mental health conditions and/or substance use disorders.[41,42]

Youth may enter TFC from three different child-serving systems and for many different clinical reasons. They may be involved in the child welfare system or the juvenile justice system, or they may simply need a certain level of mental health care. These three child-serving systems share a common goal of protection and treatment, but they have historically served populations with differing issues.

"While each of these systems has historically focused on meeting different aspects of children's needs, increasingly they share common concerns regarding the emotional and behavioral disturbances of the children and youth in their care. In the child welfare system, as a link began to be realized between the early life trauma of abuse and neglect and later problems in adjustment and functioning, the need for a more therapeutic level of foster family care was acknowledged."[43]

"Although in the early years of the founding of the juvenile court much attention was paid to the psychological functioning of juvenile offenders, emphasis on incarceration and punishment took precedence as juvenile services evolved."[44]

"Only in the last decade or two has there been a resurgence in recognition of the extensive mental health needs of delinquent youth with an accompanying search for therapeutic models of care, particularly for incarcerated youth ready for release back into their home communities."[45]

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[39] Meadowcroft, P. et al. (1994) Treatment foster care services: A research agenda for child welfare. *Child Welfare*, 73(5), 565-581.

[40] Meadowcroft, P. et al. (1994) Treatment foster care services: A research agenda for child welfare. *Child Welfare*, 73(5), 565-581.

[41] Although not the focus of this meeting it should be noted that TFC may also be used to care for medically fragile or developmentally disabled children.

[42] Administration for Children and Families. (n.d.) *Treatment foster care.* Washington, DC: U.S. Department of Health and Human Services. Retrieved April 23, 2013 from https://www.childwelfare.gov/outofhome/foster_care/treat_foster.cfm.

[43] Dore, M.M., & Mullin, D. (1996). Treatment family foster care: Its history and current role in the foster care continuum. *Families in Society: The Journal of Contemporary Social Services*, pp. 475-476

[44] Dore, M.M., & Mullin, D. (1996). Treatment family foster care: Its history and current role in the foster care continuum. *Families in Society: The Journal of Contemporary Social Services*, pp. 475-476

[45] Dore, M.M., & Mullin, D. (1996). Treatment family foster care: Its history and current role in the foster care continuum. *Families in Society: The Journal of Contemporary Social Services*, pp. 475-476

"Finally, as managed care programs have increasingly restricted funding for in-patient psychiatric hospitalization as well as for long-term residential care of children and youth with severe emotional and behavioral disturbances, the children's mental health system has also sought cost-effective community-based treatment alternatives for youth with special mental health needs."[46]

"Children in TFC have often experienced multiple failed placements prior to referral to TFC, often four or more prior placements, and typically have higher rates of severe emotional and behavioral problems and trauma histories than children referred for regular foster care (Burns, Hoagwood, & Mrazek, 1999; Kerker & Dore, 2006; Baker & Curtis, 2006; Fisher, Kim, & Pears, 2009; Hussey & Guo, 2005; Smith, Stormshak, Chamberlain, & Bridges Whaley, 2006)."[47]

"TFC is now one of the most widely used forms of out-of-home placement for children and adolescents with severe emotional and behavioral disorders and is considered to be the least restrictive form of residential care (Kutash & Rivera, 1996; Stroul 1989). An estimated 1,200 youth in the United States receive TFC at any one time, representing over 6 million 'client days' at a cost of one-half billion dollars per year (Farmer, Burns, Chamberlain, & Dubs, 2001)."[48]

Yet, little is known about TFC. The federal Adoption and Foster Care Analysis and Reporting System (AFCARS) does not separate information about youth in TFC from other foster care youth in the data, so there is no way to know the number of youth or other variables specific to those in TFC.

The Foster Family-based Treatment Association (FFTA) *Program Standards for Treatment Foster* Care (1991, p. 6) define treatment foster care as "…the coordinated provision of services and use of procedures designed to produce a planned outcome in a person's behavior, attitude or general condition based on a thorough assessment of possible contributing factors. Treatment typically involves the teaching of adaptive, prosocial skills and responses which equip young persons and their families with the means to deal effectively with conditions or situations which have created the need for treatment."[49]

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[46] Dore, M.M., & Mullin, D. (1996). Treatment family foster care: Its history and current role in the foster care continuum. *Families in Society: The Journal of Contemporary Social Services*, pp. 475-476

[47] Bruton, J. (2012). Assessing the evidence base: Treatment foster care. (Literature Review). Briefing paper presented at the Technical Expert Panel Meeting "What Does the Research Tell Us about Services for Children in Therapeutic/Treatment Foster Care with Behavioral Health Issues?" held September 2012.

[48] Chamberlain, P. (2002). Treatment foster care. In B. Burns & K. Hoagwood (Eds.). *Community treatment of youth: Evidence-based interventions for severe emotional and behavioral disorders*. New York: Oxford University Press. p. 117

[49] Berlin, J. et al. (1994). Family-centered, community-based services in treatment foster care. *A discussion paper*. Hackensack, NJ: Foster Family-Based Treatment Association.

However, Farmer et al. found that "[al]though the standards promulgated by FFTA were an effort to establish uniformity in the definition of treatment foster family care, there is currently a wide range of approaches to providing this form of foster care."[50]

Redding concurred saying, "while there is a well-articulated treatment family foster care program model promulgated by the FFTA, and certain features are generally common across programs, the clinical application of TFC varies across agencies, particularly in the structure and intensity of services, population served (child welfare, mental health, juvenile justice), and staff and foster parent characteristics.[51]

"Treatment foster care is known by a variety of names, including therapeutic foster care, foster family-based treatment, individualized residential treatment, and others."[52] "The very name of the model – treatment foster care – contributes to the confusion by suggesting that it is simply a type of family foster care. These two models share certain obvious similarities, including a common belief about the benefit and the power of family best care…[but] the differences between the models far outweigh the similarities, and warrant a recognition that they are not simply variations on a theme."[53]

"There have been attempts in the literature to differentiate TFC from family foster care. These have been important contributions to the literature. However, they have sought to achieve differentiation by comparing the two models on variables shared by both (e.g., caseload size, frequency of home visits, average number of children in a home). These are important differences, but the use of the shared variables as the bases of the comparison has perhaps unintentionally contributed to the idea that TFC is a variation of family foster care, rather than a distinct model."[54]

"…[A] lack of clarity still exists about the differences between TFC and family foster care, and between TFC and other treatment modalities, such as residential treatment facilities and other group care models. Is TFC simply an improved model of family foster care? Are there similarities between TFC and therapeutic group homes or residential treatment facilities? How does the function of TFC in the service system compare with that of family foster care and residential treatment facilities?"[55]

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[50] Farmer, E.M.Z. et al. (2002). Assessing conformity to standards for treatment foster care. *Journal of Emotional and Behavioral Disorders*, 10, 213-222.

[51] Redding, R. et al. (2000). Predictors of placement outcomes in treatment foster care: Implications for foster parent selection and service delivery. *Journal of Child and Family Services*, 9(4), 425-447

[52] Bereika, G. (Fall 1992). Treatment Foster Care: Its role in the service system. *Focus* (*Foster Family-based Treatment Association newsletter*). p. 9

[53] Bereika, G. (Fall 1992). Treatment Foster Care: Its role in the service system. *Focus* (*Foster Family-based Treatment Association newsletter*). p. 10

[54] Bereika, G. (Fall 1992). Treatment Foster Care: Its role in the service system. Focus (Foster Family-based Treatment Association newsletter). p. 10

[55] Bereika, G. (Fall 1992). Treatment Foster Care: Its role in the service system. Focus (Foster Family-based Treatment Association newsletter). p. 9

State variations in TFC. Researchers at the Boston University School of Social Work recently completed a 50-state and District of Columbia survey of all current foster care programs, policies, and financing with an emphasis on TFC. Topics covered in questions asked included: service definition, eligibility criteria, assessment tools for eligibility, standards of care, regulatory definitions and Medicaid billing practices.[56]

States were asked about their definitions of TFC. The survey indicated that states have different names for their therapeutic or treatment foster care programs. Some states (including Arkansas, Connecticut, and Indiana) use the term therapeutic foster care, whereas others (including Minnesota and California) call the service treatment foster care. Several states (including Idaho, Iowa, and Washington) use both terms to label their TFC programs. New Mexico and Wisconsin have three different levels of therapeutic foster care. TFC has also been called elevated needs, specialized foster care, specialized treatment care, TFC with enhanced services and Therapeutic Foster Boarding Home Care. Six out of 50 states and the District of Columbia do not have a name for their TFC program.[57]

Twenty states did not respond to the question about whether they have an eligibility criterion for TFC. Of the remaining 30 states and the District of Columbia, California and South Dakota do not have criteria for determining TFC eligibility. The states vary in the criteria they use to determine whether a child needs TFC. Some states have criteria such as mental health of the child, number of failed placements or medical necessity to determine eligibility. For example, to be placed into TFC in Alabama, the child needs to have a DSM-IV diagnosis on Axis 1 accompanied by a behavior that would require treatment and the structure provided by TFC.

Washington uses medical necessity as the criteria for TFC. In California, the determination of TFC eligibility is made by a local child welfare supervisor and a judge. In South Dakota, Child Protection Services staff members fill out applications provided by the child placement agencies that provide TFC to determine if the level of care is appropriate for the child.[58]

Twenty-six states and the District of Columbia did not respond to the question on whether standards of care differ for TFC from traditional foster care. Of the 24 states that responded, Alaska and Tennessee said that standards of care did not differ for TFC. Arkansas gave a detailed response on how the standards differed for TFC: Parents in the TFC program are specially trained and more intensively supervised and supported than parents in regular foster care programs to help them care for children with more complex needs. In New York, TFC social workers have lower case loads, and educational specialists provide communication with local school systems to help resolve educational problems. Foster parents also receive additional

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[56] Gonyea, J.G. et al.The 50 State Chartbook on Foster Care. Retrieved April 2013. Available from <http://www.bu.edu/ssw/usfostercare>.

[57] Gonyea, J.G. et al.*The 50 State Chartbook on Foster Care* retrieved 25 April 2013 from <http://www.bu.edu/ssw/usfostercare>.

[58] Gonyea, J.G. et al.*The 50 State Chartbook on Foster Care* retrieved 25 April 2013 from <http://www.bu.edu/ssw/usfostercare>..

support from child care workers. Extensive and specialized training is provided to foster families and staff.[59]

Twenty-two states and the District of Columbia did not respond to the question on regulatory definitions for TFC. Eight states that responded (Alabama, Alaska, Delaware, Georgia, North Dakota, Oklahoma, South Dakota and Wisconsin) did not have a regulatory definition.

The survey also asked states about Medicaid billing for TFC. Fifteen states did not respond to the question. Among the 11 states that said that they did not have Medicaid billing for TFC, the reasons varied. Nevada does not bill for TFC directly, but related services are billed individually following a CMS directive and State Plan Amendment in 2009. The Medicaid billing in South Dakota was discontinued in July 2010. The South Dakota Department of Social Services has $26 million from the state legislature to contract placements for children who qualify. The same providers have other services billed to Medicaid with prior authorization under the rehabilitation option. Although the survey identified other important funding sources, including Title IV-B and Title IV-E, it did not collect billing data from these funding sources at the service-type level.

The states that have Medicaid billing for TFC have varied requirements. Florida provides for Medicaid billing for licensed clinical supervisors, licensed foster homes, parents who receive additional training, crisis intervention, and intensive institutional care. In Texas, services provided through STARHealth, such as therapy, psychiatric evaluations, psychological evaluations, and management, are billed through Medicaid. Wisconsin does not have Medicaid billing for TFC in the state plan, but it allows for payment through a 1915(c) Home and Community-Based Services waiver.[60]

The results of the Boston University survey indicate a need to study and clarify TFC. "Greater clarity (with TFC) will help ensure that children are served in the most appropriate and least restrictive setting that can address their needs." It "…will [also] help states, counties and provinces use their limited resources effectively, by ensuring that children are served in the least restrictive and least costly program model that is appropriate to meet their complex and varied needs."[61] The lack of clarity that exists between TFC and family foster care and between TFC and other models of residential treatment manifests itself in request for proposals issued by states, counties and provinces, in licensing regulations, and in the widely disparate rates paid for TFC through the United States and Canada."[62]

Research on TFC. Unfortunately, there is a lack of literature, randomized controlled trials, and rigorous evidence-based studies on TFC programs. "Although a significant body of research

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[59] Gonyea, J.G. et al.*The 50 State Chartbook on Foster Care* retrieved 25 April 2013 from <http://www.bu.edu/ssw/usfostercare>.

[60] Gonyea, J.G. et al.*The 50 State Chartbook on Foster Care* retrieved 25 April 2013 from <http://www.bu.edu/ssw/usfostercare>.

[61] Bereika, G. (Fall 1992). Treatment Foster Care: Its role in the service system. *Focus* (*Foster Family-based Treatment Association newsletter*). p. 10

[62] Bereika, G. (Fall 1992). Treatment Foster Care: Its role in the service system. *Focus* (*Foster Family-based Treatment Association newsletter*). p. 9

over the past 25 years has documented the mental health needs of youth in foster care (Heflinger, Simpkins, & Combs-Orme, 2000), less is known about those in treatment foster care settings particularly how they may differ from children in regular foster care settings, including the long-term foster care settings more likely to encompass treatment foster care youth. Youth in treatment foster care are hard to identify and investigate as a distinct subgroup, given the varieties of samples and methods used in the published research and the lack of clarity regarding the meaning of long-term treatment, specialized, and therapeutic foster care (Reddy & Pfeiffer, 1997)."[63]

Two specific TFC programs, Multidimensional Treatment Foster Care (MTFC) and Together Facing the Challenge have been researched. MTFC was developed in 1983, based on earlier studies to treat "serious and chronic juvenile offenders."[64] MTFC is a specific evidence-based treatment model that works to "decrease problem behavior and to increase developmentally appropriate normative and prosocial behavior in children and adolescents who are in need of out-of-home placement."[65] "Youth are referred into MTFC through a variety of places including juvenile justice, foster care, and mental health systems."[66]

MTFC focuses on treatment foster parent recruitment and screening, intensive preservice treatment foster parent training, treatment fidelity, positive reinforcement, daily structure, close supervision of the youth and treatment foster parents, coordination of services with strong case management interaction, a view of treatment foster parents as professionals, intensive services, consistency of discipline, a team approach, clinical services, respite care, work with the youth's family when possible, aftercare services, and the promotion of positive peer relationships.[67] MTFC adapted for use in preschool aged children is called Early Intervention Foster Care (EIFC) or Multidimensional Treatment Foster Care Program for Preschoolers (MTFC-P). Research on these programs has shown similarly effective results.[68] MTFC is listed on SAMHSA's National

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[63] Hussey, D. & Guo, S. (2005). Characteristics and trajectories of treatment foster care youth. *Child Welfare*. 84(4), 485-506

[64] TFC Consultants, Inc. (2013). History of MTFC. *Multidimensional treatment foster care: an evidence-based solution for youth with behavioral problems, their families and their communities*. Web. Available from <http://www.mtfc.com/history.html>.

[65] TFC Consultants, Inc. (2013). MTFC program overview. *Multidimensional treatment foster care: an evidence-based solution for youth with behavioral problems, their families and their communities.* Web. Available from <http://www.mtfc.com/overview.html>.

[66] TFC Consultants, Inc. (2013). MTFC program overview. *Multidimensional treatment foster care: an evidence-based solution for youth with behavioral problems, their families and their communities.* Web. Available from <http://www.mtfc.com/overview.html>.

[67] Sprengelmeyer, P. G., & Chamberlain, P. (2001). Treating antisocial and delinquent youth in out-of-home settings. In J. N. Hughes, A. M. La Greca, & J. C. Conoley (Eds.). (pp. 285-299). *Handbook of psychological services for children and adolescents*. New York: Oxford University Press.

[68] Fisher, P. A., & Kim, H. K. (2007). Intervention effects on foster preschoolers' attachment-related behaviors from a randomized trial. *Prevention Science, 8,* 161-170

Registry of Evidence-based Programs and Practices (NREPP) and is the most-well known and well-researched model of TFC.[69]

The other well-known model of TFC is Together Facing the Challenge. This program was developed to provide in-service training for existing TFC programs. It is a hybrid intervention that includes ideas and elements from existing TFC agencies, Chamberlain's model, and other sources to fill in gaps that were seen in practice but not filled by MTFC.[70] Together Facing the Challenge is not listed on NREPP, but it is listed on the California Evidence-Based Clearinghouse for Child Welfare.[71]

Although MTFC and Together Facing the Challenge have some supporting research, there have been numerous challenges to rigorous research in this area. Dore and Mullin found that research on outcomes for children in TFC is limited in scope and scientific rigor. "Most outcomes research to date has focused on discharge status (restrictiveness of subsequent placements), placement stability (number of disrupted placements and/or moves while in care), program completion, rates of institutionalization, and reentry into care following program discharge (Bryant & Snodgrass, 1992; James & Meezan, 2002), but it is not clear if these outcomes represent improved behavioral or social outcomes (James & Meezan, 2002; Reddy & Pfeiffer, 1997)."[72] It is difficult to rely on past studies of TFC, because often the models of care being studied are not clearly specified.

"Another limitation to current research is that control or comparison groups are seldom used. As a result, findings cannot indicate whether observed changes are due to the treatment foster care program or to other factors."[73] "When comparison groups are utilized, differences between groups are usually not accounted for. For example, children placed in treatment foster care are generally not comparable demographically or in their psychosocial functioning to those placed in regular family care or institutional settings—groups to which they are often compared—so comparisons in outcomes between these groups may not be appropriate."[74]

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[69] Bruton, J. (2012). Assessing the evidence base: Treatment foster care. (Literature Review). Briefing paper presented at the technical expert panel meeting "What Does the Research Tell Us About Services for Children in Therapeutic/Treatment Foster Care With Behavioral Health Issues?" held September 2012. p. 4

[70] Farmer, E. M. Z. et al. (2009). Enhancing treatment foster care: An approach to improving usual-care practice. *Emotional and Behavioral Disorders in Youth*, 9, 79-84

[71] The California Evidence-Based Clearinghouse for Child Welfare. "Together Facing the Challenge." 2011. Online. Accessed March 2013. Available from <http://www.cebc4cw.org/program/together-facing-the-challenge/>.

[72] Dore, M.M., & Mullin, D. (1996). Treatment family foster care: Its history and current role in the foster care continuum. *Families in Society: The Journal of Contemporary Social Services*, pp. 475-476

[73] Dore, M.M., & Mullin, D. (1996). Treatment family foster care: Its history and current role in the foster care continuum. *Families in Society: The Journal of Contemporary Social Services*, pp. 475-476

[74] Dore, M.M., & Mullin, D. (1996). Treatment family foster care: Its history and current role in the foster care continuum. Families in Society: The Journal of Contemporary Social Services, pp. 475-476

A review by Turner and MacDonald in 2011 found that, "[d]espite the fact that individual studies typically indicate that TFC is a promising intervention for children with serious emotional and behavioral concerns, mental health diagnoses, and delinquency, the evidence base is weak".[75]

In addition to the challenges facing the researched models, there are many other TFC programs addressing youth with the same behavioral and emotional disorders that have not been researched.

Organizational and financing issues. Very little is known about the effects of organizational factors on the access to or quality of TFC. As previously noted, while the Foster Family-based Treatment Association has promulgated and recently revised national TFC standards, studies find differences in clinical practice, as well as wide variation across a host of implementation issues. These issues include (but are not limited to) disparate agency structures and staffing patterns, parent recruitment and retention practices, staff and parent training and supervision requirements at the local level. Nationally, the lack of uniform level of care criteria for out-of-home mental health care, coupled with variations in federal and state regulations, often makes it difficult to conceptualize TFC as a single service type.

In addition, as we have seen, TFC may be administered through at least three different public child-serving agencies: child welfare, juvenile justice, and mental health. In addition, in many cases youth in TFC may have the service paid, at least in part, by yet another public sector agency—Medicaid. Much less is known about the role and responsibility of the Individuals with Disabilities Education Act, the special education law in these cases. Suffice it to say that, in most instances, two or more child-serving agencies may have shared responsibility for many youth in TFC. Historically, this shared responsibility has manifested itself most concretely in often complex financing arrangements supporting service delivery. These historical funding issues may be compounded by upcoming changes to public health care financing, which will affect some youth and their families.

In "Policy Implications Relevant to Implementing Evidence-Based Treatment," English wrote that "[m]ultiple public agencies have an obligation to collaborate in delivering services to common clients, both for the convenience of the client and for the efficient use of public resources."[76] Realizing this and the extensive shared responsibility for youth in TFC, on September 27–28, 2012, SAMHSA, CMS, and ACYF convened a technical expert panel to address the clinical, organizational, and financing issues that surround TFC.

Technical Expert Panel Meeting

The technical expert panel reflected one aspect of the broader partnership between SAMHSA, CMS, and ACYF to improve services for children with behavioral health issues. In this case, the

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[75] Turner, W. & Macdonald, G. (2011). Treatment foster care for improving outcomes in children and young people: A systematic review. Research on Social Work Practice, 21, 501-527.

[76] English, M.J. (2002). Policy implications relevant to implementing evidence-based treatment. In Burns, B.J., & Hoagwood, K. (Eds.), *Community treatment of youth: Evidence-based interventions for severe emotional and behavioral disorders.* New York: Oxford University Press. p. 306

focus was on the population of children and youth in need of a therapeutic, home-based level of mental health care. The Panel addressed six topic areas:

- *What Do We Know About Therapeutic or Treatment Foster Care?*
- *What Do We Know About Identifying Youth Appropriate for Therapeutic or Treatment Foster Care?*
- *What Do We Know About the Essential Elements of Therapeutic or Treatment Foster Care?*
- *What Do We Know About the Psychosocial Treatment of Youth in Therapeutic or Treatment Foster Care?*
- *What Do We Know About Outcomes for Youth in Therapeutic or Treatment Foster Care?*
- *What Do We Know About Organizational Issues in Therapeutic or Treatment Foster Care?*
- The technical expert panel was designed to convene a small group of experts with different perspectives and areas of expertise to identify the population of youth in TFC, appropriate services and supports for these youth, and TFC organizational issues. Technical expert panelists examined the evidence base for the principles supporting TFC, clinical outcomes for the youth in the program, and the role of TFC organizational factors in service delivery. The panel employed a modified Delphi consensus process (see Appendix C) to identify areas of agreement.

Opening Remarks: Federal Agency Representatives

Panel facilitator Carol Spigner, MSW, DSW, opened the meeting by welcoming panel members and introducing federal partner agency observers.[77] Dr. Spigner also introduced representatives of the federal partner agencies, who welcomed the technical expert panelists and provided the rationale and context for the meeting. The following is a summary of their remarks.

Presenters: **Barbara C. Edwards, MPP**
Group Director
Centers for Medicare & Medicaid Services
CMS/CMCS/Disabled and Elderly Health Programs Group

Larke Huang, Ph.D.
Senior Advisor on Children
Lead, Trauma and Justice Strategic Initiative

[77] Federal partner agency observers included Nadia Sexton of the Administration on Children, Youth and Families; David DeVoursney of the HHS Office of the Assistant Secretary for Planning and Evaluation; Jean Close, John O'Brien, and Kara Ker of the Centers for Medicare & Medicaid Services, and Kelley Smith and Rebecca Flatow of the Substance Abuse and Mental Health Services Administration.

Director, Office of Behavioral Health Equity
Administrator's Office of Policy Planning and Innovation
Substance Abuse and Mental Health Services Administration

Clare Anderson, MSW, LICSW
Deputy Commissioner
Administration on Children, Youth and Families

Ms. Barbara Edwards welcomed the technical expert panel members and thanked them for their participation. She clarified that the CMS Disabled and Elderly Health Programs Group is responsible for benefit design in Medicaid programs for all populations, as well as for long-term care programs and services for people with chronic care needs. Ms. Edwards stated that there has been an increased commitment at CMS to understand the barriers to developing the most effective programs possible. An example of this commitment is a working committee focused on increasing the effectiveness of Early and Periodic Screening, Diagnosis and Treatment (EPSDT), which is a Medicaid benefit for children. This group has formed a subcommittee focused specifically on children with behavioral health care needs.

Ms. Edwards stated that the Medicaid Director, Cindy Mann, is interested in having a meaningful benefit package. This emphasis has increased the focus on understanding what good practice and good benefit design look like in the insurance and health care world. In turn, this emphasis has increased Medicaid's interest in being a more effective partner by addressing good practices in mental health and substance use disorders for adults and children.

Since the beginning of her tenure at CMS, Ms. Edwards has heard concerns about foster care from many sources. Many groups suggested that Medicaid should be more engaged in designing, shaping, and encouraging effective foster care services. However, she stated that from the perspective of CMS, there is no clear definition of what foster care is, nor is there evidence about what works. Thus, CMS turned to SAMHSA and ACYF to gain a better understanding of the foster care system.

The partnership between the three agencies—SAMHSA, CMS, and ACYF—began because all three agencies were engaged in understanding the process of choosing the right services for foster care youth. Ms. Edwards thanked the panel participants, reiterated the importance of their presence at the meeting, and stressed that their contributions would help CMS and other federal agencies decide how to fund and shape the system in the future.

Dr. Larke Huang, Senior Advisor on Children, Youth and Families at SAMHSA, explained that SAMHSA had received an inquiry from CMS for help to better understand TFC. At the time, John O'Brien, the SAMHSA Senior Advisor on Health Reform, suggested the creation of an expert panel to better understand the components and effectiveness of TFC. Dr. Huang stated that the partnership between SAMHSA, CMS, and ACYF began with all three agencies learning how to develop and implement the best services for children—especially those with emotional disorders.

Simultaneous with the formation of this partnership, implementation of the Affordable Care Act had started. Thus, there was a confluence of factors that encouraged the three agencies to work together to identify what a good and modern system would look like and the evidence base for that system. The technical expert panel is one effort to learn about the best evidence for TFC. Dr. Huang spoke of the modified Delphi consensus process and the importance of the consensus findings for all three agencies.

Clare Anderson, the Deputy Commissioner of the Administration on Children, Youth and Families, noted the unprecedented partnership between SAMHSA, CMS, and ACYF and stressed that all three agencies are reviewing complementary ways to use their resources to craft the best service array for each child. She thanked the panelists and stated that their work would complement ACYF Commissioner Bryan Samuels' efforts to focus on promoting the social and emotional well-being and improved functioning of children in foster care. She noted that ACYF has focused on promoting social and emotional well-being and has developed multiple documents over the last year to articulate this vision. She stated that the technical expert panel will assist ACYF in thinking strategically about how to help the field develop an optimal service array for children and youth in out-of-home care.

The Consensus Process

Presenter: **Doreen Cavanaugh, Ph.D.**
Research Professor
Georgetown University
Health Policy Institute

Dr. Cavanaugh explained that a Delphi process of successive approximation would be used for consensus. She noted that during the technical expert panel meeting, presenters and panel members would be encouraged to submit candidate consensus statements within the six agenda topic areas. The statements should address three questions within each topic area:

1. What Does the Research Tell Us About Therapeutic or Treatment Foster Care?
2. What Are Recommendations for the Implementation of What We Know?
3. What Are Recommendations for Advancing the Knowledge Base?

Dr. Cavanaugh outlined the steps for analyzing the statements. After the meeting, Georgetown University and Truven Health Analytics staff would conduct qualitative data analysis and develop a final draft of candidate consensus statements for voting. Then, the revised statements would be sent to technical expert panel member volunteers, who would review the statements for accuracy, clarity, and inclusiveness. Next, Georgetown University staff would collate the candidate consensus statements and prepare the electronic consensus ballot.

She stated that technical expert panel members would be asked to respond to each statement on the ballot using a 4-point Likert scale (Disagree [1], Somewhat Agree [2], Agree [3], or Strongly Disagree [4]). Panel members would have the option to abstain on any statement(s) that they did not feel qualified to address. All panel members would be asked to rate the statements and return

the electronic ballot to designated Georgetown University staff members, who would collate the responses and compute a mean and standard deviation for each statement.

Statements with a mean from 1.00 to 1.99 would be considered as reaching a consensus of disagreement and eliminated from further consideration. Statements with a mean from 2.00 to 2.99 would be considered a middle group with neither agreement nor disagreement. Statements with a mean from 3.00 to 4.00 would be considered as reaching a consensus of agreement and would be reported.

Georgetown University staff would collate the middle group of statements with a mean from 2.00 to 2.99 and develop a second-round ballot. In that round, technical expert panel members would use a dichotomous scale (Disagree [1] or Agree [2]), along with the option to abstain. Statements that received a mean of 1.5 or higher in the second round would be considered as reaching a consensus of agreement and added to the Round 1 consensus statements in the final report. The final voting tallies from Rounds 1 and 2 would be sent to the technical expert panel members.

Presentations: National Content Experts

The following section summarizes the research presentations at the technical expert panel meeting.

I. What Do We Know About Therapeutic or Treatment Foster Care?

Topic: What Does the Research Tell Us About Children in Therapeutic or Treatment Foster Care?

Presenter: Bryan Samuels, MPP
Commissioner, Administration on Children, Youth and Families
Administration for Children and Families
U.S. Department of Health and Human Services

Commissioner Samuels opened the meeting by commending the technical expert panel members for participating in a process that is a critical component of building an evidence base and integrating it into child welfare.

In setting a context for the work, the Commissioner stated that child welfare is organized around three outcomes: safety, permanency, and well-being. Most child welfare agencies have spent the last 10–15 years focusing on safety and permanency issues. Because those agencies have been able to decrease the number of children who are in the child welfare system, there is now an opportunity to focus more on safety, permanency, and well-being in an integrated fashion. However, the culture in state child welfare agencies encourages reticence toward engaging on the issue of well-being, because of the belief that the concept is too challenging for child welfare agencies to address.

Commissioner Samuels related his experiences running the child welfare system in Illinois. He began his tenure there after a 6-year period in which 50 percent of the children in foster care

were moved out of the foster care system. Therefore, he was able to focus his attention on the children who remained in the system, who were older than the national average age of children in foster care, and who generally had a large number of social and emotional challenges. Thus, he explained, he could turn his focus to issues of child trauma and well-being.

Commissioner Samuels initially believed that he could also address these issues when he began working at the federal level, but found that many of his colleagues did not view well-being as an obligation and were hesitant to spend more money on new interventions. Mr. Samuels learned that to gain any support, it was necessary to have a policy basis for discussion of new interventions—particularly when resources are limited. He concluded that the best way to ease child welfare into evidence-based practice was to tie it to the existing legislative requirements to address child well-being. To do this, ACYF has been working with CMS and SAMHSA to use the existing policy frame and the emerging science to move toward a discussion of evidence-based interventions to improve child well-being.

Commissioner Samuels emphasized that the current conversation on TFC is not the only evidenced-based discussion occurring, nor is it the only intervention approach that is being addressed. He stressed that the TFC conversation is happening in the context of a broader set of interventions covering a wider set of young people and families.

The Commissioner gave examples of other on-going work. He stated that ACYF has recently released a set of grants that specifically address the intersection of child welfare and family homelessness. The objective of the initiative is to examine the pathways from family homelessness to child welfare and consider the circumstances of the unique set of families who use significant behavioral health, homelessness, and child welfare resources. The goal is early identification of those families, followed by development of a set of nested interventions that could prevent placement and put the family on a trajectory toward positive outcomes. Thus, these interventions must not just be about housing, but also about mental health and substance use disorder issues for the parents and trauma issues for the children.

As another example of flexibility, Mr. Samuels cited the waivers to the requirements for Title IV-E—the largest federal funding source for child welfare services. Congress permitted ACYF to waive some of the federal Title IV-E spending requirements. Under this authority, ACYF may provide waivers to 10 states per year over 3 years. Their purpose is to examine how child welfare agencies might intervene differently if they could use flexible funding to address safety, permanency, and well-being using evidence-based practices. According to Samuels, these waivers would create a set of "laboratories" where child welfare agencies would be able to "experiment."

Commissioner Samuels also cited the regional partnership grants, which were funded under Title IV-B and reauthorized in 2011 with additional funding. Instead of releasing the same funding announcement, which focused exclusively on treatment of parental mental health and substance use issues, ACYF chose to address the effects these conditions have on parenting skills and on youth in these homes. ACYF opted to require that grantees use validated screening instruments and closely examine the literature to decide which set of interventions provides the desired outcomes. This initiative aims to prevent removal of youth from home (if possible), to return youth back home (when advisable), and to promote stability.

Commissioner Samuels stated that many people are understandably reticent to embrace an evidence-based agenda because of the well-documented limitations of the existing evidence base. However, he stressed that it is necessary to use the best evidence available to intervene when necessary.

Samuels noted that there is wide variation in how TFC is currently used and in the implementation of the model. He suggested that examining these issues should be a focus of the technical expert panel's discussion of the appropriate use of TFC.

Topic: What is the Current State of the Research Base for Therapeutic or Treatment Foster Care for Youth?

Presenter: Johna Hughes Bruton, MSW
Clinical Assistant Professor
School of Social Work
University of North Carolina

Ms. Bruton presented findings from the Therapeutic or Treatment Foster Care (TFC) systematic literature review, which she prepared as a briefing document for the technical expert panel. Ms. Bruton stated that she began the literature review process by developing an initial pool of 110 articles for consideration from a variety of databases, including the Cochrane and the Campbell Collaborations, SAMHSA's National Registry of Evidence-based Programs and Practices, the Colorado Blueprints for Violence Prevention, the National Quality Forum, the California Evidence-Based Clearinghouse for Child Welfare, the Administration for Children and Families, PsychINFO® (American Psychological Association), PubMed (U.S. National Library of Medicine and National Institutes of Health) and Social Services Abstracts. She also found publications from bibliographies of relevant articles and studies.

Ms. Bruton initially used the following search terms: treatment foster care, therapeutic foster care, and specialized foster care. Ms. Bruton later included mental health, substance abuse, substance use, outcomes, juvenile justice, child welfare, and any combination of these terms. Terms were modified as required by each database. Her primary focus was on TFC and outcomes for mental health, substance abuse, well-being, child welfare, and juvenile justice.

Ms. Bruton selected 50 articles for inclusion out of her initial pool of 110 articles. She completed summary tables for 25 articles and included an additional 25 articles in the narrative for background and context. She excluded articles if they were on regular foster care, did not refer to outcomes, had small sample sizes, or pertained to outcomes unrelated to TFC. In all, she included 19 randomized controlled trials, 1 qualitative interview study, 2 descriptive studies, 2 pretest-posttest designs, and 5 exploratory studies with secondary data analysis in her review. The articles were from 1994 to 2011. Ms. Bruton explained that several articles focused on the same studies, so the 25 articles referred to less than 25 studies.

All of the youth in the reviewed studies were in out-of-home placements or were at risk of out-of-home placements. All of the youth had severe emotional and behavioral problems; were violent or assaultive; had severe trauma, abuse, and neglect histories; and/or had juvenile justice involvement. Youth in TFC typically had higher rates of severe emotional problems and trauma

histories than youth in regular foster care. In addition, the youth often had multiple failed placements prior to placement in TFC (an average of four or more prior placements). The youth in the studies were aged 2–18 years and were mostly White and male. All but six studies were from two main research groups that examined two main models of TFC: Multidimensional Treatment Foster Care (MTFC), which was developed by Patricia Chamberlain, and Together Facing the Challenge, which was developed by Elizabeth Farmer. In addition, most of the research was completed in the United States, except for three studies from Sweden. Finally, most of the research completed within the United States occurred in Oregon or North Carolina.

The 19 randomized controlled trials included in the 25 articles had sample sizes of 20 to 247 youth. There were also multiple observational and quasi-experimental studies with sample sizes of 88 to 2,168 youth. Ms. Bruton found that the research was directed at multiple high-risk populations: youth with mental health and substance abuse concerns, youth in the child welfare system, and youth with juvenile justice involvement.

Ms. Bruton identified several recommendations for advancing the knowledge base. First, is the need for more studies conducted in a variety of settings with a variety of populations and larger sample sizes. In addition, while recognizing that randomized assignment is difficult in a foster care setting, more randomized controlled trials and more trials conducted independent of the model developers are needed. Ms. Bruton recommended increasing randomized controlled trials to test multiple TFC models in a greater variety of settings and geographic locations.

She also suggested an increase in longitudinal research to test the sustainability of short-term gains. Although much of the research to date indicates positive outcomes for youth in TFC, there is little information about the sustainability of outcomes over time. She also recommended an increased analysis of service use history prior to TFC placement, as well as post-placement service use trajectories and their impact on long-term TFC outcomes. In addition, because most of the research has been conducted with largely male, nonminority populations, she suggested more research with larger sample sizes from minority populations.

Ms. Bruton recommended more research on the impact of model fidelity on outcomes. She suggested that model implementation varies widely, and that there is little understanding of the degree to which fidelity to specific models affects outcomes. Ms. Bruton also recommended more research on training approaches, eligibility criteria, performance standards, and documentation, since she found that these vary greatly across different settings. She also noted the need for studies of TFC as an initial placement. The objective would be to develop a profile of children and youth for whom TFC would be the most appropriate first treatment so that they could be placed immediately into this setting.

Ms. Bruton concluded by stating that there are two tested models of TFC that have produced promising outcomes. These two models should be implemented in a greater variety of settings and with a greater variety of children and youth. The two models should be implemented with fidelity checks to ensure each model's ability to produce positive outcomes that endure beyond the initial 6 to 12 months of a study. Finally, she stated that additional research with increased rigor is needed to increase the power of the results, improve generalizability, and ensure sustainability.

II. What Do We Know About Identifying Youth Appropriate for Therapeutic or Treatment Foster Care?

Topic: Screening, Assessment and Level-of-Care Placement Criteria for Therapeutic or Treatment Foster Care

Presenter: Ann Doucette, Ph.D.
Research Professor of Evaluation and Health Policy
Director, Midge Smith Center for Evaluation Effectiveness
Director, The Evaluators' Institute
The George Washington University

Dr. Doucette welcomed the opportunity to address measurement issues with the technical expert panel. She noted that she has conducted secondary analyses on a number of measures, particularly those that have been used for children and adolescents. She indicated that although she would share some data examples with the group, she would not identify any specific measures.

According to Dr. Doucette, measurement is important because it assigns numbers to children and youth and informs the decisions that are ultimately made about the integrity of those numbers. Although other aspects of research are hotly debated, it is uncommon to find the same level of scrutiny applied to the measures that are used. Instead, measures are frequently used primarily because they are the most popular measures that have been cited in the literature.

Dr. Doucette stated that TFC is often considered synonymous with Multidimensional Treatment Foster Care, Therapeutic Foster Care, and Specialized Foster Care without differentiation or distinct definitions. Treatment foster care is a complex system that serves children with a variety of needs and conditions that place them at a high risk of poor life outcomes. Examples include children with physical and behavioral health conditions (including mental health and substance use disorders), those with delinquency and conduct disorders, those who have experienced parental abuse and neglect, and those who are at risk of incarceration or of being placed in more highly restrictive placements.

Dr. Doucette explained that there are several areas of care that must be assessed. First, it is important to measure population characteristics, including basic demographic information, as well as prior placement histories, prior abuse, victimization, and other relevant factors. The complexities experienced by these children mediate and moderate the outcomes experienced as a result of any type of care, including TFC. Thus, the complexity of these individuals necessitates a move away from "one-size fits all" measures that cannot accurately capture an individual child's story and placement needs.

Second, Dr. Doucette explained that it is important to look at the effectiveness of foster care in terms of services received; the characteristics of the foster care family; and the dose, duration, stability, and disruption of those placements.

There are some mediating and moderating factors to consider. First, most children and youth attend school. Therefore, they may be in multiple systems that are independent of whether they

are in foster care. They may have relationships within the mental health and substance abuse treatment systems. These systems have different approaches, characteristics, and treatment expectations that mediate and moderate outcomes. In addition, all of the children and youth have family relationships. Foster family relationships are particularly important within this context, as are the relationships the child has with his/her teacher, therapist, physician, counselor, and others.

Dr. Doucette stated that is important to investigate whether there are measures currently available to accurately capture short-term and long-term progress and improvement across biopsychosocial areas. The issue of impact is often the immediate target, without sufficient attention to tracking outcome history. She posited that the discussion of impact in foster care should be characterized as a discussion focusing on reconciliation, reunification, and transition into adulthood.

Dr. Doucette also noted that rigorously assessing child outcomes associated with intervention is possible, and she shared examples taken from the Cochrane and the Campbell Collaboratives, as well as other studies. She identified a variety of areas that are already being measured through self-reporting and rating by others. These areas include child emotional and psychological health, which include symptomatology, functional status, attachment, resilience, adaptability, well-being, self-esteem, adherence to medication and treatment protocols, interpersonal functioning, and relationships (e.g., with the foster family, peers, the school, and biological parents). These can all be measured by assessing the child's needs and strengths, the treatment outcomes, and the impact experienced. Additional measures that may be used capture behavioral problems, antisocial behaviors, use of drugs or alcohol, physical or verbal aggression, rule breaking, oppositional defiant behavior, and truancy. Biological markers also may be used. Finally, there are measures available related to education, including teacher reports, student achievement, attendance, training and employment, and engagement in extracurricular activities.

Dr. Doucette emphasized the importance of assuring that a child is placed in a setting that can meet his or her needs. Therefore, it is important to look at measures relating to the placement, such as foster parent interpersonal skills, the therapeutic alliance, the cohesion that is offered in terms of the consistency of the approach, behavioral management, attitudes of the foster care family, and problem-solving skills. Dr. Doucette indicated that the federal government is interested in optimizing outcomes for every child, but when aggregating data for policy decisionmaking, it is critical to consider how the range of children are represented in aggregate summary data.

Dr. Doucette stated that her measurement bias is Item Response Theory (IRT) measurement models, which are used by the National Institutes of Health and the Patient Reporting Outcome Information Monitoring System (PROMIS) initiative. IRT has the capacity to offer stronger, more precise information at the item and response levels—information that would be far more burdensome to estimate using traditional classical test theory.

Dr. Doucette stated that there are several questions that should be asked of any measure being used in investigations. First, does the measure yield actionable data? In other words, can the results be used to determine what steps should be taken to optimize outcomes? What should be changed about the program or intervention? What policy options can be informed using these

data? She recommended concurrent data collection, collecting data while a child is in treatment, and providing feedback so that treatment can be modified if the child is not making expected progress.

Second, does the measurement data empirically inform the decisions being made about the effectiveness of care? Does the measure provide strong evidence about the effectiveness of the treatment model? This question examines the treatment planning process in order to clarify what works, for whom, and under what conditions, as well as appropriate dose (i.e., how much of the treatment an individual needs).

Third, is the measure sensitive to assessing youth with different levels of impairment and different kinds of need? Can the measure detect improvement or deterioration over time, across a continuum (e.g., high to low, mild to severe, minimal need to high need)?

Fourth, does the measure score reflect the construct to be assessed? Is it unidimensional? Do the numbers assigned as a consequence of measures represent a single unified dimension? If the measure is assessing unknown dimensions, then the numbers assigned are reflective of unknown measured phenomena that likely have not been considered in the evaluation or research study.

Fifth, are "strength-based" measures equivalent to problem-based measures? Dr. Doucette observed that strength-based measures may reinforce a sense of achievement, but there is a need to clarify whether these measures reflect the absence of a problem and whether there is good data utility from the measures.

Dr. Doucette provided a definition of measurement as a "scientific…way of finding out (more or less reliably) what level of an attribute is possessed by the object or objects under investigation."[78] In the case of TFC, she stated that the objective of measurement is to determine the level of impairment, level of treatment need, and so on that are possessed by the youth under investigation. Measures also should determine the magnitude of that level via its numerical relationship to another level. Measurement precision is needed when deciding which children need and could benefit from TFC.

In addition to the reliability, validity, and unidimensionality, Dr. Doucette emphasized that measures should be sensitive to change (i.e., having sufficient items that adequately assess change at the low and high ends of a scale). Many measures lack items at the ends of the measured continuum, making it impossible for an individual to demonstrate change simply because there are no items representing very mild or most severe areas.

Because of this, she suggested that it is important to contextualize stability in terms of characterizing the children. Stability at the mild end of the measured continuum may be a consequence of insufficient items to demonstrate continued improvement. Funders such as insurance companies often interpret the lack of change over time as a reason to discontinue treatment, when the lack of change is actually a measurement artifact.

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[78] Michell, J. (2001) Teaching and misteaching measurement in psychology. *Australian Psychologist, 36*(3), 211–218 (p. 212).

Dr. Doucette stressed that there is a common assumption that each and every item contributes equally. She noted, however, that it might not be the case for all items. She stated that it is important to map the items to different levels of impairment. Youth with minimal need should receive different questions than those with moderate or severe need. When using one measure to capture children with a wide range of problems and needs, it is important to have items distributed across that continuum. In many of the existing measures, it is difficult to find ways to characterize the children in terms of their well-being. She noted that when adding across a measure to arrive at a score, it is important to consider whether all of these items are the same. Does the measure have standardized weighting, so that items that are more serious contribute to the score more appropriately? Does it reflect a single unified dimension?

Dr. Doucette shared a measure that was used by a large commercial health plan with 30 items—27 items on psychological distress and 3 items on substance abuse. In this case, there was an assumption that every item equally contributed to the score, yet this was not the case. A child who scored high on all 3 substance abuse items would only have a score of 12; however, as a clinician, Dr. Doucette stated that she would see that child as in high need of a specific treatment. However, the score from the subscale of mental health items ultimately precluded recognition of that child's substance abuse needs.

For her summary statements, Dr. Doucette considered whether the items or questions that are being asked elicited actionable information. She asked whether the measures used were reflective of a theory of change that is attributable to TFC. Considering the fact that children and youth enter foster care for varying reasons, she asked whether one measure was sufficient for all of these children in terms of the effectiveness and the efficiency of TFC.

In her suggestions for consensus statements, she asserted that multiple measures might be needed to assess the level of need and the outcomes and impact of care, rather than a one-size-fits-all approach. Criteria should be established for measures assessing the level of care as well as measures assessing outcome and impact. Measures should capture progress and improvement over time. They should provide actionable information and information that assists with treatment planning and policy decisions. They should be selected on an established set of criteria, including scientific soundness, reliability, validity, and dimensionality.

Measures should be stable. Agencies and states should not be held hostage to management information systems that already use a specific measure. Measures should not be so idiosyncratic that there are different versions in different states because idiosyncratic changes make it impossible for federal funders to conduct research synthesis.

In closing, Dr. Doucette stated that cost is also an increasingly important component. The effectiveness of TFC treatment can no longer be considered without considering the program cost and cost benefits that are associated with it.

III. What Do We Know About the Essential Elements of Therapeutic or Treatment Foster Care?

Topic: What is the Evidence Base for Essential Elements of Therapeutic or Treatment Foster Care for Youth?

Presenter: John Landsverk, Ph.D.
Director, Child & Adolescent Services Research Center
Rady Children's Hospital

Dr. Landsverk began by providing background on TFC and locating it on the spectrum of placement types. He explained that TFC was developed as a community-based alternative to placement in group residential care for children and adolescents with severe emotional and behavioral problems. He stated that TFC serves a heterogeneous population of children, who have been referred to TFC from the mental health, juvenile justice, or child welfare systems. TFC may function as a step up from regular family foster care or a step down from group or residential care. Many systems regard TFC as an entry level to residential care in the child welfare system.

Dr. Landsverk made a distinction between TFC standards and models. Standards should be thought of as guidelines. He referred to the pioneering work conducted by Dr. Elizabeth Farmer in North Carolina, which systematically examined group care and TFC in North Carolina. Dr. Farmer then contrasted the findings with the Foster Family-based Treatment Association's 73 standards for care and with Multidimensional Treatment Foster Care (MTFC), the dominant model of TFC. Dr. Farmer found enormous variability in North Carolina and a lack of fit with the standards and the MTFC model of care. Dr. Landsverk stated that if Dr. Farmer found such variability in North Carolina, which had made TFC a priority, then it was likely that there was also significant variability in other states.

TFC functions as a bundled service. Dr. Landsverk compared it to intensive outpatient treatment for substance use disorders, which Medicaid treats as a bundled service with a single code. He noted that there has not been any work to establish an evidence base for any of the individual essential elements of TFC. Instead, the evidence base is for all of the TFC services bundled together. The elements have not been tested in a disaggregated design; therefore, there is work needed to delineate the contributions of each of the components.

Dr. Landsverk explained that he examined two separate models that had been rigorously tested with randomized controlled trials. The first, MTFC, is a suite of models that has been developmentally tested on preschoolers, younger children, and adolescents. The second model, Together Facing the Challenge, is the TFC model developed by Elizabeth Farmer and tested in North Carolina. He stated that there is overlap between MTFC and Together Facing the Challenge. He also consulted the California Evidence-Based Clearinghouse for Child Welfare (CEBC) for reviews on MTFC-A, MTFC-P, and Together Facing the Challenge. Finally, he reviewed the *Assessing the Evidence Base* report prepared for the technical expert panel.

Dr. Landsverk stated that for the next section of his talk he was careful to choose language that indicated the critical function of each TFC element, but avoided being too specific and concrete, which he thought might result in limiting the testing of any future evidence-based models.

Dr. Landsverk divided the 12 essential elements into 3 topic areas. The first area encompassed TFC parent training and support. First, he stated that it was essential to consider parents in TFC programs as members of the treatment team. Second, he stated that it was essential to provide

specialized training for these parents so that they could be better equipped to handle any emotional and behavioral health problems exhibited by the youth in their care. Third, he stressed the importance of providing continuing parent support, which might include weekly meetings, group sessions, or 24/7 support.

The second set of essential elements encompassed youth treatment, training, and monitoring. First, it is essential to provide individual mental health treatment for youth in TFC. This treatment could include nonspecific treatment, condition-specific treatment (e.g., trauma and depression), and social skills training. Second, it is essential to provide academic support for these youth. Third, it is essential to provide preparation for adulthood training for adolescents. Fourth, it is essential to provide close monitoring of a youth's behavior, school attendance, school performance, and homework completion.

The third set of essential elements encompassed the supervisory function. First, it is essential to provide coordination of the services that the child receives in different settings, such as a supervisor who coordinates case management for TFC elements for family, peer, and school settings. Second, it is essential to provide reduced supervisory caseloads (e.g., a limit of only 10 families per supervisor). Third, it is essential to provide supervisory availability 24/7. Fourth, it is essential to limit TFC to one youth per TFC home, with the exception of kinship groups. Finally, because many children in TFC are on psychiatric medications, it is essential to provide psychiatric consultation for medication management where appropriate.

Dr. Landsverk concluded with recommendations for TFC implementation and for advancing the knowledge base. Regarding implementation, he advocated the development of efficient and cost-effective models for fidelity adherence measurement and monitoring. He also advocated the development of TFC implementation strategies that promote scale-up and sustainability. Regarding advancing the knowledge base, he recommended further research on essential elements linked to developmental and racial, ethnic, or cultural variations of children in TFC in the United States and internationally. He also recommended further research on a full continuum of parent training models and research on effective and efficient youth transitions between levels of care. In addition, he recommended further research on the effects and costs of fidelity or adherence monitoring, as well as further research on the impact of implementation strategies on TFC scale-up and sustainability.

IV. What Do We Know About the Psychosocial Treatment of Youth in Therapeutic or Treatment Foster Care?

Topic: What Does the Research Tell Us About Mental Health and Other Service Use by Youth in Therapeutic or Treatment Foster Care?

Presenter: J. Curtis McMillen, Ph.D.
Professor
School of Social Service Administration
University of Chicago

Dr. McMillen stated that there is little available data on mental health treatment or other service use by youth in TFC. This dearth is due to the fact that only a small number of youth in the

foster care system are in TFC at any one time, so it is difficult to draw conclusions from larger studies of children and youth in the foster care system. In addition, even if a youth is designated as being in TFC, Dr. McMillen indicated that it is difficult to state with certainty exactly which services that individual receives. He also indicated that the nature of the services that are delivered is affected by location because different states contract for different services for youth in TFC.

Data about services that youth receive are obtained in two main ways. One way is through structured interviews, which ask caregivers what services the youth receives, while utilizing previously agreed-upon language to describe these services. However, there are reliability issues with data obtained this way. Although the interviews employ agreed-upon service definitions, the interviewees may interpret the questions differently and report that they do not receive services that they actually receive, or vice versa. For example, if the individual is asked whether he or she sees a therapist at a community mental health center or an office, that individual may respond based on how he or she understands the relationship with that contracted therapist.

A second way to learn about service use is to mine Medicaid data for information about what services youth receive. Dr. McMillen stated that there are also reliability issues in this method. For example, an MFTC program may bill Medicaid for individual and family therapy sessions that are provided as part of the MTFC package, but the Medicaid data may show youth being referred out for therapy, even though the services are actually embedded in the MTFC program. As a result, Dr. McMillen stated, "we aren't sure we know what we know" about any of the services data for these youth.

Dr. McMillen cited the first nationally representative study of child welfare agencies' investigations of maltreatment, in which researchers analyzed a separate subsample of children who had been in out-of-home care for a year. The study found that half of these children received outpatient mental health services. Another study of youth in Minnesota paired administrative data from the state educational system with treatment foster care records and concluded that about half of the TFC youth had an open special education case in their states, although researchers could not conclude that meant that they actually received services.

Dr. McMillen stated that although many consider the number of children receiving mental health services to be too low, he considers the use of mental health services to be fairly high among foster care youth and children with demonstrated need. Even within the general foster care system, he noted that the use of inpatient psychiatric care is relatively frequent.

In his own Missouri study, Dr. McMillen reviewed the mental health service use for 404 17-year-old youth within TFC or the traditional foster care system. He found that the youth received a high number of intensive mental health services, with 93 percent receiving at least 1 service at some time in their lives. He noted that there were counties where nearly every youth received outpatient psychotherapy. Rates of service use were high for the more invasive services, such as psychiatric care and residential care. Dr. McMillen believed this finding indicated an overuse of mental health services. He explained that either through systems of care or through the courts, many youth are ordered to undergo mental health treatment regardless of actual need.

Dr. McMillen used the data from his Missouri study to focus on three groups of youth: one group who had been in TFC, another group who had been in residential care but not TFC, and a third group who had never been in either type of care. He found that the percentage of youth who received outpatient psychotherapy did not differ strikingly between these three groups. However, TFC youth were the most likely to receive outpatient psychotherapy. There were greater differences across the groups with respect to inpatient rates; TFC youth had the highest inpatient rates, followed by youth in residential care. This finding suggests that in Missouri, youth in TFC received many other services, especially the invasive services.

Dr. McMillen stated that in Missouri, where he conducted his own research, group care contracts and TFC contracts state that children must receive weekly psychotherapy, yet when he conducted interview studies, the percentage of youth who received therapy was much less than 100 percent. He noted that few conclusions can be drawn from the data.

Dr. McMillen also stated that much of what is known comes from a study conducted in North Carolina, led by Dr. Elizabeth Farmer. He shared an example from one of these studies, which compared children who were in group care and TFC in North Carolina. Foster parents were asked what services the youth had received in the prior four months. A majority of the foster parents responded that the youth received some therapy, and about 50 percent reported that the youth received special classroom services. Many also reported that the youth received other special school services.

Dr. McMillen stated that it is difficult to draw conclusions from these findings. He noted that the limited evidence available suggests that youth in TFC in North Carolina typically receive several mental health services. He noted that that the volume of mental health care is often the same in TFC and group care. He also indicated that state treatment foster contracts require that children receive some degree of mental health care and questioned whether the number of children receiving treatment should be even higher than reported.

Dr. McMillen also examined the trajectory of youth before and after placement in TFC in order to gain an increased understanding of their lifetime psychiatric history. He found that in the North Carolina study, youth primarily moved to TFC from a more restrictive residential care setting and very rarely moved to TFC from a less restrictive traditional foster care setting, although they occasionally moved to TFC from a private home. After TFC, youth were either moved to residential care or they returned home. They rarely moved to a traditional foster care environment. Dr. McMillen hypothesized that this finding may be because in North Carolina, TFC works primarily with a population of youth who have mental health system involvement.

Dr. Farmer, who was in attendance, concurred with Dr. McMillen, stating that in North Carolina, TFC is licensed through the Department of Mental Health. She noted that in the study that Dr. McMillen referenced, roughly 50 percent of the children were still in the custody of their parents and were not part of the child welfare system. She clarified that a TFC placement in North Carolina occurs because of the child's mental health disorder and not solely because of family difficulties. Dr. McMillen noted that in the North Carolina data, there were no reports of the next placement being another TFC home. He also noted that the pre- and post-placement trajectories for the youth in his Missouri study are distinct from North Carolina. The youth in his

Missouri study entered TFC from traditional foster homes and moved to either residential homes, foster homes, or another TFC home.

Dr. McMillen closed by stating that there are few consensus statements that can be drawn from the existing evidence. Based on the limited evidence available, he could conclude that children and youth in TFC typically receive multiple mental health services. In addition, during their time in foster care, these youth tend to receive services in more restrictive levels of care. Finally, he concluded that there is no research basis for a statement on the ideal mental health service constellation for children and youth in TFC.

V. What Do We Know About Outcomes for Youth in Therapeutic or Treatment Foster Care?

Topic: What Does the Research Tell Us About Juvenile Justice and Mental Health Outcomes for Youth in Therapeutic or Treatment Foster Care?

Presenter: Leslie D. Leve, Ph.D.
Senior Scientist
Oregon Social Learning Center

Dr. Leve addressed juvenile justice and mental health outcomes drawn from evidence-based trials. She explained that she would include a developmental framework in her discussion, incorporating research on youth from preschool through adolescence.

Dr. Leve stated that although research on MTFC has been conducted primarily on adolescents, there have also been models tested for early and middle childhood. She would address several studies, including a study of Fisher's model for Multidimensional Treatment Foster Care for preschool (MTFC-pre). In this study, 117 children aged 3–5 years who were referred from child welfare to foster care were randomly assigned to MTFC or regular foster care. All of these children had experienced documented maltreatment. For middle childhood, she cited the Fostering Individualized Assistance Program (FIAP), which had a sample of 132 youth with emotional and behavioral disorders. Finally, she cited several MTFC trials for adolescents, including one trial with males, two trials with females, a trial in Sweden, and a nonrandomized controlled trial in England. She also cited the sample group used by Dr. Farmer to develop the Together Facing the Challenge model of enhanced TFC.

Dr. Leve explained that in the MTFC model, foster parents receive 20 hours of preservice training before being certified as MTFC foster parents. A highly experienced program clinical supervisor oversees the team, which includes family therapists, individual therapists, and a staff member who works on skill development with the youth. The final key program component is a connection between the parents and the teachers—children bring a daily card to school and the teacher signs it to foster bi-directional communication with MTFC parents about attendance and academic performance.

Dr. Leve stated that there were several behavioral outcomes in the findings for Fisher's MTFC-pre study at 12 months, including increased attachment security and reduced avoidant attachment for the children in MFTC-pre. This same group also experienced underlying neurobiological

improvements. Other studies indicate that these neurobiological changes are linked to improved mental health and behavioral outcomes, including more regulated cortisol, longer sleep duration, and improved executive function. Dr. Leve explained that other studies have shown that these neurobiological outcomes affect broader behavioral health outcomes over time. She also noted that even though MTFC-pre improved security and attachment outcomes for these children, they were still less secure overall than children in the community control group.

Dr. Leve also addressed outcomes for middle childhood-aged youth involved in the Fostering Individualized Assistance Program (FIAP), which is certified as an evidence-based practice. She acknowledged that studies of this intervention were dated, since there has not been a recent randomized controlled trial of FIAP. Dr. Leve stated that at 12 to18 months, mental health outcomes included fewer symptoms of withdrawal, fewer attention problems, and fewer days incarcerated. Researchers found no overall effects on internalizing or externalizing disorders for the sample as a whole, but when separated out by sex, males showed improvement on externalizing effects. Juvenile justice outcomes included fewer days incarcerated among youth in the program.

Dr. Leve cited three randomized controlled trials of MTFC for adolescents in Oregon—one trial with males and two trials with females. All three trials included youth aged 13–17 years who were in detention and were mandated by a court to out-of-home care. The samples were relatively homogenous, since 85 percent of the males and 68 percent of the females were Caucasian. A judge referred youth to the study, and they were then randomly assigned by the project coordinator to either group care or MTFC. Although the youth in this sample entered MTFC through the juvenile justice system, many also had a history in the child welfare system for abuse, maltreatment, and neglect (95 percent of females). The sample had an average of two to three foster care placements prior to the study. Regarding outcomes, the study found that the MTFC males spent less time in detention and incarceration during the following 12–24 months. They were also half as likely as males in group care to commit a criminal offense and less likely to commit a violent crime or to have friends involved in delinquent or antisocial activities.

When two samples of adolescent females in MTFC studies were combined, MTFC was found to reduce the number of subsequent teen pregnancies over the next 2 years from 47 percent to 27 percent for females in MTFC compared to the females in group care. Dr. Leve stated that teen pregnancies are related to young adult mental health outcomes, since the study found correlations between teen pregnancies and increased drug use and a higher likelihood of child welfare involvement for the children of females in the sample throughout their young adulthood. The study also found that the females in MTFC had fewer depressive symptoms, spent less time incarcerated, had fewer overall offenses, and had fewer antisocial peers than females in group care. Dr. Leve also stated that when researchers combined the two adolescent study samples and examined subpopulations, they found that MTFC was most beneficial for adolescent females who had the most offenses. For females who had a lower level of problems, group care was about as effective as MTFC.

Dr. Leve cited work done by Dana Smith to integrate trauma-focused cognitive behavioral therapy (TFCBT) into the MTFC model as a means of addressing trauma. Dr. Leve stated that a trial of MTFC incorporating TFCBT found that the delinquency and mental health outcomes for females in MTFC compared to females in group care were similarly positive, with lower rates of

clinical depression and fewer days incarcerated among females in MTFC at the 24-month mark in the study. She noted that 10 to 12 percent of youth in group care at the study's 24-month mark had a clinical depression diagnosis, whereas the percentage of youth in MTFC with a clinical depression diagnosis approached zero. Dr. Leve also highlighted a difference between the two sexes with regard to the number of days spent in detention. Dr. Leve explained that although MTFC decreased the number of days spent in detention for both sexes, it had a greater effect on males, who experienced a greater decrease than females in days spent in detention while in MTFC compared to the males in group care. However, on average, females still spent less overall time in detention than males.

Dr. Leve explained that the studies of adolescent males and females in MTFC in England and Sweden were conducted independently and apart from the MTFC development team. The MTFC study in England of 47 adolescent "serious offenders" employed a quasi-experimental design but found similar outcomes to the American MTFC studies, including fewer reconvictions, fewer and less serious recorded offenses, and a longer time to commit a first offense. However, because of the nature of the design, there was insufficient data to determine if the effects persisted after placement. Dr. Leve cited a randomized controlled trial in Sweden, which found fewer externalizing and internalizing problems—in particular, depression in MTFC youth—when compared to the control group at 12 to 24 months.

Dr. Leve also cited Farmer's Together Facing the Challenge trial, which found fewer behavioral problems at 6–12 months, fewer symptoms and total difficulties at 6 months, and fewer behavioral and emotional problems at 6 months when compared with regular (nonenhanced) TFC. She noted that 63 percent of the group in Together Facing the Challenge improved, compared to 40 percent of those in regular TFC.

Dr. Leve also noted that a 2009 independent cost analysis by the Washington State Public Policy Institute of MTFC for males found a 17.9 percent reduction in crime, as well as cost savings (approximately $88,000 per youth), compared to the costs of keeping males in services as usual (group care). To date, no similar analysis has been done for females or for other MTFC models.

Dr. Leve stated that the research indicates that there are effective TFC programs for reducing juvenile justice involvement and improving mental health outcomes in children across the age span from preschool through adolescence. MTFC for adolescents is the most widely tested of these programs. Although females in both MTFC and group care show improvements over time, the females in MTFC show greater improvement. For males, group care was detrimental to their outcomes, whereas MTFC had positive effects.

She also stated that although TFC programs vary in duration, cost, effect, sizes, outcomes, and implementation readiness, MTFC is the only TFC program that has been validated with an independent research trial with a team who is not connected to the development team. TFC interventions are multifaceted and require manualized protocols and adherence to the model in order to be successfully implemented. Dr. Leve suggested that child welfare and juvenile justice systems could save money and improve each youth's outcomes through greater implementation of evidence-based TFC programs.

Finally, in order to advance the knowledge base, Dr. Leve stated that there is a need for more information about the cost effectiveness of TFC programs across service systems and populations. In addition, she identified the need for better understanding of the most effective methods of going to scale with a TFC intervention. She emphasized that it is also important to learn more about the instances when and for whom TFC services do not work and why the services are not effective in those cases.

Topic: Substance Use Disorder and Child Welfare Outcomes for Youth in Therapeutic or Treatment Foster Care

Presenter: Johna Hughes Bruton, MSW
Clinical Assistant Professor
School of Social Work
University of North Carolina

Ms. Bruton indicated that she would address the effects of TFC on substance use disorder and child welfare outcomes, specifically focusing on the issue of placement disruption.

Ms. Bruton noted the lack of research on substance use disorder outcomes. She cited a 2010 study by Smith et al. of 79 males.[79] All of the participants were in the juvenile justice population, and 85 percent of them were White. MTFC participants were found to have significantly lower levels of other drug use compared to group care participants at 12 months. In addition, MTFC participants had significantly lower levels of tobacco use, marijuana use, and other drug use compared to group care participants at 18 months post treatment. Ms. Bruton stated that this study was the extent of the available information about substance use disorder outcomes in TFC populations.

Ms. Bruton then turned her focus to child welfare outcomes. She first looked at a 2006 study by Smith, et al.[80] This study had a sample size of 51 males and 39 females aged 2–16 years. The children had an average of 3.33 Axis-1 diagnoses, primarily post-traumatic stress disorder, oppositional defiant disorder, and attention deficit hyperactivity disorder. They also had an average of 4.75 placements prior to the target TFC placement.

Ms. Bruton quoted the study's definition of placement disruption as "any change in treatment foster home placement that interrupted the stabilization or treatment efforts, or any instance in which a youth was moved from a foster home as a result of 1) a foster parent's inability to manage and treat the youth's emotional and/or behavioral difficulties as judged by program staff and/or 2) a foster parent's request that a youth be removed from his or her home."[81]

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[79] Smith, D., Chamberlain, P., & Eddy, M. (2010). Preliminary support for Multidimensional Treatment Foster Care in reducing substance use in delinquent boys. *Journal of Child & Adolescent Substance Abuse, 19*, 343–358.

[80] Smith, D. K., Stormshak, E., Chamberlain, P., & Bridges-Whaley, R. (2006). Placement disruption in treatment foster care. *Journal of Emotional and Behavioral Disorders, 9*, 200–205.

[81] Ibid.

In the Smith study group, placement disruption rates were 17.8 percent during the first 6 months of treatment, and 9.2 percent during the second 6 months, for a combined 12-month disruption rate of 25.5 percent. Seventy percent of the disrupted placements were in the first six months. The study found that older youth were significantly more likely to disrupt during the first six months, and older females were more likely than older males to disrupt.

Ms. Bruton also looked at an international study (Westermark et al., 2008) on placement disruption that combined three different samples. In total, the sample size was 396 and combined two samples from Sweden (n=31 and n=275) and one from the United States (n=90). She stated that the sample from the U.S. study comprised many nonadolescents, whereas the two Swedish samples were composed completely of adolescents.

In these studies, placement disruption was 2.7 times more likely in regular foster care than in MTFC. One-third of the females in regular foster care experienced disruption, which placed them at a 4.7 times higher risk than those in the Swedish MTFC program. At 12 months, the difference in placement disruption rates between Swedish MTFC and the Swedish breakdown study were larger—females in regular foster care were 8 times more likely to experience disruption within 1 year than were the females in the Swedish MTFC sample. The disruption rates in the United States study were two times higher, regardless of follow-up time; however, the finding was not significant because of sample size.

Next, Ms. Bruton looked at data from North Carolina (Farmer et al., 2003). In this study, the sample size was 184 youth with an average age of 13 years. Three-fourths of the sample was male and nearly half were minorities. The study found that 64 percent of these youth remained in TFC for the entire year following the TFC placement, and the most common post-TFC placement (43.3 percent) was the child's home. Placements immediately after TFC were often less restrictive, but in the long-term there was often a move toward higher levels of care, including group home care. Finally, age at placement was also associated with a significant increase in the likelihood of a placement disruption event.

Ms. Bruton discussed a MTFC-P study by Fisher, Kim, and Pears from 2009. Here, the sample size of 52 children aged 3–5 years was drawn from a larger sample by selecting for a high degree of placement instability (defined as more than 4 placements) prior to the study. Males comprised 50 percent of the sample and 90.4 percent were White, with an average of six transitions prior to entry into the study. In addition, there was an average of eight maltreatment incidents per child, with an average of three perpetrators and three different types of maltreatment. Physical abuse was reported in one-third of the sample, and sexual abuse was reported in one-quarter of the sample. The majority of the sample experienced moderately severe physical neglect, supervisory neglect, or emotional maltreatment.

The study found that 80.8 percent of the sample had at least one permanency attempt (defined as attempted adoption or return to home) during the first 24 months in foster care. However, researchers could not find a significant group difference in the permanency attempts by type. Sixty-four percent of the youth with a permanency attempt were successful. Thirty-nine percent of the regular foster care attempts were successful versus 83.3 percent of MTFC-P attempts, which was a significant difference. Ms. Bruton added that no maltreatment variables were significantly associated with permanent placement.

Ms. Bruton closed with recommendations for advancing the knowledge base. She recommended more studies in a variety of settings with a variety of populations and larger sample sizes. She also suggested that more randomized controlled trials test models in various settings, as well as more longitudinal research, research with larger samples of minority populations, and research in more geographic locations in the United States and other countries.

She concluded by stating that there are only a small number of studies measuring either substance abuse or child welfare outcomes. Existing studies show positive outcomes for TFC. However, the majority of research focuses on children and youth with multiple placements prior to TFC. Therefore, a future implementation recommendation would be to study TFC as a first placement to determine if results could be replicated or even improved. She added that additional studies of TFC on substance use disorders and child welfare outcomes are needed to inform the effectiveness of TFC for youth with substance use and/or trauma issues.

Topic: Long Term Mental Health Outcomes for Ethnically Diverse Adults Placed in Family Foster Care as Children

Presenter: Susy Villegas, Ph.D., LCSW
Assistant Professor
Anne and Henry Zarrow School of Social Work
University of Oklahoma

Dr. Villegas discussed research findings addressing long-term mental health outcomes for ethnic minority foster care alumni. She addressed predictors of mental health outcomes for adults who were placed in foster care as children and stated her recommendations for advancing the knowledge base.

Dr. Villegas discussed what is already known about mental health outcomes for adults who are foster care alumni. First, she stated that there is a long-term mental health impact of childhood trauma, adversity, and abuse on children who have been in foster care. She also stated that there are a disproportionate number of children from ethnic minority backgrounds in foster care and that there are disparities in the services they receive, based on ethnicity. She stated that there is very limited research on mental health outcomes of adults with foster care experiences.

Dr. Villegas explained that she used logistic regression models to conduct a secondary analysis of the Casey National Alumni Study Database (Pecora et al., 2003) with a sample of 810 foster care alumni composed of individuals who are White, African American, and Hispanic.

The measures used in the study included the Composite International Diagnostic Interview (CIDI), a psychiatric diagnostic interview administered by nonclinicians that generates a diagnosis based on the DSM-IV, and the Social Function-12 (SF-12), a 12-item validated measure that assesses overall physical and mental health in large and diverse populations. For the latter, a score of 50 or higher indicated good health. A successful mental health outcome was defined as no CIDI Diagnostic and Statistical Manual (DSM) diagnosis during the last 12 months and an SF-12 score of 50 or higher.

Dr. Villegas found that ethnicity did not predict mental health status in bivariate or multivariate regression models. Instead, seven predictors emerged as significant for the combined mental health measure: sex, age, maternal mental health problems, abused while in care, age at entrance to child welfare, number of placements, and level of preparation for leaving care. Overall, younger people (particularly young women) were at higher risk of less desirable mental health outcomes. Children of mothers with mental health problems were at a slightly elevated risk of negative outcomes, and children who were abused while in care were at a much higher risk of poor outcomes. Children who entered child welfare between birth and 5 years of age were likely to have better mental health outcomes, as did children who had fewer placements and more preparation before leaving care.

Dr. Villegas concluded that mental health concerns for many children persist until adulthood, and that many adult foster care alumni will need to utilize the mental health system. She stated that transition-age youth and young adults leaving the system are at a higher risk for mental health concerns, and that it was extremely important to address the needs of adult women foster care alumni. Also, factors such as an older age of entrance into the system, a higher number of placements, maternal mental health problems, maltreatment while in care, and preparation for exiting the system should be examined to determine the continuing need for mental health care.

Dr. Villegas recommended further research include larger samples of adults, with placement experiences from private and public foster care programs, to determine the trajectory of their mental health needs over time. She also recommended longitudinal studies with larger samples of foster care alumni with ethnic minority backgrounds who are overrepresented in foster care. In addition, she recommended follow-up studies on the mental health of women with placement experiences, research on the impact of mental health practices and agency models of care on alumni on long-term mental health outcomes, and comparative studies of mental health care for youth in foster programs, including evidence-based models.

Finally, Dr Villegas stated that workers and clinicians need to routinely screen and assess youth at higher risk for mental health problems. She stated that mental health service organizations and professionals should focus on the particular long-term needs of foster care youth and alumni. Mental health service providers should specifically target women with foster care experiences. Access to mental health services for transitioning youth and alumni should be extended past age 21, and transitioning programs should prepare youth to access mental health services and resources after exiting care.

VI. What Do We Know about Organizational Issues in Therapeutic or Treatment Foster Care?

Topic: What Does the Research Tell Us About Organizational Issues Related to the Provision of Therapeutic or Treatment Foster Care?

Presenter: Elizabeth M.Z. Farmer, Ph.D.
Professor, School of Social Work
Virginia Commonwealth University

Dr. Farmer stated that very little is known about the organizational factors of TFC due to the lack of research. However, she noted that in the course of other studies, some useful information has been produced.

Dr. Farmer explained that early in her own research on "usual care" TFC, she discovered a high degree of variability in almost every dimension: the treatment model, who licenses the service, who pays for it, where youth are from when they enter TFC, and where youth go when they leave TFC.

Shortly before she and her colleagues started their research, the Foster Family-based Treatment Association (FFTA) developed standards for TFC. These standards had three subsets: Program Standards, Standards for Treatment Parents, and Standards for Children and Families in TFC. Dr. Farmer and her colleagues examined the degree to which TFC agencies utilized these standards. They created a 104-point scale and found that TFC agencies ranged from 53–91 points on the scale, with an average in the 70s, which indicated significant variability. Dr. Farmer discussed whether it would be possible to determine at what point someone is or is not delivering TFC, based on this scale. She questioned whether a number on the scale could indicate that any score above or below this number would mean that the agency was or was not delivering TFC, respectively.

Dr. Farmer raised other issues in the area of Standards for Treatment Parents and Standards for Children and Families in TFC. She addressed what the treatment team does, what treatment parents do, how to work with children and biological families, and how to work with people from different cultures. In her research, she had hypothesized that these variables would affect outcomes; however, she discovered that they did not. What did affect outcomes was organizational and program standards (e.g., the organizational infrastructure to provide good care), careful documentation, and standardized training and supervision.

Dr. Farmer identified factors that affect outcomes for youth from an organizational perspective, based on her research and research on MTFC. Evidence suggests that treatment foster care parent training is important prior to placement and once the child has been placed in the home, yet there is currently little follow-up training in usual care TFC. She noted, however, that although it is often difficult to find a cost-effective way to do this, MTFC has identified a process. Second, she explained that there is a mismatch between how mental health professionals view treatment parents (as another type of treatment professional) and how the treatment parents view themselves (as akin to a parental substitute). Third, there is the need for quality supervision of the TFC parents. Dr. Farmer found that there is a curvilinear relationship between the level of supervision and its positive effects. Too little contact is not good. Too much contact suggests that either the supervisor did not pay enough attention previously and is now trying to handle a crisis or that the supervisor is micromanaging. However, in the middle range, more contact correlates to better outcomes. Finally, Dr. Farmer highlighted the importance of developing good regulations. She cited the example of North Carolina, where the state rewrote a regulation to require additional supervision and, consequently, levels of TFC supervision increased. She also indicated that an increased focus on writing strong regulations resulted in a more consistent treatment plan development and implementation in North Carolina. Providers do not get paid until there is a treatment plan filed.

Next, Dr. Farmer discussed several organizational-level challenges. First, she addressed the issue of capacity. Parents in TFC programs are individuals who agree to take a child with serious difficulties into their homes. These parents are inherently scarce resources and must be treated as such. Many people have suggested that TFC should be used as a first-time intervention instead of a placement for children who have experienced repeated placement disruptions. Dr. Farmer noted that to use these parents for children new to the system would mean that they would no longer be available for children who have failed, and the system would essentially be "giving up on" those children. It is important to identify the balance in the use of the resource, she said. Another organizational challenge is determining the appropriate number of children in a TFC home. Dr. Farmer stated that it is currently common to see five or six children in a TFC home. Often, the house may also include the parent's biological children or traditional foster care children (in the case of dual licensing). Although there is still some debate over the question of whether one or two youth in a TFC home is best, Dr. Farmer stated that five or six youth in one home is not acceptable.

Dr. Farmer stated that, within the broader context in which TFC agencies operate, there is the issue of interagency competition for foster parents. Many agencies say that they cannot require foster parents to commit to trainings, because doing so will cause the foster parents to go to a different agency with fewer requirements. To retain their foster families, agencies often do not enforce what research recommends. Dr. Farmer stated that there should be a way to reconceptualize these parents as professional employees who have certain training requirements that they must fulfill as part of their responsibility.

Dr. Farmer emphasized the need for better supervision as an important organizational challenge. The focus should be less on administrative issues and more on clinical supervision, which will improve treatment outcomes. There is a need to work with supervisors on creating a supervisory structure and manualized process, because many workers will just chat with the family unless there is a crisis that needs to be addressed. Another organizational consideration is the question of what other resources are available in the community in which the TFC agency operates. How much the agency has to accomplish depends in a large part on what help they can find in the community.

Dr. Farmer also highlighted that TFC is held responsible for treatment outcomes and foster care outcomes, and that it is a difficult task. For example, she suggested that many children in TFC will likely be in their placements for the long term because it is the least restrictive environment in which they can be placed. However, meeting the long-term mental health needs may come at the expense of shorter-term child welfare-mandated time frames.

Dr. Farmer indicated that it is important to clarify the definition of a treatment foster parent, since there is confusion over associating treatment foster parents with foster parents. This confusion is a disservice to the parents in TFC programs and to the field in general because parents' roles as frontline treatment providers are complex and expectations should be clearly delineated. Finally, she stated that financing plays an important role in agencies across the country because many agencies are losing money delivering TFC. It is important to determine how much TFC costs and to reimburse the service appropriately.

Dr. Farmer concluded by stating the need for new regulations that reflect the current state of the knowledge and practice base. While supporting the need for randomized controlled trials, she indicated the importance of examining what works in practice, since randomized controlled trials take a substantial amount of time. She expressed the need for an increased focus on the balance between business and treatment models, to help people in the field learn to provide quality care with limited resources. In addition, she highlighted the need to expand the knowledge base and to understand the organizational factors that support high-quality implementation, including training and supervision models that are effective, assessments of readiness and fit, and understanding the implementation context.

Dr. Farmer stressed that it is important to assess organizations to determine their capabilities. She stated the need for a two-pronged approach that includes learning from evidence and from practice, and then finding a way to bring them together to increase the knowledge base. Finally, she emphasized that TFC and the treatment foster parent role should be renamed and rebranded, in order to set clear expectations and to reflect a focus on the treatment aspects of the service.

Technical Expert Panel Consensus: Knowledge and Implementation

Throughout the technical expert panel meeting presenters and panel members submitted candidate consensus statements by topic area (see Consensus Process, Appendix C) and in response to three overarching questions:

1. *What Does the Research Tell Us About Therapeutic/Treatment Foster Care?*
2. *What Are Recommendations for the Implementation of What We Know?*
3. *What Are Recommendations for Advancing the Knowledge Base?*

This section synthesizes the panel member consensus on the first two questions.[82] Consensus on recommendations for advancing the knowledge base is reported in the following section.[83]

I. What Do We Know About Therapeutic/Treatment Foster Care?

Question 1: What Does the Research Tell Us About Therapeutic/Treatment Foster Care?

Therapeutic/Treatment Foster Care (TFC) is a community-based, less restrictive alternative to more restrictive settings (e.g., group care, psychiatric residential treatment facilities, long-term residential programs). TFC models generally treat seriously emotionally disturbed youth who have a high likelihood of needing more restrictive long-term residential treatment. Many

[82] Editorial Note: The following section synthesizes the results of two rounds of consensus process voting.

[83] See consensus statement voting results in Appendix D to identify the strength of the agreement for each consensus statement.

variations of TFC models exist. TFC plays a different role in states' systems of care depending upon its location in the system (e.g., child welfare, juvenile justice, mental health). States license TFC in different systems for different purposes. The design of TFC programs administered by child welfare agencies may differ significantly from the design of TFC programs administered by mental health agencies.

Youth may be in TFC for medical, behavioral, developmental or justice-related reasons. The placement histories of TFC youth are dictated by the systems (e.g., mental health, juvenile justice, child welfare) in which they are served. Currently the purpose of TFC varies depending on how it is used in the continuum of out-of-home care. TFC needs to be available for youth who need that level of care as an initial placement but also may be used as a step down resource for youth leaving residential treatment.

Relationships matter in the lives of youth. TFC serves a range of youth at risk of more intensive placements and poor life outcomes. While youth in regular foster care may also have high mental health service utilization, many youth need more structure and services than is provided through regular foster care. Youth in TFC are a high service-need group who have a wide range of presenting problems including significant social, emotional and mental health problems. Youth in TFC have high mental health service utilization and for many youth mental health concerns persist until adulthood. Transition-age youth and young adults are at high risk for mental health problems. It is important to have a range of treatment models to address youth with diverse mental health needs. Some youth can benefit from regular foster care kinship placements. The TFC model must fit the youth's diagnostic profile and needs.

Placement disruption is a common event in foster care. Many youth come into TFC after experiencing multiple out-of-home placements. Research indicates that the older the age of youth at entrance into foster care, the higher the number of out-of-home placements experienced and that experiencing multiple placements may compound a youth's problems. The majority of TFC research has focused on these youth.

While it is important to provide trauma-informed services for youth in TFC, it is important to discriminate between traumatic responses to maltreatment, and other mental health conditions affecting youth in TFC. Addressing trauma/stress symptoms and other behavioral health needs of youth can successfully reduce their risk of adverse child welfare outcomes.

There is evidence of the efficacy of TFC for youth in the short and long term. Some models of TFC can be effective. TFC is promising for youth with complex emotional, psychological and behavioral needs. Behavioral health problems in youth may improve through this service.

The research on TFC has concentrated primarily on two models, MTFC and Together Facing the Challenge, both of which are well specified in the existing research. Multidimensional Treatment Foster Care (MTFC) is the original Therapeutic/Treatment Foster Care model. Youth enter MTFC because of behavioral problems or involvement in the juvenile justice system rather than for internalizing problems typically addressed by informed trauma treatment. MTFC has been implemented in child welfare settings, mental health settings, and juvenile justice settings and has indicated effectiveness in producing positive outcomes for youth.

MTFC has been shown to be a cost-effective TFC model; however, the dissemination of the MTFC model is quite limited. Together Facing the Challenge, a modified MTFC model, was developed because it is difficult to implement MTFC in real world settings. Together Facing the Challenge has shown effectiveness in producing positive outcomes for youth.

Both MTFC and Together Facing the Challenge were shown to result in improvements in both youth well-being and permanency outcomes in randomized controlled trials. Youth with serious problems have a better than chance likelihood of improving with either MTFC or Together Facing the Challenge and children with serious problems have a better than chance likelihood of improving with MTFC-preschool.

The research on the MTFC and Together Facing the Challenge models, while well-specified and tested, is not sufficient to provide a full understanding of what is needed, for whom, under what conditions with what outcomes. Most of the research on MTFC and Together Facing the Challenge has been conducted by the developers of the models, and many other models of TFC have not been tested. Pilot studies should be conducted before widespread funding and utilization of TFC.

TFC is a treatment setting yet there is no standard implementation of TFC across child-serving systems or across states. While many TFC agencies are incorporating key components of the Foster Family-based Treatment Association Standards, there is widespread variation in TFC programs' conformity to those Standards.

There is no uniform set of enrollment criteria for TFC. States license TFC in different systems for different purposes. TFC programs vary in implementation readiness and duration. TFC as widely implemented in the United States does not follow established evidence-based practices. TFC programs also vary in cost.

It is important to clarify the distinction between a TFC practice and a TFC model. There is a need for widespread implementation of evidence-based TFC models. However, few agencies are implementing evidence-based TFC models with fidelity, although fidelity to the model leads to improved outcomes for youth. There is a need to adhere to TFC practice standards. A goal is to move from providing generic interventions to different youth to matching specific interventions to specific youth.

Question 2: What Are Recommendations for the Implementation of What We Know?

There is a need for a clear operational definition of TFC that distinguishes between TFC standards of care and TFC model components. TFC needs to follow clear manuals and protocols.

TFC requires multifaceted interventions. The field needs to determine the services that comprise TFC and develop clear standards of practice. There is a need for federal and state regulations that encourage fidelity to basic standards of TFC and a clear process to measure adherence to TFC standards of care.

Placement of a youth should be based on needs. In current practice, youth with a wide range of mental health needs may be placed in either regular foster care or in TFC, not based on need but

on the availability of foster care placement slots. Information from existing regular foster care and TFC practices needs to be analyzed to identify differences between the two. The field needs to identify the target population who benefit from the TFC treatment modality, clarify the criteria for admission of young children into TFC and identify the developmental treatment trajectory that youth in TFC are likely follow. Many states need standardized criteria for TFC enrollment and services.

There is a need to expand the use of best practices in TFC. Higher education training programs for mental health professionals must include education in TFC. MTFC is not available for the vast majority of youth who could benefit from it. The field needs greater uptake of evidence-based TFC programs. TFC interventions require fidelity to a model in order to be successfully implemented. It is essential to correct fidelity drift from a TFC model using a continuous quality improvement process.

The Administration on Children, Youth and Families (ACYF) considers child well-being as important as safety and permanence. Youth well-being should be considered at intake into the child welfare system however there is a need for an operational definition of youth well-being.

It is important to connect TFC youth to supportive, caring adults. The TFC treatment plan must be individualized, address the specific needs of each youth and include preparation for that youth's transition out of child welfare services. The field must consider youth attachment to providers in the transition from TFC and assess alternative permanency supports for TFC youth in case planning, including making TFC available to youth as a treatment option for as long as it is needed. Providing ongoing step-down services to maintain treatment gains is beneficial to TFC youth. It is also critical to match the needs of TFC families with appropriate services. TFC families should be reimbursed at higher rates than regular foster care families. TFC caseworkers' caseloads should be limited to 10-15 youth.

Funding restrictions greatly influence the decisions about which youth will have access to evidence-based TFC. While Medicaid reimbursement is based on medical necessity, the federal definition of medical necessity does not require a DSM diagnosis. There is a need for flexible funding options that promote both youth treatment and youth well-being. Child welfare and juvenile justice systems would save money through greater implementation of evidence-based TFC programs.

II. What Do We Know About Identifying Youth Appropriate for Therapeutic/Treatment Foster Care?

Question 1: What Does the Research Tell Us About Therapeutic/Treatment Foster Care?

Screening instruments, assessment requirements and level of care criteria vary widely in practice and in published research. No one measure meets all needs. Existing assessment measures for youth have limitations; there is a need to improve measures used to assess key youth and family domains. Rather than using a "one size fits all" assessment for youth in foster care, systems serving youth receiving child welfare services should employ an array of assessment tools to

appropriately evaluate the domains of social-emotional well-being for youth and evaluate functioning across age groups.

Measures must be developmentally appropriate. Assessment measures should be selected based on an established set of criteria (e.g., reliability, validity, feasibility). It is also critical to evaluate the sensitivity of measures used in making decisions about treatment intensity. Understanding the limitations of measures used to assess the mental health status of children and youth is important.

Youth entering foster care should receive a functional assessment that includes an assessment of psychological, emotional and substance use status to determine the need for placement in TFC or another intensive intervention. A comprehensive functional assessment (i.e., assessment of youth's day-to-day functioning across TFC domains) is important for determining the appropriate service needs and level of care as well as monitoring the youth's progress while receiving services. It is important to assess issues that precipitated TFC placement (e.g., emotional and psychological health, interpersonal functioning, behavior problems, education, physical health care status and time in treatment).

There is a need for actionable data on TFC youth outcomes. Measures used to assess TFC youth outcomes vary in terms of dimensionality, sensitivity, validity, and reliability. Measurement criteria should be established for all measures used in assessing care outcomes. Measures should provide actionable information (i.e., information that assists in treatment planning and policy decisions). Little attention has been given to the psychometric qualities of the measures used in TFC. Standardized measures do not capture the nuances of a youth's psychological status.

Length of stay in TFC will vary by a youth's diagnostic profile. Young children with attachment problems need a longer-term TFC model. MTFC, a model focused on changing behavior, is most appropriate for youth with conduct disorder.

Question 2: What Are Recommendations for the Implementation of What We Know?

The field needs to better understand how to identify youth who are appropriate for TFC. Placement and treatment decisions would be improved by having a documented connection between screening and assessment tools and treatment needs.

Measures of youth functioning and symptomatology are one component of the decisionmaking process in determining whether a youth may benefit from TFC. Assessment must include measures of trauma symptoms and experiences. The field also needs measures that are sensitive to racially, ethnically and culturally diverse youth populations using items that are reviewed in terms of cultural sensitivity.

It is important to operationally define a functional assessment. TFC placement decisions should be based on a functional assessment of the youth, and funders should require at least one functional assessment as part of determining assignment to the TFC level of care. Measurement items must encompass the range from mild to serious impairment so that a youth's treatment needs can be accurately identified using measures that assess real world functioning of youth as well as symptomatology.

There is a need for knowledgeable clinicians to interpret standardized assessment data. Both individual items as well as assessment measure sub-scores and total scores can be useful in placement planning. The field knows very little about the quality of measures for specific populations. There is a need for different measures to determine placement for different youth populations. The limitations of measures and tools should be considered in determining the level of care for TFC.

In practice, the placement of some youth in TFC may be a business decision rather than a clinical decision. It is important to sort out the influence of the business component versus the youth's needs when conducting assessments for placement in TFC. Assignment to TFC must be based on the youth's needs independent of the referral source.

A validated assessment tool and regular re-assessments must inform the development and updating of the youth's TFC treatment plan. Staff consensus is not a substitute for sound empirical measurement which should inform all changes in placements. There is a need for multiple measures to be available for TFC providers and clinicians.

The field needs assessment measures that are sensitive to change in youth over time. Measures developed for assessing appropriate level of care at intake should not be assumed to be adequate measures of outcomes. Strengths based assessments may overlook important considerations in assessing improvement.

Measures that inform practice have greater utility. Funding should not drive the decision to adopt specific measurement instruments. Assessment measures and tools should be free or open source. The field should not employ measures simply because they are included in existing management information systems (MIS). Functional assessments and psycho-diagnostic evaluations of youth in TFC should be reimbursable.

The field needs to develop fidelity measures of TFC model implementation. TFC measures should be scientifically sound and assure that TFC fidelity measures have established validity. Measuring the level of fidelity to TFC models is essential in evaluating TFC's contribution to youth outcomes.

In setting standards for funders, it is important to distinguish case level measures versus program evaluation measures. Child and Family Services Reviews (CFSRs) and other evaluative tools should be adapted to better reflect the needs of sub-populations of youth, especially those youth, such as TFC youth, with high-service needs.

Cost is a component that should be included in evaluating the quality of TFC. The field does not know the cost-effectiveness of TFC services thus there is a need to study the cost-effectiveness of different approaches and models.

III. What Do We Know About the Essential Elements of Therapeutic/Treatment Foster Care?

Question 1: What Does the Research Tell Us About Therapeutic/Treatment Foster Care?

It is important to identify the essential elements of Therapeutic/Treatment Foster Care (TFC). There are some essential elements in TFC that need to be consistent across models. They include:[84]

- demonstrating the TFC agency's ability to support treatment foster parents,
- including TFC parents as members of the treatment team,
- assuring reduced caseloads for staff supporting TFC parents,
- investing in TFC parents,
- assuring the TFC agency's ability to supervise treatment foster parents,
- providing specialized training to TFC parents,
- monitoring the behavior of TFC youth,
- establishing therapeutic alliance between TFC foster parents and the youth in their care,
- providing 24/7 support/coaching to treatment foster parents,
- providing appropriate aftercare resources for youth,
- providing older youth in TFC with preparation and training for adulthood,
- coordinating services for everyone involved in the TFC treatment plan,
- monitoring the use of psychotropic medications for TFC youth,
- assuring that treatment foster parents are able to meet the psychosocial needs of youth in their care,
- supporting and engaging the family to whom the TFC youth will go following TFC,
- providing individual mental health treatment for TFC youth,
- conducting service planning for youth in TFC,
- providing academic support for TFC youth,
- providing social skills training for youth in TFC,
- providing 24/7supervision to TFC foster parents,
- scheduling regularly held clinical supervision for TFC staff to assure their effective working relationship with TFC parents,
- maintaining treatment foster homes with professional treatment parents,
- involving birth or biological parent(s) in treatment planning and implementation,
- providing higher reimbursement rates for TFC parents, and
- bundling of TFC services.

TFC models often employ some but not all of the TFC essential elements. Typical TFC practice does not adhere to the principles of the essential elements in MTFC. The essential elements of TFC have not been identified through randomized controlled trials. The field is currently limited in its knowledge of the relationship between race, ethnicity and culture and the essential

[84] The following essential elements are listed in rank order according to the consensus voting.

elements of TFC. Given the state of research knowledge on TFC, it is premature to consider any list of essential elements as the standard for funding a TFC program.

Although not elements per se, there are other important considerations. There should be flexibility in the definition of an aftercare resource depending on the TFC youth's permanency plan (e.g., adoption, reunification, independent living, emancipation). Allowing some youth to remain in TFC into early adulthood is essential to achieve lasting treatment outcomes.

It is important to assure that there is a match between youth needs and treatment foster parent ability or placements may fail. Child trauma is an underlying issue for many of the youth who may benefit from TFC. There is a need to assure that therapists working with TFC youth are competent in therapeutic modalities (e.g., individual and family therapy) and are competent in addressing intergenerational trauma through trauma-informed treatment. Higher education institutions must prepare behavioral health students to work in TFC programs. There is a need to identify the credentialing requirements and professional expertise of mental health professionals who work in TFC. Therapists working with TFC youth should also be compensated for delivering care management services.

Addressing length of stay is also important. Length of stay in TFC may be driven by the TFC model's theory of change. Many funded TFC programs do not have limits on length of stay. It is essential that TFC models estimate the intended length of stay from the outset. The clinical judgment of the treatment team should determine the appropriateness of length of placement in TFC for youth. TFC may be a long-term placement option.

Question 2: What Are Recommendations for the Implementation of What We Know?

It is important to keep youth in the community in as normal a setting as possible. TFC needs to be designed to serve youth, regardless of custody status. TFC should link with a youth's biological family or other designated post-discharge caregiver; however, eligibility for TFC should not be based on having a pre-determined post-discharge caregiver. The TFC model should also include genuine engagement of the TFC parents and the youth. TFC should not mix TFC youth with regular foster care youth within the same home. TFC parents should be reimbursed at a rate that enables one parent to be in the home at all times.

TFC parents and providers should work with supportive aftercare resources to connect the youth to the community. The Parent Daily Report is a validated assessment tool that can monitor caregiver and youth well-being. In addition to identifying a youth's problematic behaviors the Parent Daily Report should capture what is going well for the TFC youth as well as what is being done to reinforce prosocial behaviors in TFC youth.

There is a need for a more widespread uptake of TFC programs that contain the identified essential elements. Funding must support evidence-based, trauma-informed TFC. It is crucial to sort out how to integrate the TFC resource demands within the context of financial redesign and privatization models that are being developed in various states.

IV. What Do We Know about the Psychosocial Treatment of Youth in Therapeutic/Treatment Foster Care?

Question 1: What Does the Research Tell Us About Therapeutic/Treatment Foster Care?

The field knows little about mental health outcomes for youth currently served by TFC. There is little information about psychosocial treatment of children (age 8 and younger) in TFC. MTFC is the only TFC program that has demonstrated efficacy over a range of important outcomes.

Service coordination alone is unlikely to generate improved youth behavior. TFC youth receive services from a wide range of providers and need access to an array of high quality services from the child serving agencies. Psychosocial treatment of TFC youth should also include the biological parents when they are available. Clinicians must be trained in appropriate evidence-based practices.

Question 2: What Are Recommendations for the Implementation of What We Know?

Youth in TFC should receive behavioral health care that is evidence-based. Mental health therapy should be included as part of any TFC model, should be tailored to the treatment goals of each TFC youth and should be embedded in the TFC model rather than referring TFC youth out for mental health treatment. TFC therapists need to coordinate care. In TFC, one well-trained, informed staff member on each youth's team should coordinate the mental health treatment care delivered by all other providers and all ancillary services. The TFC treatment team must have a coordinator who has skill in coaching treatment foster parents to help improve TFC youth's behavior. TFC must be youth-centered and meet the individual needs of each youth.

There is a need to monitor progress for both reduced symptoms and improved youth functioning. When a foster home placement fails, the youth's mental health needs should be reevaluated. Decisions regarding re-placement following a placement disruption should reflect the youth's psychosocial needs. To maintain treatment gains, there is a need to extend access to long-term mental health services for TFC alumni. Mental health therapists embedded within the TFC team should be funded at the same reimbursement rates as comparable mental health practitioners.

Reimbursement approaches need to support the range of auxiliary services that TFC youth need. While there is a need to identify the TFC components billable to health insurance, reimbursing TFC as a bundled service should be considered. Carefully designed TFC has the opportunity for cost-effectiveness.

V. What Do We Know about Outcomes for Youth in Therapeutic/Treatment Foster Care?

Question 1: What Does the Research Tell Us About Therapeutic/Treatment Foster Care?

Existing studies demonstrate positive outcomes for TFC including improving mental health outcomes for youth in this level of care. Short-term outcomes are consistently improved in the efficacy trials for the clearly articulated TFC models for populations tested thus far; however, TFC programs vary in effect sizes for outcomes.

MTFC is an effective model for preventing placement disruptions, with some evidence of fewer placement disruptions for TFC youth versus regular foster care youth. MTFC is most effective for youth with severe behavioral problems.

Randomized controlled trials of MTFC have demonstrated:

- improved child welfare outcomes for TFC youth;
- improved mental health outcomes for TFC youth, including youth with severe behavioral problems, who have better outcomes from MTFC than from regular foster care;
- improved juvenile justice outcomes, including reduced recidivism for males and females in the juvenile justice system, for TFC youth;
- improved substance abuse outcomes for TFC youth with one study showing that MTFC youth had significantly lower levels of marijuana or other drug use than group care youth; and
- improved outcomes for crossover youth (i.e., youth who are involved in both the child welfare and the juvenile justice systems).

The MTFC-preschool model provides strong evidence for improving children's behavior, including evidence of changing children's cortisol levels and changing children's executive functioning. Randomized controlled trials of Together Facing the Challenge have demonstrated improved mental health outcomes for TFC youth.

TFC shows greater improvements than regular foster care over time for girls. TFC has the potential to significantly reduce juvenile justice involvement and has been shown to reduce recidivism in females in the juvenile justice system however variability in adherence to existing TFC standards affects TFC youth outcomes. There is very little research on substance abuse outcomes in TFC.

Question 2: What Are Recommendations for the Implementation of What We Know?

TFC should be designed to address the needs of youth across the developmental range. The field also needs to focus on services that improve outcomes for transition-age youth in TFC. The field needs to monitor youth well-being on a regular basis following TFC placement. Youth behavioral health functioning should be measured as a TFC outcome.

TFC outcomes have been studied for only a small number of the sub-populations of youth in TFC. The field should be cautious when implementing TFC for youth under-represented in research studies. Variations in child-rearing practices among racial, ethnic and cultural subgroups may have significant effects on the TFC practice model and outcomes for subgroups of youth (e.g., Hmong, Native American).

While therapeutic alliance is an important predictor of change in TFC youth outcomes, other factors in addition to therapeutic alliance may also be important predictors of change in outcomes for TFC youth. It is important to assess TFC youth outcomes in terms of real life activities or life skills that optimize the transition to adulthood. The field needs to collect data on

a relevant range of outcomes for youth in TFC. Developing strategies for holding TFC providers accountable to youth-level outcomes is an important priority.

Outcomes for youth in both the juvenile justice and child welfare systems would improve with greater implementation of evidence-based TFC programs. MTFC is more cost-effective than group care. Given its strong evidence base, certification process and manualization, MTFC is an excellent candidate for bundled reimbursement.

VI. What Do We Know about Organizational Issues in Therapeutic/Treatment Foster Care?

Question 1: What Does the Research Tell Us About Therapeutic/Treatment Foster Care?

The field has a limited understanding of TFC organizational issues due to a limited empirical base. TFC agency organizational factors are important in shaping outcomes of youth in TFC. The field needs to attend to how TFC is operationalized in practice.

There is a need for nationwide uniform TFC standards that differentiate regular foster care from TFC. The field needs to develop level of care criteria for clinical decisionmaking. TFC programs and each TFC component need to be manualized to assure treatment fidelity. Variability in adherence to TFC standards affects the identity of TFC in the field.

The field must define the selection criteria for TFC parents/families. The supervision of treatment foster parents must address the youth's needs. TFC parents see themselves as substitute parents. Providing on-going training for treatment foster parents after the initial implementation of the TFC model is very important.

Currently reimbursement for TFC is insufficient to provide essential services. Reimbursement levels and designs should be informed by level-of-care criteria.

Question 2: What Are Recommendations for the Implementation of What We Know?

Implementation of TFC may be affected by both policy and personnel issues. TFC implementation must address organizational factors that determine whether providers maintain fidelity to a TFC model. Developing the human capital resources of both TFC parents and program staff is an important priority. TFC parents see themselves as substitute parents; however, TFC parents should be considered as professionals/employees and be identified using a more appropriate title. TFC regulations on training should reflect the current state of the knowledge base. TFC agency management needs to provide support and coaching sessions to assist staff in effectively working with TFC foster parents, as well as provide systematic training for TFC supervisors.

There is a need to clarify which child serving agency/agencies should be responsible for placing youth in TFC. SAMHSA and the Children's Bureau should provide training, technical assistance and on-going support for evidence-based, youth-focused mental health interventions. SAMHSA should assure that those interventions are delivered with fidelity to the model. There is a need

for implementation strategies that encourage the development of regional resources to assure MTFC fidelity.

The field should develop clear measures of best practices in TFC. Currently the number of children in a TFC home is variable. Regulations regarding supervision and number of youth per TFC home need to reflect the current state of the knowledge base. There is a need to develop TFC discharge criteria and a need for quality assurance to monitor TFC model fidelity.

Collaborative partnerships should be developed between researchers and practitioners across TFC models to better understand the TFC theory of change.

The field needs to integrate research findings across child-serving agencies to assure effective out-of-home care practices. The field needs a vehicle for disseminating generic information about the implementation of TFC. Interaction with community leaders is essential to developing TFC for racially, ethnically and culturally diverse youth. There is also a need to maintain cultural humility when implementing TFC in a community. Additionally, there is a need for more careful designation of TFC youth in the Statewide Automated Child Welfare Information Systems database.

Effective TFC is expensive. There is a need to clarify how to determine the responsibility for funding a TFC placement. The field needs to accept the cost of implementing TFC well. Reimbursement rates need to reflect the additional requirements of TFC. Without adequate funding, it is impossible to fully implement evidence-based practices. TFC may lend itself to blending funding across two or more child-serving agencies.

Technical Expert Panel Consensus: Advancing the Knowledge Base

This section synthesizes the technical expert panel consensus on advancing the knowledge base on services for children in therapeutic/treatment foster care with behavioral health issues.

I. What Do We Know About Therapeutic/Treatment Foster Care?

Question 3: What Are Recommendations for Advancing the Knowledge Base?

There is a need to study the efficacy and effectiveness of TFC in a number of areas including TFC as an initial out-of-home placement, trauma-informed interventions in TFC, and approaches to step-down care following TFC. There is also a need to study the main causes of TFC placement disruption.

The field needs funding to support short- and long-term research on TFC youth and TFC alumni. There is a need for more research on child welfare system-involved youth in TFC, on the efficacy of TFC for Native American youth and on how TFC works for different racial, ethnic and cultural youth populations in order to implement it in real world practice. Researchers should assure racially, ethnically and culturally diverse representative samples of youth currently in TFC and the disaggregation of outcomes associated with TFC by racially, ethnically and culturally diverse groups of youth. The field needs funding support for research on racially, ethnically and culturally diverse youth in TFC. TFC models may require model adaptation for

racially, ethnically or culturally diverse populations. The field also should study whether the models of TFC are appropriate for medically fragile youth.

There is a need for more research on the effectiveness of the types of TFC currently in use nationwide and on short- and long-term outcomes of currently implemented TFC programs. The field lacks research about which youth will do well in TFC, thus there is a need to increase knowledge of who benefits from what models of TFC, under what conditions. There is a need to study how TFC builds resilience in youth. The gap in TFC effectiveness research could be a barrier to TFC implementation.

The field should conduct propensity studies of TFC practices that have evidence of good outcomes in real world settings. It is important to move promising models of TFC with good outcomes in real world settings to rigorous randomized controlled trial testing.

The field lacks research about the impact of the individual components of aggregated TFC models such as MTFC. Researchers should study which components of TFC models predict desirable outcomes for the family of the youth in TFC.

There is a need for studies on specific aspects of TFC including to what extent biological/birth family parent involvement contributes to TFC youth outcomes, prior youth and family service use history and its impact on TFC outcomes, the trajectory of service needs of youth in TFC and post TFC placement, how outcomes differ for youth who are referred to TFC from different child-serving agencies (e.g., child welfare, juvenile justice, mental health) and the sustainability of TFC programs.

The field needs rigorous research in order to increase the power of the results and improve generalizability of TFC findings. The field should use both qualitative and quantitative research methods to determine the efficacy of TFC. Randomized controlled trials, the accepted standard of measuring treatment efficacy, should be conducted on manualized TFC models. Research on TFC needs to include variables for the provider and system characteristics that impact the services provided. Randomized controlled trials, comparative effectiveness research and real time program evaluation of TFC models should be used to study TFC across diverse regions of the United States.

Quasi-experimental research when done with methodological rigor can contribute to the knowledge base on TFC. The samples of youth in TFC studies currently represent only specific segment(s) of the out-of-home placement population. Currently MTFC model trials have small numbers in homogenous samples. There is a need for both short- term and long-term research of TFC youth with larger sample sizes. The field needs to better understand how sample selection (e.g., youth history, characteristics, connection to community) affects outcomes of youth in TFC research. There is a need to clarify appropriate comparison groups for studies of TFC. The field needs researchers with the ability to successfully implement studies of TFC with representative samples of TFC youth. There is a need to publish research on TFC models.

There is a need for studies of different theoretical approaches to TFC and how well mature TFC programs are implemented with fidelity to the model. The field needs to determine the impact of TFC model fidelity on meeting performance standards and how it impacts outcomes of TFC

programs that already show promise as an evidence-based practice. The field should implement the two currently tested TFC models with fidelity checks to ensure each model's ability to produce long-term positive outcomes. There is a need for more research on the fidelity of TFC models with racially, ethnically and culturally diverse populations.

There is a need for information on problem-based interventions for youth in TFC and a need to use practice-based evidence to add context to what is known about TFC. Large private TFC providers' in-house researchers have significant unpublished research that could benefit the field; thus, they should be included in the conversation about necessary research. There is a need to fund studies of TFC using secondary analysis of administrative data from TFC providers.

Research should be conducted on the business aspects of TFC including causes of turnover of therapists/staff in TFC, the costs of TFC, cost-effective ways of providing TFC to youth prior to youth experiencing multiple other placements, as well as an evaluation of cost-effectiveness of TFC. Medicaid should not base reimbursement decisions on findings from research on only two TFC models.

II. What Do We Know About Identifying Youth Appropriate for Therapeutic/Treatment Foster Care?

Question 3: What Are Recommendations for Advancing the Knowledge Base?

There is a need for research to identify best practices for assessing youth entering TFC. The field needs to develop scientifically sound, comprehensive measures to establish criteria for appropriate levels of out-of-home care and to continue refining the psychometric properties of assessment tools to improve referral to appropriate therapeutic interventions. It is also important to study the sensitivity of measures that are used to assess the progress of youth in TFC.

There is a need to establish relative importance of assessment components used in TFC (e.g., symptomatology versus functioning). Person or item fit data can be valuable. Measures of therapeutic alliance between TFC caregivers and youth need to be developed and tested. There is a need to develop tools to assess the strengths and needs of biological families of youth entering TFC. There is also a need to develop better screening to identify TFC parents who will fully participate in the treatment team. Multiple scientifically sound, comprehensive measures are needed to assess the outcomes of care. There is a need for studies that identify the relative contributions of the TFC system, parents and youth to outcomes.

The field needs to develop valid, reliable and comprehensive outcome measures for TFC. More research is needed on the quality of TFC fidelity measures and on whether existing TFC fidelity measures are generalizable to all TFC treatment sites. The field needs a consistent measurement approach to assess the fidelity to TFC models. Idiosyncratic changes and tweaks to measures compromise the ability to compare information. There is a need for additional public funding for measure development.

III. What Do We Know About the Essential Elements of Therapeutic/Treatment Foster Care?

Question 3: What Are Recommendations for Advancing the Knowledge Base?

There is a need to develop a research framework to study TFC. Existing TFC research is not sufficient to provide a full understanding of the TFC elements that contribute to outcomes. There is a need to study the relative contribution and the direct and indirect contribution of each essential element (e.g., 24/7 support for TFC parents) on outcomes for TFC youth as well as study whether every TFC model must employ all essential elements.

Further research is needed on essential TFC elements that promote effective transitions for TFC youth between levels of care. There is a need to determine the essential elements that must be provided by the TFC parent(s) and to further investigate how race, ethnicity and culture impact the essential elements of TFC care. There is a need for research to determine the needs of young people who remain in TFC until age 26 and how well states address these needs.

Implementation science paradigms must inform the evaluation of TFC implementation. It is important to have input from TFC youth, TFC parents, the biological family and the TFC clinician into the evaluation of TFC. There is a need to determine the impact of length of stay limits in TFC.

Currently research has only studied bundled TFC models. There is a need to clearly define the tested models of TFC in research studies and conduct more research on both the short- and long-term effectiveness of TFC, as well as more research on a tiered level model of TFC.

There is a need to study which aftercare resources (e.g., bio/adoptive parent or community caring supportive adults) are most effective for TFC youth under which particular permanency discharge option (e.g., reunification, emancipation). Research linking organizational characteristics, TFC treatment model, other implementation factors and outcomes will help the field better understand which TFC models can be implemented in which settings. The field needs to research solutions to implementation issues related to access to TFC for rural populations.

There is a need to fund TFC implementation studies and conduct research on less costly versions of TFC as well as further research on the use of technology in TFC to improve fidelity monitoring and cost-effectiveness. There is a need for more cost-effectiveness research on TFC especially for non-juvenile justice populations. There is a need for comparative cross-national studies of TFC.

IV. What Do We Know About the Psychosocial Treatment of Youth in Therapeutic/Treatment Foster Care?

Question 3: What Are Recommendations for Advancing the Knowledge Base?

There is a need for more research on the mental health and other service needs of TFC youth. There is a need to identify specific mental health disorders that can effectively be addressed within the context of TFC and to identify the most effective array of mental health services for youth in TFC. Research in TFC needs to specify the types and amounts of mental health services that youth in TFC study samples are receiving and study patterns of service utilization for young children (birth–3), children (ages 4–12) and for youth (age 13 and older) in TFC. The field needs to study the long-term mental health outcomes of TFC intervention models for youth in

state custody. There is a need for more research on the effects of TFC parents' engagement in TFC youth's mental health treatment.

It is necessary to better understand the variations that exist in the TFC models. There is a need to compare TFC to other types of 24-hour care in real world settings and to use common definitions of levels of out-of-home care in this research. There is a need for research on the appropriate length of stay for youth in residential care and how residential facilities identify community resources at intake for the purpose of an appropriate transfer of the youth back to the community. There is a need for more research on trauma-informed models of TFC and how trauma-informed treatment affects the developmental trajectory of youth. There is a need to understand the relative contribution of behavioral consultation to TFC foster parents on youth outcomes. Research should inform the minimum education and training levels of staff needed to implement TFC programs with fidelity.

The organization of TFC providers, the Foster Family-based Treatment Association (FFTA) should be involved in evaluating TFC. Their studies could contribute to the knowledge base on evidence-based practice in TFC. In addition, there should be a similar consensus process for in-house researchers and providers of TFC.

Given the limited knowledge on the state of treatment foster care nationally, researchers should explore the possibility of extracting national level data on treatment foster care from the Chapin Hall Multi-State Child Welfare data archive as well as the possibility of extracting national level data on treatment foster care from the National Survey of Child and Adolescent Well-Being.

V. What Do We Know About Outcomes for Youth in Therapeutic/Treatment Foster Care?

Question 3: What Are Recommendations for Advancing the Knowledge Base?

The field needs to look beyond safety and permanency and focus on well-being outcomes for youth in TFC. Comparative effectiveness studies should be conducted on evidence-based models of mental health treatment for foster care youth. There is also a need for follow-up studies of mental health outcomes of former TFC youth by gender.

Evaluation of wide scale implementation of evidence-based TFC practices should be conducted to assess outcomes, sustainability, and fidelity to the models. There is a need for more studies of TFC across a variety of settings and sub-populations. TFC outcomes should be clearly differentiated from outcomes of regular foster care and should be compared with appropriately matched samples of youth in more restrictive treatment settings (e.g., group care, psychiatric residential treatment facilities, residential treatment).

There is a need for research on ways to assess readiness and fit of both youth and TFC parents so that these factors may be examined in relation to outcomes. Alternative permanency supports (e.g., connections to caring, supportive adults) should be a variable in TFC outcome measurement. It is also important to understand the relative contribution of ancillary services (e.g., wraparound, recovery supports, prosocial skills development) on outcomes for TFC youth.

There is a need to study outcomes for youth in kinship TFC versus non-kinship TFC and a need to determine which characteristics of TFC youth mediate/moderate positive outcomes. Additional studies should be conducted on the effects of TFC on youth substance use disorder outcomes as well as on specific TFC outcomes across genders. It is also important to conduct retrospective research on adults who were in regular foster care versus TFC.

The field needs research on the connection between short-term and long-term well-being outcomes for TFC youth and a need to learn more about why TFC services do not work for specific youth. There is a need for concurrent randomized trials and field-based studies on TFC best practice models as well as a need to use varied research designs beyond randomized controlled trials in studying TFC outcomes.

There is a need for more research on how TFC improves outcomes and a need to determine if promising TFC outcomes can be replicated with other diverse populations in diverse geographic locations. There is a need for more research on the applicability of MTFC for Native Americans and a need for longitudinal studies with larger samples of racial, ethnic and cultural minority TFC alumni.

There is a need to study the most effective methods of taking a TFC intervention to scale as well as why TFC implementation fails. Unevaluated models of TFC may have data that could inform the question of TFC efficacy. There are outcomes data available from large TFC providers on outcomes for youth who have completed TFC programs that could inform the understanding of this intervention.

More randomized controlled trials of MTFC should be supported because of the limited sample size and limited outcomes in existing studies. Randomized controlled trials should provide supports to participating agencies to enable them to address random assignment requirements in research.

Research should be conducted on cost-savings for child welfare youth in TFC versus other placement settings and a need for cost-effectiveness studies of TFC that incorporate a range of outcomes measures beyond the cost to child-serving agencies (e.g., child welfare, juvenile justice, mental health). There is a need for a paper describing the current practices in foster care (e.g., regular foster care, Together Facing the Challenge, MTFC, KEEP).

VI. What Do We Know about Organizational Issues in Therapeutic/Treatment Foster Care?

Question 3: What Are Recommendations for Advancing the Knowledge Base?

The field needs research on barriers to implementing TFC programs and studies on the influence of business practices on treatment aspects of TFC models. There is also a need for research on the organizational structure needed to sustain TFC, the essential organizational components that influence youth outcomes in TFC and research to determine the appropriate models and reimbursement rates for TFC.

There is a need for more research on the common elements and components of clinical supervision in TFC. The field needs research on what types of out-of-home care are working in

practice and how usual care TFC agencies are organized/operating. There is need to study the causes of turnover in TFC families and to identify the common elements of optimal, effective training and supervision models for TFC parents and providers. The field needs studies to determine the optimal number of youth in a TFC home. There is a need to evaluate TFC models based on the existing evidence base and practice. The field needs to study how to avoid unintended consequences of providing access to TFC only through a specific agency or funding mechanism.

Conclusions

Research and experience demonstrate that 20 percent of American youth have a diagnosable mental disorder and 10 percent have a disorder that is serious enough to affect functioning at the home, school, and within the community. Through the evolution of policy and practice over the past 50 years, there has been an increasing emphasis on serving these youth in home or home-like, community-based settings. Whether youth first present to the child welfare, juvenile justice, or mental health system, they share a common need for state-of-the-art behavioral health treatment, continuing care, and community supports to maximize their full potential. Yet, even in the face of scientific breakthroughs and a 25-year focused effort to develop comprehensive community-based systems of care, the field is still challenged with questions about the most effective interventions for these youth and their families.

To address an aspect of developing a good and modern treatment and recovery system for youth, SAMHSA, CMS, and ACYF convened a technical expert panel to identify what the research indicates about services for children with behavioral health issues who are in TFC. Through participation in a panel and consensus process, 16 national content experts identified key findings on TFC, actions to be taken, and the next set of questions to address.

There was consensus in many areas. Although they acknowledged a significant lack of research on all aspects of TFC, participants focused on what is known. Through the consensus process, the panel clearly defined TFC as a community-based, less-restrictive alternative to more restrictive settings such as group care, psychiatric residential treatment facilities, and long-term residential programs. They clarified that TFC models generally treat seriously emotionally disturbed youth who have a high likelihood of needing more restrictive long-term residential treatment. Youth in TFC may enter from the child welfare, juvenile justice, or the mental health systems.

Although there are established TFC models, much informal variation exists in implementation. However, it is possible to identify essential elements of TFC. While assuring adherence to these requirements, TFC models must also include a focus on best practices for culturally relevant care for racially, ethnically, linguistically, sexually, and culturally diverse populations. TFC models must also be able to address the youth's challenges, including traumatic life events and placement disruption.

Participants concurred that there is a need for level-of-care criteria for all out-of-home mental health care that includes TFC. There is also need for an array of accurate, sensitive measures to screen and assess youth to inform level-of-care placement decisions.

The group also agreed that organizational and financing issues significantly influence the TFC delivery. Standards should be enforced at state and federal levels. Provider agencies should ensure the ability to train and clinically supervise agency staff members and parents in TFC programs. There is a need for federal and state child-serving agencies to clarify oversight and responsibility for financing TFC. The cost effectiveness of TFC should be examined by comparing it to more restrictive mental health placements rather than to regular foster care.

Although there was significant agreement on these and many other issues, the panel generated a robust research agenda responding to the pervasive theme of inadequate research and evaluation of TFC. Participants agreed on the need for extensive research to provide more insight into developing specific level-of-care criteria for out-of-home mental health care as well as to identify which youth benefit most from TFC and under which conditions.

Additional studies are needed on evidence-based TFC models by testing them with different populations and in varied geographic settings. Promising practices should be rigorously examined to move the field forward, incorporating the most recent knowledge in science and technology. All research on TFC must produce actionable data that can be used to examine the influence of clinical and organizational factors on youth outcomes in order to inform future TFC implementation. Health services research should identify organizational factors and financial arrangements that optimize TFC.

Throughout the consensus process, participants stressed using what is currently known about TFC—assuring accountability for best practices and providing adequate on-going support, while continuing to encourage more clarity about TFC by reviewing administrative practices and expanding the knowledge base. The combination of the panel's best thinking and extensive experience has provided insight into an aspect of the development of a good and modern treatment and recovery system for youth with behavioral health issues. Work lies ahead.

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Contributors

The Therapeutic/Treatment Foster Care Technical Expert Panel Planning Committee consisted of Larke Huang, Ph.D.; Jean Close, M.A.; Clare Anderson, MSW, LICSW; Kelley Smith, Ph.D., MSW; David DeVoursney, MPP; Rebecca Flatow, J.D., MSSW; Nadia Sexton, Ph.D.; Kara Ker, MSW, LCSW-C; Paul DiLorenzo, ACSW, MLSP; Sam Schildhaus, Ph.D.; and Doreen Cavanaugh, Ph.D.

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