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TREATMENT FOSTER CARE: A COST-EFFECTIVE STRATEGY FOR TREATMENT OF CHILDREN WITH EMOTIONAL, BEHAVIORAL OR MEDICAL NEEDS

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- Executive Summary

Child welfare and mental health systems today are under extraordinary pressure to do more with less. The foster care population in the U.S. has grown by one-third since 1990. More than a half million children currently are placed—nearly 100,000 in group care facilities. Equally troubling, the relative proportion of foster children with serious mental health problems also has grown in recent years. This group presents the greatest challenges to care givers and the highest costs to taxpayers—both now and in their future.

Traditional foster care does not meet the needs of our most troubled children. Facility-based treatment—while essential for youth who cannot be managed safely in a community—offers too little effect at too great a cost when other less restrictive options can be employed.

Therapeutic or Treatment Foster Care (TFC) bridges the service gap for substantial numbers of youth whose needs fall between the capacities of regular foster care and residential treatment. The model has proven more effective than regular foster care and at least as effective as facility-based group care in meeting the treatment needs of many in this population. TFC costs are much lower than group care costs and are economical compared to the true costs of traditional foster care for our most troubled youth.

Treatment foster care has been an enormous help to states and localities facing hard financial decisions. Effective and cost-efficient, TFC is a key component in our child welfare and mental health systems. Research supports both the *efficacy* and the *economy* of the model.



TFC Efficacy

- TFC serves very troubled children and youth similar to those served in more restrictive group settings with equal or better outcomes.
- TFC provides greater placement stability than regular foster care, reducing the rate of placement disruptions by 20 to 30% over regular foster care despite serving a more challenging population.
- For delinquent youth, TFC has reduced runaways, delinquent peer associations and recidivism as much as half, compared to group care.
- TFC is better structured than either facility-based programs or regular foster care to promote permanence for our most troubled youth.

TFC Economy

- TFC serves youth typically placed in group care at half the cost or less.
- TFC can prevent or shorten costly residential placement.
- TFC compares favorably to traditional foster care when all costs and outcomes are considered.

TREATMENT FOSTER CARE: COMBINING EFFICACY AND ECONOMY

Background

More than a half million children currently reside in out-of-home placements in the U.S., with more than a quarter million entering care each year (U.S. DHHS, 2003). The rate of increase over the past three decades has far outstripped the rate of population growth in this country, placing extraordinary stress on local child welfare and mental health systems (U.S. DHHS, 1999a; U.S. DHHS, 2003). As the number of children in care has grown, the number of foster homes nationally has declined (Chipungu & Bent-Goodley, 2004). The proportion of children in foster care with significant mental health problems has expanded even as the total number of children in care has increased (Kortenkamp & Ehrle, 2002; Leslie et al, 2000). These children are the most likely to experience disruption of their placements in foster and adoptive homes and as a group represent the bulk of youth placed in more restrictive forms of care (Barth & Miller, 2000; Fanshel & Shinn, 1978; Festinger, 2001; Pardeck, 1982). Of the 542,000 children in out-of-home care in September of 2001, 18% - nearly 100,000 - were placed in group care settings (U.S. DHHS, 2003) at a cost two to three times higher than treatment foster care (Barth, 2002).

What Is TFC?

Treatment foster care was developed as an alternative to facility-based group care and is considered the least restrictive form of out-of-home treatment and care for troubled children at risk of or returning from residential placement (U.S. DHHS, 1999b). Despite specific variations in practice, the model characteristically combines elements of foster family care and residential treatment (Bryant, 1980; Hawkins et al, 1985; Meadowcroft, 1989; Stroul, 1989). In doing so, it offers many of the advantages of both forms of care while eliminating or minimizing the limitations of each. Foster family-based, TFC offers a more normalizing



living environment and real opportunities for permanence as compared to group care settings. Treatment oriented and more intensively staffed than traditional foster care, TFC provides greater placement stability to troubled children and addresses their individual needs more effectively.

In TFC, professional support is wrapped around care givers to maximize the family's effectiveness and the child's gains. Such supports include intensive preservice and ongoing skill training, careful child-family matching before placement, around the clock crisis intervention services, and planned and emergency respite care. Case managers with low caseloads offer frequent face-to-face consultation to TFC care givers for individualized problem-solving and in-home treatment planning. Because TFC children require exceptional levels of skill, time and supervision, the number of unrelated children placed per home is limited, while care giver payment is high enough to cover children's needs and additional care giver responsibilities (Foster Family-based Treatment Association, 1995; Meadowcroft, 1989; Snodgrass & Bryant, 1989; Stroul, 1989). Together, such supports have been shown to help minimize placement disruption and care giver burnout (Burns et al, 1999; Chamberlain, et al, 1992; Cooper, Peterson & Meier, 1987; dosReis et al, 2001; Dore, 1999; Fisher, et al, 2000; Testa, 2004).

Treatment Foster Care: Efficacy

Youth Served. Studies of TFC client characteristics show that the model serves children and youth with serious emotional and behavior problems who have experienced significant abuse or neglect and multiple out-of-home placements, including hospital or residential treatment settings (Burns, et al, 1999; Chamberlain & Reid, 1998; Jones, 1990; Snodgrass & Bryant, 1989; Stroul, 1989). There is ample evidence that TFC and group care programs serve largely comparable client populations with comparable outcomes or outcomes favoring TFC (Meadowcroft et al, 1994). While some studies show group care serving a somewhat older population (Handwerk, et al, 1998; Barth, 2002), most suggest little or no difference in presenting problems and other characteristics (Berrick et al, 1993; Burns, Hoagwood, & Mrazek, 1999; Curtis et al, 2001; Meadowcroft et al, 1994). An early comparison of TFC and group home client populations, for example, showed little demographic or behavioral difference between the two except that a greater proportion of TFC youth presented problems of significant verbal and physical aggression (Jones, 1990). A review of all residential mental health services in New York noted few significant differences among children placed in different types of programs, although TFC children appeared to have suffered greater degrees of family upheaval and dysfunction than children in other settings (NYS Commission on Quality of Care for the Mentally Disabled, 1993).

Outcome Studies

Treatment foster care draws much of its therapeutic effect from the power of family. In families, youth who have suffered abuse and neglect have opportunities to participate in healthy family functioning, to witness positive parenting styles, to establish trusting relationships with care givers, participate responsibly in community life and to learn prosocial skills through modeling. A critical review of 40 published outcome studies found that treatment foster care contributes to improved social skills and psychological adjustment, reduced behavior problems and reduced restrictiveness—and therefore, cost—of post-discharge setting (Reddy & Pfeiffer, 1997). In TFC, trained and supported care givers serve as part of the treatment team,



working directly with one or two children in their home. TFC staffing compares favorably to group care with regard both to staff-child ratios and direct care giver experience (Barth, 2002; NYS Commission on Quality of Care for the Mentally Disabled, 1993). TFC also is less susceptible to the “contagion” effect, whereby negative behavior is modeled, reinforced and passed on among peers housed together in congregate facilities (U.S. DHHS, 1999b).

Comparative Studies

Chamberlain and colleagues at the Oregon Social Learning Center have thoroughly examined TFC efficacy with adjudicated delinquent youth. Their random assignment study comparing Multi-Dimensional Treatment Foster Care and group care programs, serving youth diverted from a state training school, showed that TFC families provided closer supervision, more consistent discipline and allowed fewer delinquent peer associations than group care. Compared to group care, TFC reduced delinquent acts and rearrests, incarceration rates/duration, and runaways by half or more and proved far more successful in returning youth home after treatment (Chamberlain et al, 1996; Chamberlain & Reid, 1998; Chamberlain & Reid, 1994).

Chamberlain and Reid also compared outcomes for children with serious emotional disorders leaving hospital care for TFC, residential treatment or homes of relatives. TFC youths showed more behavioral improvement, lower rates of reinstitutionalization and lower costs over the long term (Chamberlain & Reid, 1991). A two-year random assignment study comparing TFC with regular foster care (RFC) for troubled youth showed that TFC youth were less likely to run away or be incarcerated and showed better emotional and behavioral adjustment (Clark et al, 1994).

TFC efficacy also has been studied with challenging young foster children. In a random assignment study comparing RFC and early intervention TFC with foster children below the age of 5 years, Fisher and colleagues found lower levels of stress and higher rates of retention for therapeutic foster parents than for RFC care givers. For children in the TFC sample, problem behavior and measures of stress decreased while increasing for those in RFC. Perhaps most significantly, TFC care givers demonstrated significantly greater skill in using proven parent management techniques, while RFC care givers’ parenting skills actually decreased over time as their responses to children became increasingly coercive and more rigid (Fisher et al, 2000).

A stable, supported family setting is especially important for younger children with severe emotional and attachment problems (Dozier & Tyrrell, 1998). Group care does not effectively meet the developmental needs of younger children, and may well have adverse developmental effects (Barth, 2002). While regular foster care may serve some younger children well, it is not structured to effectively serve the most challenging children. The Fisher study is consistent with broader studies linking challenging child behavior to foster parent reactivity and burnout in regular foster care (Barber et al, 2001; Cooper et al, 1987; Horwitz et al, 2000; Pardeck, 1982; Simms, 1989; Teather et al, 1994).



Placement Stability

In traditional foster care, reported disruption rates range from one-third to more than a half of all placements during the first 12 to 18 months of placement and increase with length of stay (Berrick, et al, 1998; Palmer, 1996; Smith et al, 2001; Staff & Fein, 1995; Stone & Stone, 1983). Placement disruption has been linked to a variety of child, care giver and systemic factors. Older children and those with serious emotional and behavior problems are most likely to experience multiple placements including higher-level residential treatment (Barth, 2002; Pardeck, 1982; Pardeck, Murphy, & Fitzwater, 1985; Fanshel, et al, 1990). The quality of the foster parent–child relationship and the fit between care giver and child characteristics also appear to impact placement stability (Berrick, et al, 1998; Doelling & Johnson, 1990). Systemic factors include degree of agency support, formation of positive relationship with care givers, frequency of social worker contact with care givers and lower numbers of children placed per home (Moore, Osgood, Larzelere, & Chamberlain, 1994; Pardeck, 1984; Stone & Stone, 1983; Testa, 2004). Each of these factors is addressed through the core service elements defining the treatment foster care model (FFTA, 1995).

Comparative studies of placement stability, though limited, favor treatment foster care over regular foster care for youth most at risk of disruption (Timbers, 1990). Serving older, challenging youth whose rate of disruption in regular foster care falls between 38% and 57%, Smith and colleagues reported an overall disruption rate of 25% in their TFC program, without an increase in disruptions over time (Smith, et al, 2001). A 2004 study of all placement failures in the Illinois foster care system found treatment foster care disruption rates lower than in regular foster care, again despite the generally more difficult population served in TFC versus traditional foster homes (Testa, 2004).

Permanence

Placement stability and permanence for children are closely linked. Children who do not achieve stability in regular foster care are the most likely to experience reentry into care from their birth families and from failed adoptions, and to experience homelessness, poverty and other poor outcomes when emancipated from care (Barth & Berry, 1988; Festinger, 1990; Lieberman, 1987; Walsh & Walsh, 1990). TFC can offer a more solid bridge to permanence for these more challenging young people than either group care or regular foster care and can play an important role in helping states meet federally mandated Child and Family Service Review goals.

Return Home & Independent Living

Because TFC programs are not facility-dependent, they may be flexibly located in or near children's home communities. They are better situated than facility-based programs to promote birth family involvement in treatment—a variable linked to sustained improvement in clinical status, academics, peer relations and successful return home (Hooper, et al, 2000; Leichtman, et al, 2001; Lewis, 1988; Wells, 1991). For older, troubled youth who remain in care until emancipation, a supported family setting offers clear advantages with regard to preparation for independent living. Community-based and family-based programs are better structured than residential facilities to offer youth practical opportunities to learn basic life skills needed for independence (McKenzie, 1999). Normalizing opportunities to participate in work, public schooling and community social activities are greater for youth in supportive family settings than for those placed at a remove from community life.



Adoption

For younger children who cannot return home, TFC can lead directly to permanence through adoption or guardianship by the treatment foster family without further placement change. This is a particularly important consideration with regard to the adoption of children most at risk of disruption. Adoption failure rates for children with serious emotional and behavior problems range from 19% to 53% (Festinger, 1990), suggesting that legal finalization does not necessarily predict true permanence for this group. Since the advent of the Adoption and Safe Families Act of 1997, the number of adoptions has increased dramatically, rising from 17,000 in 1990 to 51,000 in FY2000 (U.S. DHHS, 2003). Adoption by foster care givers accounted for 61% of all adoptions of foster children in FY2000 (U.S. DHHS, 2003).

TFC can play an important role in assuring that adoptions do not fail for our most vulnerable children. Fisher's study, cited above, bears particular relevance here in showing the capacity for TFC to reduce both child behavior problems and care giver stress. It would seem reasonable to conclude that children who present fewer behavior problems and create less stress for care givers are more likely to experience greater stability in their birth or adoptive homes upon leaving foster care for a more permanent setting. The same supports that enhance placement stability in treatment foster care can continue if, and as needed, to support foster-to-adoptive families beyond legal finalization to true permanence. For our most troubled young foster children, the use of treatment foster care as an early intervention and to support adoption merits close consideration as a preventive and potentially large-scale cost-saving measure.

Treatment Foster Care: Economy

In a landmark report on the nation's mental health, the U.S. Surgeon General concluded that studies of the TFC model make clear that "therapeutic foster care produces better outcomes at lower costs than more restrictive types of placement" (U.S. DHHS, 1999). Costs for residential treatment for a comparable population are at minimum two to three times higher for facility-based care than for treatment foster care (Barth, 2002). Given the efficacy of treatment foster care, cost clearly favors TFC over facility-based care for those most challenging youth who can be served safely in a family and community.

Even for those youth with longer lengths of stay in treatment foster care, efficacy promotes economy. Older, more challenging youth tend to be the most difficult to serve effectively. They remain longer in all forms of out-of-home care, have the lowest rate of adoption and return home, and, as a group, represent a larger proportion of those served in more costly group care settings (Barth, 2002; Festinger, 1990; U.S. DHHS, 2003). For these youth, a longer tenure in TFC can prevent a succession of residential placements during adolescence. In a study of 125 youth leaving TFC over a seven year period, Snodgrass found striking similarities between older youth discharged to more restrictive settings and those transitioning to independence after lengthy stays in TFC (Snodgrass, 1996). Because TFC can serve many older, troubled youth effectively, it can provide them stable and more economical care over a longer period.

Cost differences are linked primarily to program structure. Residential group care requires extensive facility-related building and maintenance costs, which to some extent must be paid for regardless of the number of children served at any one time. In TFC, most such costs are borne on a child-by-child basis. The great



proportion of ordinary room and board costs—rent/mortgage, utilities, household supplies and repairs—already are paid by foster care givers in maintaining their own homes and families. An additional child placed in the home brings only marginal cost increases. While certain professional and support staff costs are relatively fixed in both models, direct care costs are much lower in TFC where care givers' payment falls well below minimum wage levels and rarely includes any form of fringe benefit. The result for TFC is a richer staffing structure at a lower cost than group care (NYS Commission on Quality of Care for the Mentally Disabled, 1993). TFC care giver payment is made on a per-child basis and only when a child is in care. Other costs such as individual therapies, aide and mentor costs may be included as needed in TFC rather than as a fixed expense. For these reasons, TFC costs are both lower and less entrenched than residential expenses.

From a cost perspective, regular foster care and TFC structures share much in common. Partly for this reason, cost comparisons between the two usually have focused on such highly visible differences as monies paid to care givers, which generally are higher in TFC. In TFC, stipends to care givers are intended to cover the real costs of adding another child to the household budget and to include compensation for the extra work, supervision, training and skill level expected. Since caseload sizes must be much smaller in TFC in order to deliver intensive support to care givers, TFC requires more direct service staff than regular foster care to serve the same number of children.

When all costs are considered, however, there may be little significant difference between regular and treatment foster care. Indirect and overhead costs in public child welfare agencies typically are much higher than in private agencies. In public agencies—where most regular foster care is provided—both management and direct service staff salaries and benefits are considerably higher, on average, than in private agencies where most TFC is delivered. The discrepancy is greatest at the middle management and direct service levels where staff numbers and, therefore, costs are highest. For example, in 2001 the average compensation for Directors of Programs in public agencies in the U.S. was more than \$13,000 higher than for their private sector counterparts. Supervisors' average compensation in public agencies ranged from \$8,010 (Supervisor I) to \$14,970 (Supervisor II) higher than in private agencies. Controlling for education level, the difference in compensation between public and private direct service staff ranged from \$3,548 to \$12,696, favoring the public sector. On average, the cost of fringe benefits as a proportion of total compensation for public agency employees was 27.1% in 2001 compared to just 22.6% for private agencies (Drais-Parrillo, 2002).

TFC services require flexibility as well as intensity. Support is provided around the clock and many critical case decisions are made by TFC workers during what would be overtime hours for public employees constrained by civil service work rules and union contracts. Especially in large urban areas where caseloads have grown exponentially in the last two decades, public agency workers operate at a considerable remove from the point of direct service. They are expected, nonetheless, to maintain responsibility for individual case planning as well as for legal reporting, court appearances and oversight of privately delivered services. For TFC children, such an arrangement, in effect, creates the need for both a public and a private caseworker. At a time of greatly diminished resources, such duplication of effort should be avoided wherever possible. In areas where caseload size and work rules limit the real per-case capacity of public workers, it likely would be more economical to focus public



worker efforts on broad case oversight and court duties while trusting TFC staff with ground-level service and decision-making. For those jurisdictions willing to delegate a broader range of case planning functions to the TFC agency, such an arrangement very well could enhance the capacity and cost-efficiency of services to all foster children—particularly those TFC youth whose only other realistic option is residential care.

- **Summary**

Given the increasing challenges presented by the needs of foster children and their families, it is critical to sustain efforts to make treatment foster care services available and viable in all communities. The model has had more than 30 years to evolve into clearly defined and increasingly well-researched components. TFC today is essential to an effective and cost-efficient system of care for troubled youth and children. It would be imprudent and costly to abandon or dilute the effectiveness of the only family-based therapeutic placement option currently bridging the gap between foster family care and facility-based residential treatment.

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