ASPE Research Summary

Office of the Assistant Secretary for Planning and Evaluation

U.S. Department of Health and Human Services

Challenges and Opportunities in Treatment Foster Care

Treatment foster care (TFC, also called therapeutic foster care) is a promising approach for serving children with serious emotional and behavioral disorders in the least restrictive possible setting. Although no single definition of TFC exists, key elements have been identified (see box). TFC may represent an opportunity to serve children with extensive needs in a family setting rather than in congregate care (group home or inpatient care). However, better information is needed to guide TFC program design, policy, and reimbursement.

Between 2016 and 2019 ASPE carried out, through a contract with RTI International and Chapin Hall, a multi-phase and multi-method research study examining state practices in implementing TFC programs. The purpose of this research was to better understand how TFC programs are used in the field and to explore the extent to which TFC could be used effectively as a family-based alternative to congregate care.

What is Treatment Foster Care?

TFC serves children who have behavioral or emotional disorders or medical conditions that cannot be adequately addressed in a family or foster home and who would otherwise be served in a residential or institutional setting.

TFC is provided in a family-based setting by foster, kinship, or biological parents who are trained, supervised, and supported by qualified TFC program staff.

Services within TFC may address social functioning, communication, and behavioral issues, and typically include crisis support, behavior management, medication monitoring, counseling, and case management.

This research summary presents the key findings across the three phases of the study. The study's first stage updated an existing literature review and interviewed key informants knowledgeable about TFC in research and practice. The second phase produced in-depth profiles of six states' TFC programs, exploring programs' admissions criteria, assessment practices, services arrays, and funding strategies. Finally, the third phase of the study analyzed three states' child welfare administrative data in order to document the characteristics of children who spent time in TFC programs and the patterns in which they entered and exited those placements. The characteristics and placement patterns of children in TFC placements were compared with those of children in other child welfare settings, including traditional foster care, kinship foster care, and congregate care.

Key Findings:

- **While all states use some form of TFC, these programs vary widely.** The programs are most often implemented by state or county child welfare agencies, most frequently through contracts with private providers. Some also serve children who are primary clients of juvenile justice or mental health agencies. While states vary in their funding strategies, most often they are paid for with a combination of child welfare and Medicaid funding, with child welfare paying children's room and board costs and Medicaid covering therapeutic costs.

- **Few states implement either of two evidence based TFC models in their entirety.** Two TFC service models have robust research evidence regarding their effectiveness: Treatment Foster Care Oregon and Together Facing the Challenge. However, most states do not implement these models specifically. They instead typically use homegrown programs that incorporate some elements of evidence-based or evidence-informed models but adapt them through contract

requirements, generally decreasing the intensity of the intervention. The limited use of evidence-based models is usually driven by resource constraints, both financial and in the limited availability of TFC parents able and willing to provide the intensity of care necessary to implement the evidence-based models.

- **There are both commonalities and differences among states in their use of TFC.** Across the three states whose administrative data was analyzed (Illinois, New York, and Tennessee), relatively few children experience TFC (range 8 to 19 percent across the three states). Typically, TFC was not a first placement but was either a step up in intensity from an initial placement in a traditional foster home or a step down in intensity from a congregate care placement. Among the three states studied, Tennessee primarily used TFC as a step up in care, while Illinois primarily used it as a step down, and New York used it both ways with approximately equal frequency. Congregate care, in contrast, was much more frequently used as a first setting in all three states and was more common for children in the oldest age group examined, youth 13 to17 years of age, while TFC was used more widely across age groups. Children typically spent about a year in a TFC placement as compared with about 3 months in a congregate care placement.

- **Children in both TFC and congregate care have high needs.** Overall, children in congregate care had higher levels of assessed needs than did children in TFC, according to scores on the Child and Adolescent Strengths and Needs instruments used by two states studied in which this information was available (Illinois and Tennessee). However, the distributions overlapped, with many children in TFC and congregate care having similar levels of needs. Given how few children receive TFC, it is likely that TFC programs could be expanded to serve additional children who currently are served in congregate care settings.

- **Children typically leave foster care following a stay in TFC.** Upon leaving a TFC placement, most children left foster care. The second most common destination was a traditional (non-kin) foster home. Few children entered TFC from or exited TFC to kinship foster homes.

Overall, this research makes clear that there is considerable variety among states in the implementation of services labeled Treatment (or Therapeutic) Foster Care. Even among states that use it most frequently, service models and intensity vary widely, if indeed the state uses a formal model at all. Also varying were the ages of children served and the role the service played in the state's child welfare continuum.

Few states track outcomes for TFC services or conduct research on service effectiveness. Many providers wish they could provide more evidence-based services but are not funded to do so. In addition, the existing evidence-based models do not always suit how a state child welfare agency wishes to use TFC in their system. Recruiting, training, supporting, and retaining TFC parents is also a challenge. TFC is a service for children with very high needs and it is difficult to recruit and retain qualified caregivers. Nonetheless, TFC holds promise as a part of a comprehensive child welfare system that seeks to meet the needs of a range of troubled children in the least restrictive settings possible.

This research was conducted under contract to the Office of the Assistant Secretary for Planning and Evaluation (ASPE) by researchers at RTI International and Chapin Hall at the University of Chicago. Products of this contract may be found at: [ADD URL FOR PROJECT LANDING PAGE]

Distinctions between Standard Foster Care and Treatment Foster Care

Dimension	Standard Foster Care	Treatment/Therapeutic Foster Care	Why Is This Important?
Program components	Required standards defined in state statute or administrative regulations	Program components for the dimensions in this exhibit may be defined by theory-driven, "named" models that are evidence-based or evidence-informed, or specified by state agency administrative rules or contractual requirements	Theory-driven models build on rigorous research and incorporate all relevant components of TFC; contractually or administrative-defined programs adapt these models but may risk diluting their essential elements
Treatment services	Community services as identified by a child welfare treatment team	Services for a child are delivered or arranged by the TFC provider, with coaching and supervision for the TFC parents who care for the child	Credentialed treatment providers respond to behaviors in the child's home environment
Child entry	Child welfare custody	Children with serious mental, emotional, behavioral, or medical issues, who may be in child welfare, juvenile justice, or parental custody	TFC eligibility is ideally driven by child needs rather than by state agency custody and is available to children in parental or relative custody
Agency case manager credentials	Not specified, or a bachelor's degree	At least a bachelor's degree with experience, sometimes more	Highly skilled case managers respond to behaviors in the home environment, model responses, and actively train TFC parents
Foster parent role	Parent substitute	Member of the therapeutic team	Trained TFC parents allow a constant therapeutic response in the child's natural situations
Foster parent training	Curricula such as Model Approach to Partnerships in Parenting (MAPP) or Parent Resources for Information, Development and Education (PRIDE) foster parent training	Higher level pre-service and ongoing training requirements for TFC parents, with additional specialized training related to children's needs	In addition to standard training for foster parents, TFC parents need training that equips them to respond to children's extensive needs
Number of children in home	Agency specifies maximum number of children in home	One or two TFC children	Fewer children in the home increase time and attention available to the therapeutic process
Medicaid funding	Medicaid reimburses behavioral health care services delivered by external providers	State Medicaid agencies use varied approaches to paying for TFC, including state plan amendments, waivers, bundled payment, or reimbursement for specific services	Flexible funding mechanisms allow provider agencies to respond to individual child needs, but adequate reimbursement rates may be more important than a particular reimbursement mechanism
Other funding	Federal Title IV-E funds for child welfare board and care	State and local funds, and occasionally agency funds, may support therapeutic services	Child welfare and juvenile justice funds can extend resources for noncustodial services