QUICK LESSON ABOUT

Therapeutic Foster Care: Child Welfare

Description/Etiology

Therapeutic foster care (TFC) is a family-based treatment model for children with severe emotional and/or behavioral issues. Although children may be referred to TFC by mental health or juvenile justice agencies, the majority are referred by child welfare services (CWS) agencies subsequent to being placed in foster care as a result of child maltreatment (CM) or dependency. For children in the custody of CWS due to abuse, neglect, or dependency, foster care placement is necessary in order provide a safe, stable living situation while CWS makes efforts to reunify them with their birth parents or establish permanency through legal custody or guardianship with relatives or adoption. Children's initial placements usually are with relatives, extended family members, or traditional foster homes, but those children with significant emotional and/or behavioral issues may experience multiple disruptions and escalating difficulties. Placement in TFC is often the least restrictive setting available for a child with challenging behaviors and has the benefit of allowing children to remain in a family and community setting, as well as avoiding the introduction of negative peer influences such as may be found in a group home or residential care facility. Referral to TFC may be initiated by the child welfare social worker, but authorization for payment purposes also requires a clinical assessment indicating that the child needs a higher level of care than can be provided in a traditional family foster-care setting.

The implementation of TFC varies considerably among agencies in terms of administration and therapeutic approach, although some common standards for programs in North America have been established by the Foster Family-Based Treatment Association. Despite individual variations, TFC programs generally share the following core components:

- Foster parents receive specialized training, are licensed to care for only one or two children at a time, and receive a higher rate of compensation than parents in non-therapeutic foster homes
- Foster parents are regarded as full members of the child's treatment team and are expected to implement treatment goals in accordance with the child's individualized service plan and to provide more structure and supervision than parents in non-therapeutic foster homes
- Agency workers carry a small caseload of families and are expected to provide a high level of guidance, support, crisis intervention, and respite to families
- Agency workers may provide consultation and/or service coordination for school staff, mental health clinicians, medical providers, and other team members
- Programs include a family component to engage birth parents in education, visits, and/or family therapy and an aftercare plan to support transition to birth family or other permanent placement

One evidence-based TFC model, Multidimensional Treatment Foster Care (MTFC), has demonstrated positive effects including reducing violence and delinquency, enhancing resilience,and increasing the probability of successful placement in permanent homes. Certified MTFC programs have been established in the United States, England, Norway, Denmark, Sweden, and New Zealand. The majority of MTFC homes serve youth ages 12–17, although there also are programs for preschoolers 3–6 years old and children ages 7–11. The MTFC model is time-limited, typically involving 6 to 9 months of treatment and 3 months of aftercare. Critical elements that distinguish this model include grounding in social learning theory, vigilant attention and response to children's behaviors in home and

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community settings, consistent limits, predictable rewards and consequences for behavior, skills training for children, daily contact between staff and foster parents, implementation of behavior management strategies by foster parents, and supportive therapy for the child and involved adults. Early Intervention Foster Care (EIFC/MTFC-P), for preschool children, also incorporates a therapeutic playgroup, in-home behavioral services, and parent training for parents who are expected to reunify with their children.

Research shows that therapeutic mentoring for foster children can reduce trauma symptoms significantly. Therapeutic mentoring involves mentors who are in helping professions and are extensively trained and supervised to mentor foster youth. The trainings the therapeutic mentors receive include information about working with children with emotional and behavioral disorders, therapeutic crisis interventions, and boundaries. Each mentor-mentee relationship is closely monitored by a master's-level clinician. The mentors see their mentees on a weekly basis for 3-5hours and engage in activities together such as playing outdoors, attending cultural events, or going to sporting events. A study in 2013 found that foster youth who participated in a therapeutic mentoring program for 18 months experienced a significant decrease in their trauma symptoms compared to foster youth who did not participate in the therapeutic mentoring (Johnson & Pryce, 2013).

Another study reported that adolescents in long-term therapeutic foster care emphasized positive aspects of their placement such as being treated as adults, being listened to, and being made to feel safe. The study noted positive changes in the adolescents' attachment security over time (Dallos et al., 2014).

Outcomes for children in foster care are influenced by a number of factors. Most children in foster care have experienced significant trauma and disruption, which in turn is associated with high rates of mental health problems and attachment issues. Children with severe emotional and behavioral issues are more likely to have families with multiple adversities, experience changes in placement, and stay longer in foster care. Trauma-informed practices, service coordination, and engagement of birth parents, relatives, or others who are committed to providing a permanent home for the child support more favorable outcomes.

Facts and Figures

In 2012 approximately 400,000 children in the United States were in the legal custody of a CW agency and placed in foster care, with an average length of stay of 22.4 months (U.S. Department of Health & Human Services, 2013). Children in foster care have significantly higher prevalence rates for mental health disorders than the general population, and most have also experienced significant trauma. A large study of children in foster care who were referred to a National Child Traumatic Stress Network site for services found that 50% of the children had suffered neglect, traumatic loss or separation, caregiver impairment, intimate partner violence,and/or emotional abuse; 48% had experienced physical abuse and 32% had experienced sexual abuse (Greeson et al., 2011).

Risk Factors

Children in foster care are at significant risk for medical, developmental, educational, behavioral, and mental health problems. Most have experienced an array of adversities prior to placement, including parental substance abuse and/or mental health issues, the incarceration of one or both parents, exposure to intimate partner violence, poverty, unstable living situations, prenatal exposure to drugs and alcohol, lack of adequate stimulation and care during early childhood, developmental delays, and maltreatment (physical, sexual, and emotional abuse and/or neglect). Foster care introduces additional stressors, including the trauma of removal from the child's family and resulting losses and having to adjust to new environments. These children may have difficulty with attachment, self-regulation,and prosocial behaviors. As maladaptive behaviors become entrenched, children become increasingly at risk for academic difficulties, negative peer relationships, and other social difficulties. Children with severe emotional and/or behavioral issues are more likely to experience multiple placements,which in turn is strongly associated with escalating behavioral issues and poor long-term outcomes. Serious mental health issues are also the greatest predictor for children having extended lengths of stay in foster care.

Signs and Symptoms/Clinical Presentation

The majority of children in TFC have disruptive, defiant, aggressive, antisocial behaviors that have created significant difficulty in home and school settings. They may have a history of substance abuse, truancy, school suspensions and failures, chronic delinquency, stealing,sexual abuse perpetration, psychiatric hospitalizations, multiple living situations, and episodes of running away. Diagnoses may include attention deficit hyperactivity disorder, oppositional defiant disorder, conduct disorder, post-traumatic stress disorder, and mood disorders. Children entering TFC from CW tend to be younger than children referred by mental health or juvenile justice. They are likely to have had several disrupted foster care placements prior to placement in TFC.

Social Work Assessment

› **Client History**

- Complete a comprehensive biopsychosocialspiritual assessment to include information on physical, mental, environmental, social, and financial factors as they relate to the child and his/her family
- Ask about history of physical/sexual/emotional abuse or neglect, exposure to violence or other trauma, family history, placement history, level of functioning, history of psychiatric symptoms or issues that pose risk to self or others (e.g., suicide ideation/attempts, self-harm, substance abuse, aggression, fire setting, running away, sexual abuse perpetration), history of mental health treatment and psychotropic medication, child's involvement with other systems (e.g. school, corrections), family and community supports

› **Relevant Diagnostic Assessments and Screening Tools**

- Child and Adolescent Functional Assessment Scale (CAFAS) for children 6–17 or Preschool and Early Childhood Functional Assessment Scale (PECFAS) for children 3–7
- Child Behavioral Checklist (CBCL) for ages 6–18
- Child and Adolescent Needs and Strengths, Mental Health (CANS-MH)
- Strengths and Difficulties Questionnaire (SDQ)
- UCLA Posttraumatic Stress Disorder Reaction Index (PTSD-R)

› **Laboratory and Diagnostic Tests of Interest to the Social Worker**

- Toxicology screen for drug and/or alcohol use

Social Work Treatment Summary

A system of care framework is recommended to manage the complex needs of youth in TFC, who typically are involved with one or more public agencies in addition to child welfare services (e.g., mental health, juvenile delinquency) and multiple service providers. Although TFC is itself a psychosocial intervention, many children also need specialized treatment, individual and/or group skills training, special education, and/or vocational training.

TFC recognizes that the home is a natural learning environment for children, with foster parents serving as powerful change agents in the child's treatment. Preparation and support of both foster parents and the caregivers with whom the child will reside upon discharge are critical. A good alliance between therapeutic parents and children is associated with more positive outcomes, as is the foster parents' identifying themselves more as parents than as professionals.

The social worker should utilize an ecological approach to ensure that the child's individual needs are addressed, that foster parents have adequate training and support, that ongoing and aftercare services include the biological, foster, or adoptive family that will care for the child upon discharge, and that involved agencies and systems work in coordination, addressing any barriers that arise.

Social workers should be aware of their own cultural values, beliefs, and biases and develop specialized knowledge about the histories, traditions, and values of their clients. Social workers should adopt treatment methodologies that reflect their knowledge of the cultural diversity of the societies in which they practice.

Problem	Goal	Intervention
Child is exhibiting maladaptive and/or disruptive behaviors, lacks prosocial skills and behaviors	Reduce problem behaviors, teach and reinforce prosocial skills and behaviors	Individualized behavioral strategies focused on reinforcing positive behaviors, close supervision, limiting negative peer associations, and strengthening adult-child relationships; individual and group skills coaching for parents and children; mentoring

Child has underlying mental health condition	Support resolution of mental health symptoms, enhance adaptive coping	Refer for specialized mental health therapy; e.g., anger coping, substance abuse treatment, psychotropic medication
Child experiences symptoms resulting from history of trauma	Support resolution of symptoms related to exposure to trauma	Screen all youth in TFC for trauma history, refer for trauma-focused cognitive behavioral therapy (TF-CBT), abuse-focused cognitive behavioral therapy (AF-CBT); ensure that foster parent is adequately informed of history of trauma so he or she can recognize symptoms and provide support
Parent lacks skills to establish limits, rewards, and consequences to promote and reinforce prosocial behavior; parenting approach may be inconsistent or coercive	Parent will gain increased understanding and capacity to respond to and shape child's behaviors	Provide information and coaching regarding effective discipline, strengthen parent-child relationship, refer to parent-child interaction therapy (PCIT), parent management training
Frequency or severity of behaviors causes high degree of parental stress	Parent will have realistic expectations of child, sense of competence in responding to child's behaviors, enhanced coping skills, and reduction in stress	Provide education regarding child's emotional/behavioral issues and strategies for reducing stress, assist parent to identify supports and coping strategies, offer respite services, refer to parent support groups

Applicable Laws and Regulations

› The licensure and operation of TFC homes generally are governed by laws and regulations on the national and local level
› In the United States, professionals are mandated by state statutes to report suspected or known child maltreatment to child protective services and/or law enforcement
› The 1980 United States Adoption Assistance and Child Welfare Act requires that states provide out-of-home placement for children in CW agency custody in the least restrictive, most family-like setting appropriate for their needs and facilitate reunification or placement in a permanent home in a timely manner
› The 2011 Child and Family Services Improvement and Innovation Act requires that states specifically address trauma, psychotropic medications, and developmental needs of children in foster care as part of their healthcare plan
› Each country has its own standards for cultural competency and diversity in social work practice. Social workers must be aware of the standards of practice set forth by their governing body (National Association of Social Workers, British Association of Social Workers, etc.) and practice accordingly

Available Services and Resources

› Child Welfare Information Gateway, https://www.childwelfare.gov/
› Foster Family-Based Treatment Association, http://www.ffta.org
› Multidimensional Treatment Foster Care, http://www.mtfc.com/
› National Child Traumatic Stress Network (NCTSN), www.nctsn.org

Food for Thought

- Hundreds of programs identify themselves as TFC and share common elements, but there are also significant differences between programs in terms of their implementation of an evidence-based model or best practices and standards. These differences may lead to significant differences in outcomes and should be considered during the referral process
- Regulations commonly restrict TFC to one or two children, which works against placing siblings together

Red Flags

- Child welfare social workers often approach readiness for reunification primarily in terms of parental progress toward resolving safety concerns that led to the child's removal and are less attuned to the impact of the child's mental health issues on reunification or the parents' ambivalence or lack of readiness to manage the child's behaviors
- A significant number of youth in TFC are on psychotropic medication, but caregivers and staff often do not receive adequate training in administering and monitoring medications and side effects. Additional training is needed in this area
- The educational needs of children in TFC often are overlooked. Greater attention is needed to ensuring that children are referred for early intervention or special education if indicated, as well as encouraging foster parents to participate in school meetings
- Many youth in TFC have a history of suicidal ideation and previous psychiatric hospitalization. TFC and program staff should be adequately trained to recognize warning signs and have a plan for responding to psychiatric crises
- Youth with a history of sexual perpetration should immediately be assessed and provided with intensive treatment. Therapeutic foster parents must be adequately trained to recognize problematic behaviors

Discharge Planning

- Ensure that parents/caregivers are adequately prepared for reunification, understand the child's diagnoses and needs, are educated about psychotropic medications if applicable, have realistic expectations for the child's behaviors, and are prepared to manage challenges
- Ensure that transitions occur in a planned and coordinated manner, with input from all providers, parents, and child
- Provide linkage to community services (e.g., support groups, mentors, recreational programs) as appropriate to provide additional supports
- Provide written information regarding the child's mental health condition or needs as applicable; e.g., parent handouts available through MedLinePlus, http://www.nlm.nih.gov/medlineplus/childmentalhealth.html

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References

1. Akin, B. A., Bryson, S. A., McDonald, T., & Walker, S. (2012). Defining a target population at high risk of long-term foster care: Barriers to permanency for families of children with serious emotional disturbances. *Child Welfare*, *91*(6), 79-101.
2. Baker, A. J., Kurland, D., Curtis, P., Alexander, G., & Papa-Lentini, C. (2007). Mental health and behavioral problems of youth in the child welfare system: Residential treatment centers compared to therapeutic foster care in the Odyssey Project population. *Child Welfare*, *86*(3), 97-123.
3. Boyd, L., Brylske, P., & Wall, E. (2013). Beyond safety and permanency: Promoting social and emotional well-being for youth in treatment foster care. *Foster Family Based Treatment Association*. Retrieved from http://www.imis100us2.com/ffta/AsiCommon/Controls/BSA/Downloader.aspx?iDocumentStorageKey=3effd1b1-35f2-4b28-baa6-e4fd87438310&iFileTypeCode=PDF&iFileName=Beyond
4. Breland-Noble, A. M., Farmer, E. M. Z., Dubs, M. S., Potter, E., & Burns, B. J. (2005). Mental health and other service use by youth in therapeutic foster care and group homes. *Journal of Child & Family Studies*, *14*(2), 167-180.
5. British Association of Social Workers. (2012). *The Code of Ethics for Social Work: Statement of Principles.* Retrieved March 7, 2015, from http://cdn.basw.co.uk/upload/basw_112315-7.pdf
6. Dallos, M., Morgan-West, K., & Denam, K. (2014). Changes in attachment representations for young people in long-term therapeutic foster care. *Clinical Child Psychology and Psychiatry*, 1-20. Advance online publication.
7. Dore, M. M., & Mullin, D. (2006). 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.
8. Dorsey, S., Burns, B. J., Southerland, D. G., Cox, J. R., Wagner, H. R., & Farmer, E. M. Z. (2012). Prior trauma exposure for youth in treatment foster care. *Journal of Child and Family Studies*, *21*(5), 816-824.
9. Fisher, P. A., Kim, H. K., & Pears, K. C. (2009). Effects of multidimensional treatment foster care for preschoolers (MTFC-P) on reducing permanent placement failures among children with placement instability. *Children and Youth Services Review*, *31*(5), 541-546. doi:10.1016/j.childyouth.2008.10.012
10. Greeson, J. K. P., Briggs, E. C., Kisiel, C. L., Layne, C. M., Ake, G. S., Ko, S. J., ... Fairbanks, J. A. (2011). Complex trauma and mental health in children and adolescents placed in foster care: Findings from the National Child Traumatic Stress Network, *90*(6), 91-108.
11. Hussey, D. L., & Guo, S. (2005). Characteristics and trajectories of treatment foster care youth. *Child Welfare*, *84*(4), 485-506.
12. International Federation of Social Workers. (2012). *Statement of ethical principles.* Retrieved March 7, 2015, from http://ifsw.org/policies/statement-of-ethical-principles/
13. Jamora, M. S., Brylske, P. D., Martens, P., Braxton, D., Colantuoni, E., & Belcher, H. M. E. (2009). Children in foster care: Adverse childhood experiences and psychiatric diagnoses. *Journal of Child & Adolescent Trauma*, *2*, 198-208. doi:10.1080/19361520903120491
14. Johnson, S., & Pryce, J. (2013). Therapeutic mentoring: reducing the impact of trauma for foster youth. *Child Welfare*, *92*(3), 9-25.

15. Jonkman, C. S., Bolle, E. A., Lindeboom, R., Schuengel, C., Oosterman, M., Boer, F., & Lindauer, R. J. L. (2012). Multidimensional treatment foster care for preschoolers: Early findings of an implementation in the Netherlands. *Child & Adolescent Psychiatry & Mental Health*, *6*(38), 1-5. doi:10.1186/1753-2000-6-38
16. Leve, L. D., Fisher, P. A., & Chamberlain, P. (2009). Multidimensional treatment foster care as a preventative intervention to promote resiliency among youth in the child welfare system. *Journal of Personality*, *77*(6), 1869-1902. doi:10.1111/j.1467-6494.2009.00603.x
17. Major federal legislation concerned with child protection, child welfare, and adoption. (2012). *Child Welfare Information Gateway*. Washington, DC: Author. Retrieved April 4, 2014, from http://www.nrc4tribes.org/files/Tab%204_1%20Major%20Federal%20Child%20Welfare%20Legislation.pdf
18. Madden, E. E., Maher, E. J., McRoy, R. G., Ward, K. J., Peveto, L., & Stanley, A. (2012). Family reunification of youth in foster care with complex mental health needs: Barriers and recommendations. *Child & Adolescent Social Work Journal*, *29*(3), 221-240. doi:10.1007/s10560-012-0257-1
19. Mandatory reporters of child abuse and neglect. (2012). *Child Welfare Information Gateway*. Washington, DC: U. S. Department of Health and Human Services, Children's Bureau.
20. McAuley, C., & Davis, T. (2009). Emotional well-being and mental health of looked after children in England. *Child and Family Social Work*, *14*, 147-155. doi:10.1111/j.1365.2206.2009.00619.x
21. Mizrahi, T., & Mayden, R. W. (2001). *NASW Standards for Cultural Competence in Social Work Practice*. Retrieved March 7, 2015, from http://www.socialworkers.org/practice/standards/NASWCulturalStandards.pdf
22. Neely-Barnes, S., & Whitted, K. (2011). Examining the social, emotional and behavioral needs of youth involved in the child welfare and juvenile justice systems. *Journal of Health & Human Services Administration*, 206-238.
23. Pavkov, T. W., Hug, R. W., Lourie, I. S., & Negash, S. (2010). Service process and quality in therapeutic foster care: An exploratory study of one county system. *Journal of Social Service Research*, *36*(3), 174-187. doi:10.1080/01488371003697897
24. Shipman, K., & Taussig, H. (2009). Mental health treatment of child abuse and neglect: The promise of evidence-based practice. *Pediatric Clinics of North America*, *56*(2), 417-428. doi:10.1016/j.pcl.2009.02.002
25. Southerland, D., Mustillo, S., Farmer, E., Stambaugh, L., & Murray, M. (2009). What's the relationship got to do with it? Understanding the therapeutic relationship in therapeutic foster care. *Child & Adolescent Social Work Journal*, *26*(1), 49-63. doi:10.1007/s10560-008-0159-4
26. U. S. Department of Health and Human Services, Office of Data, Analysis, Research, and Evaluation. (2013). *Data Brief 2013-1: Recent demographic trends in foster care*.
27. Westermark, P. K., Hansson, K., & Olsson, M. (2010). Multidimensional treatment foster care (MTFC): Results from an independent replication. *Journal of Family Therapy*, *33*, 20-41. doi:10.1111/j.1467-6427.2010.00515.x