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ASPE RESEARCH BRIEF

OFFICE OF THE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION

OFFICE OF HUMAN SERVICES POLICY - U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

PATTERNS OF TREATMENT/THERAPEUTIC FOSTER CARE AND CONGREGATE CARE PLACEMENTS IN THREE STATES

Key Findings

1. There is substantial variation in treatment/therapeutic foster care (TFC) placement patterns including distribution of initial placements, subsequent placements, and length of stay within placement types for the three states included in this study: Illinois, New York, and Tennessee.
2. In the three states studied, TFC is not typically a first placement and, when used, is most often a finite, short term placement.
3. Marked differences between TFC and congregate care utilization were observed across the three states, with congregate care more commonly used as an initial placement compared to TFC.
4. Across the three states, there are different patterns in the use of TFC as a step up or step-down placement; however, there are similar patterns regarding where children are placed after an initial TFC placement.
5. Both TFC and congregate care serve high needs children, though on average those in congregate care have significantly higher assessed needs in some domains.
6. There are different sociodemographic patterns for children in different placement types in the states included in the study. Children initially placed in TFC and congregate care tend to be older than children placed in other placement types, and boys are more likely to be placed in congregate care than girls. Racial/ethnic distribution of children for each placement varies as well.

Background

The foster care system serves some of the most vulnerable children in the child welfare, juvenile justice, and mental health systems. In 2017, approximately 270,000 children entered the public foster care system (Children's Bureau, 2018). Studies indicate that nearly 80 percent of children entering foster care have been subjected to adverse childhood experiences such as neglect, physical and sexual abuse, exposure to substance use, and incarceration of parents or legal guardians (Bramlett & Radel, 2014). These potentially traumatic experiences may lead some children to develop serious emotional disorders that require more intensive services than are typically provided in traditional foster care settings.

Because of the high needs and limited availability of alternative services, these children are often placed in congregate care, a setting that offers 24-hour care in a licensed or approved small group home or childcare facility (U.S. Department of Health and Human Services, Administration for Children and Families [ACF], 2015). However, multiple stakeholders agree that, although there is an appropriate role for congregate care in the foster care continuum, children are best served in family-based settings (Ryan, J. P., et al., 2008; Washington State Institute for Public Policy [WSIPP], 2010; Southerland, D. G., 2014).

Federal and state policy makers have recognized the need for effective alternatives to congregate care to serve the needs of this population. In February 2018, Congress passed the Family First Prevention Services Act (FFPSA), which aims to reduce the number of children placed in congregate care by significantly restricting federal funding for this placement type. Under the FFPSA, states are incentivized to seek alternative forms of care for children who do not meet clinical criteria for congregate care (NCSL, 2018). Therapeutic or treatment foster care (TFC) is an alternative being considered by many states.

TFC is designed to serve children who have behavioral or emotional disorders or medical conditions that cannot be adequately addressed in a traditional foster home and who might otherwise be placed into congregate care. It is an intensive, treatment-focused form of foster care provided in a family-based setting by trained caregivers, with the addition of case management and behavioral health services and clinically based supervision. Although TFC programs can vary, most state programs incorporate elements of evidence-based models that have been thoroughly assessed and have demonstrated improved outcomes (Office of the Assistant Secretary for Planning and Education [ASPE], U.S. Department of Health and Human Services [HHS], 2018; Bishop-Fitzpatrick et al., 2014; Harold et al., 2013; Rhoades et al., 2013).

Models of TFC are currently used by several states as a successful alternative to congregate care and growing evidence indicates that TFC could be an appropriate alternative to congregate care for some children. Children in TFC are more likely to receive proactive services (e.g., in-home counseling, medical doctor visits), whereas children in congregate care settings are more likely to receive reactive services (e.g., placement in detention facility, emergency room visits) (Breland-Noble, Farmer, Dubs, Potter & Burns, 2005). Also, studies have found that models of TFC are associated with decreased drug use over time, reduced rates of post-treatment felony charges, and greater reductions in depressive symptoms, as compared to congregate care models (Rhoades et al., 2014; Harold et al., 2013; Robst, Armstrong, & Dollard, 2011). There is also some evidence that TFC is more cost-effective than congregate care (Washington State Public Policy Institute, 2010).

In an effort to further understand how states are using TFC services, this brief sheds light on the characteristics and care trajectories of children who receive TFC compared with children placed into congregate care and traditional foster care in Illinois, New York, and Tennessee. Using administrative data, this brief quantitatively characterizes children using TFC services and how they move in and out of these placements as compared with children in congregate care and traditional foster care.

Methods and Data

This brief describes the characteristics and care trajectories of children up to 18 years of age experiencing their first foster care episode with the child welfare system in the states of Illinois, New York and Tennessee. Data are from the Chapin Hall Multistate Foster Care Data Archive, augmented as necessary with state-specific data. Data comprise cohorts of children entering care from 2008 through 2015, who were followed through December 31, 2016. The study sample size and placement definition by state are described in Table 1.

Table 1. Study Sample Size and Placement Definition, by State

Care Details	Illinois	New York	Tennessee
Number of unique children with a first foster care episode	38,385	60,193	37,724
Placement definition			
Treatment/therapeutic foster care	Specialized foster home placements	Foster home placements with a level of difficulty code of "exceptional"	Foster home placements designated as "Level II Continuum"
Congregate care	Group home and institutional placements	Group home and institutional placements	Group home and institutional placements
Traditional foster care	Foster home, non-relative	Foster home, non-relative	Foster home, non-relative
Kinship foster care	Foster home with a relative	Foster home with a relative	Foster home with a relative

Note: States permit kinship foster parents to become licensed as treatment/therapeutic foster care parents. In this case, families are classified as treatment/therapeutic foster care.

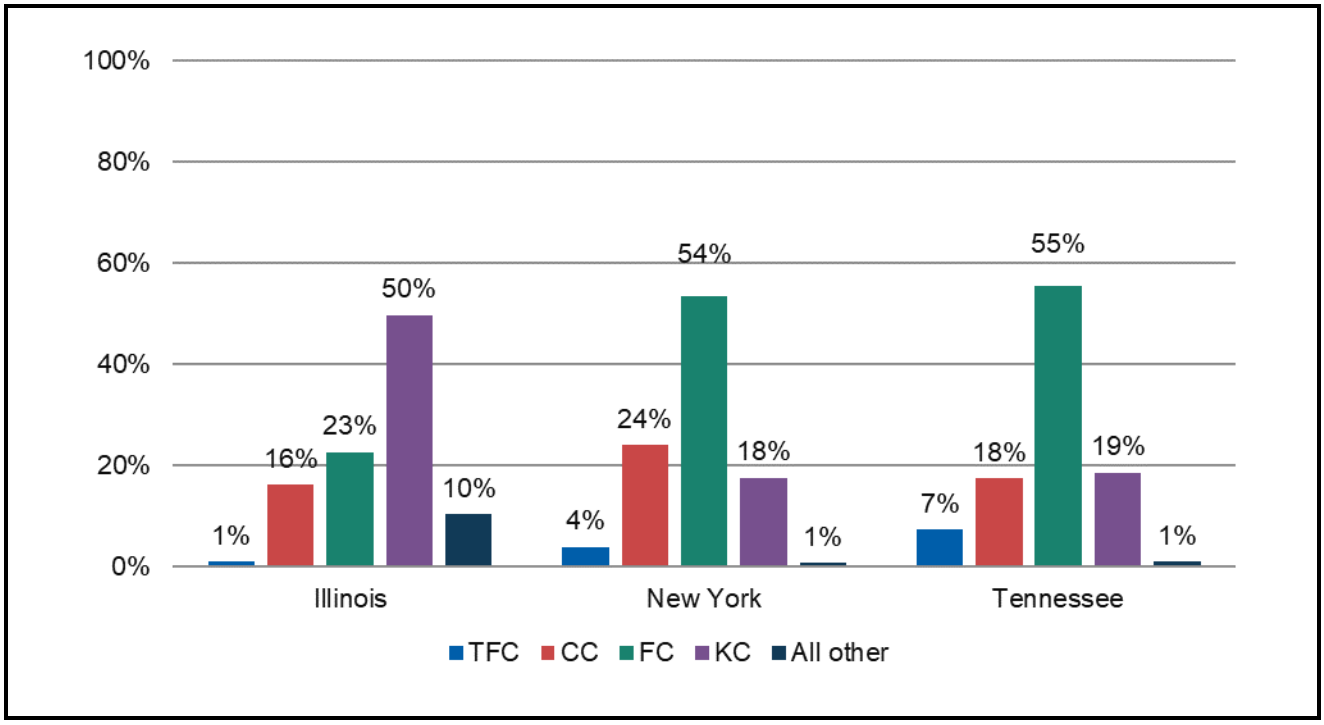
This brief also includes data from the Child and Adolescent Needs and Strengths (CANS) assessment for Illinois and Tennessee. The CANS is a tool used to support decision making (including level of care) for children placed in out-of-home care. The CANS is a flexible assessment tool allowing states to tailor the types of data collected from children and their families. In Tennessee, the CANS data reflect assessments made within the first 30 days of a child's entry into the child welfare system, while in Illinois, the CANS is administered within the first 40 days. Additional information about the domains and items in each state's CANS tool is found at the end of this brief.

Findings

Initial Placement:

Based on data from the Chapin Hall Multistate Foster Care Data Archive, the most common initial child placement varies by state. In Illinois, kinship foster care is the most common initial placement (50 percent of children with an initial placement in the state), while non-kin foster care is the most common initial placement in both New York (54 percent) and Tennessee (55 percent). For each state, TFC is not commonly used as an initial placement. Overall, the number of children who are placed in TFC as their first placement during their first out-of-home episode is small relative to other care arrangements. The number and proportion of children initially placed in TFC varies greatly by state. In Tennessee, seven percent of children with an initial placement are initially placed in TFC (2,788 of 37,724; see Figure 1 note for denominators), whereas in Illinois and New York, one percent and four percent are initially placed in TFC. Congregate care is more common than TFC as an initial placement. The proportion of children initially placed in congregate care ranges from 16 percent of children in Illinois to 24 percent in New York. Together, TFC and congregate care accounts for less than one-third of all initial placements.

Figure 1. Distribution of Initial Placements by Placement Type, 2008–2015



CC = congregate care, FC =non-kin foster care; KC = kinship foster care; TFC = treatment/therapeutic foster care.

Note: There are 38,385 initial placements in Illinois, 60,193 initial placements in New York, and 37,724 initial placements in Tennessee during the study period.

Length of Stay:

The time spent in TFC and other placements may indicate the degree to which a state uses TFC as a temporary step up or step down from other levels of care. Length of stay may also be a reflection of resource constraints within a state. There is some variation in length of stay within placement types for Illinois, New York, and Tennessee (See Figure 2). With the exception of Illinois, the median placement length of care for children served in TFC across states is equal to or higher than other placement types, with the TFC length of stay for New York and Tennessee hovering around 12 months. Also, in Tennessee and New York, children spend more or equal time in TFC compared to other placement types, particularly congregate care. In contrast to this finding, in Illinois and for the first and second placements only, children spend less time in TFC than in traditional or kinship foster care. The 70 median days spent in TFC for the first placement in that state, for example, is less than one-third the 295 days spent in traditional foster care. For the third placement in Illinois, however, duration of stay in TFC increases to 500 days. This length of time is greater than that for all other placement types in Illinois and is greater than the duration for any other placement in any other state. Also, in Tennessee, median days in placement in TFC, traditional foster care, and kinship foster care are fairly similar.

Figure 2. Median Days in First Through Fourth Placement, by Placement Type, 2008–2015

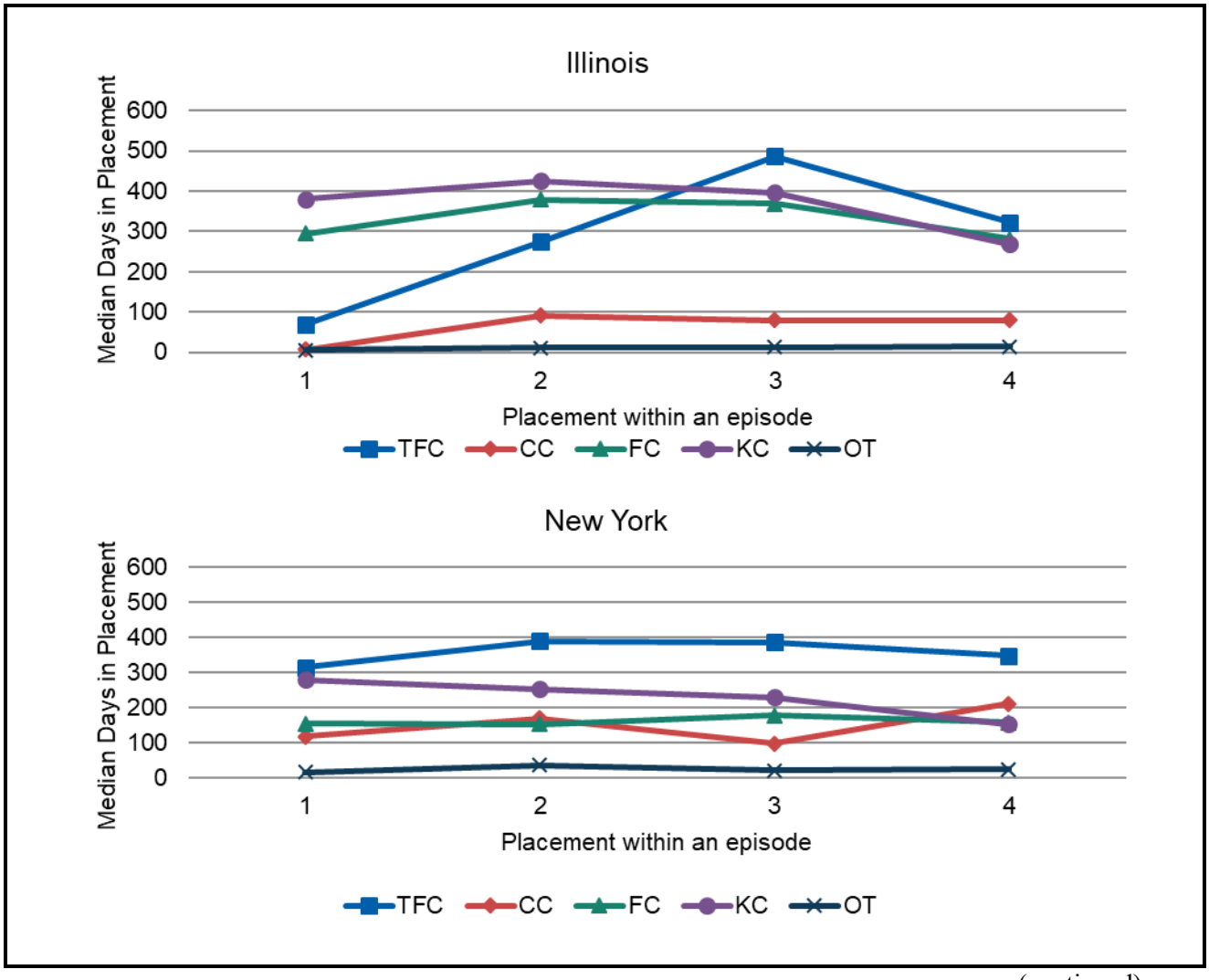


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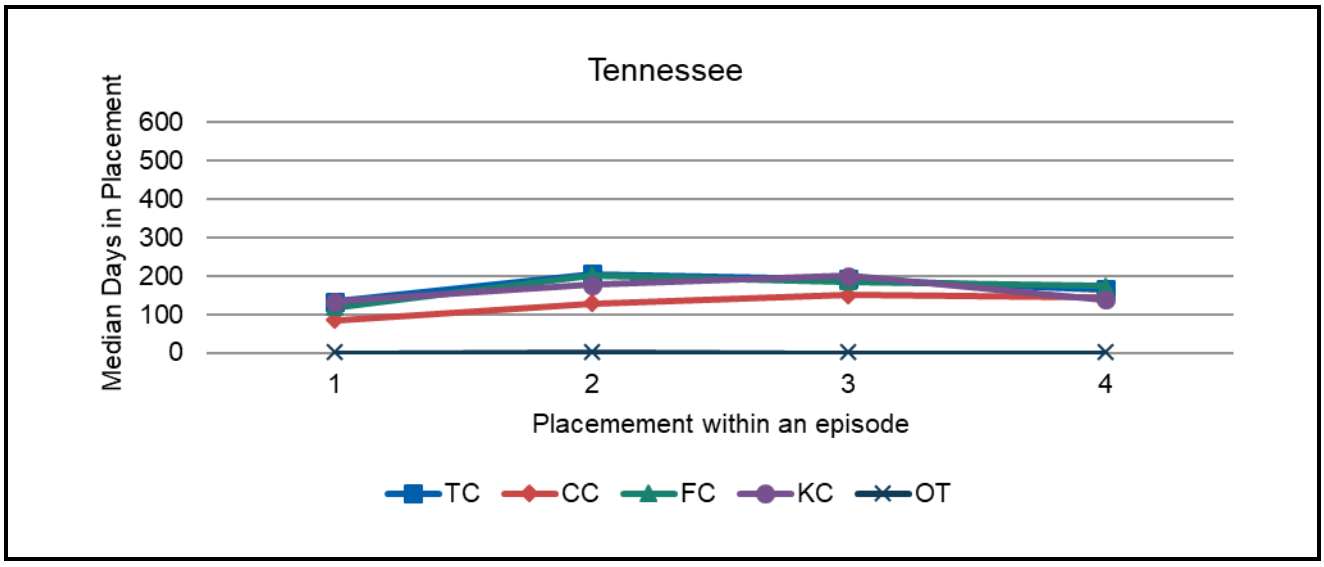
Figure 2. Median Days in First Through Fourth Placement, by Placement Type, 2008–2015 (continued)



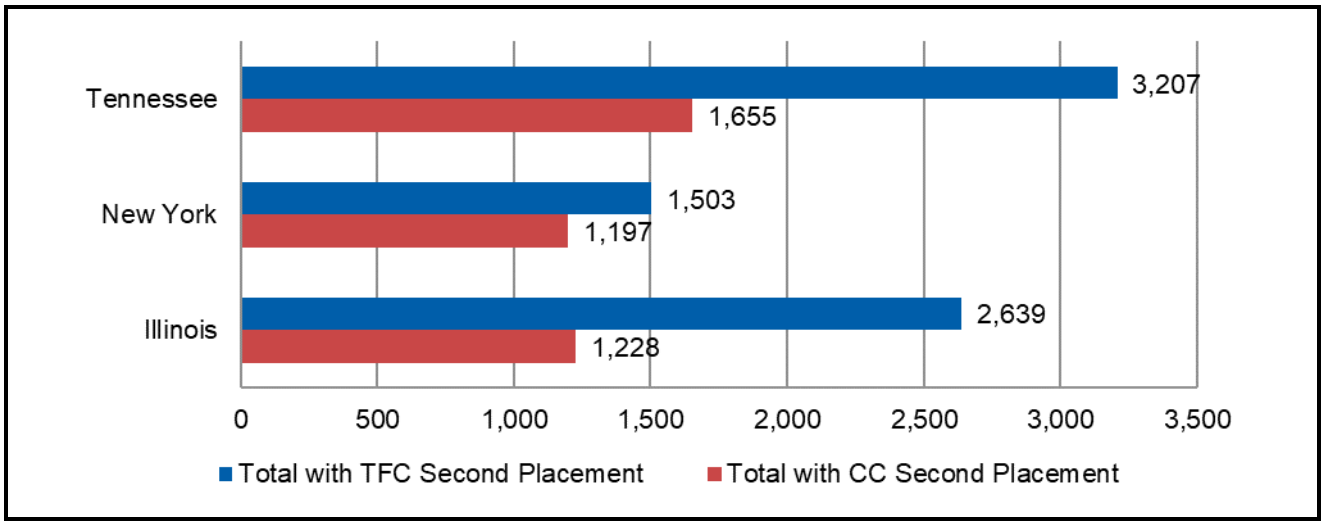
CC = congregate care; FC = non-kin foster care; KC = kinship foster care; OT = other; TFC = treatment/therapeutic foster care.

Note: In Illinois, there are 38,385 first placements, 15,631 second placements, 7,854 third placements, and 4,316 fourth placements. In New York, there are 60,193 first placements, 11,698 second placements, 3,680 third placements, and 1,375 fourth placements. In Tennessee, there are 37,724 first placements, 11,698 second placements, 3,414 third placements, and 1,226 fourth placements.

Second Placement:

Placement patterns reflect the extent to which the state initially identifies children who need a more-intensive or less-intensive level of care. Placement patterns also identify how frequently children step-up and step-down placement types during an episode. TFC is more commonly used as a subsequent placement than is congregate care. As shown in Figure 3, regardless of initial placement type, more children with a second placement type are placed in TFC than in congregate care. In Illinois and Tennessee, the number of TFC second placements (n = 2,639 and n = 3,207, respectively) is double the number of congregate care placements (n = 1,228 and n = 1,655, respectively). New York has fewer second TFC placements (n = 1,503), and TFC as a second placement is similar to congregate care (n = 1,197).

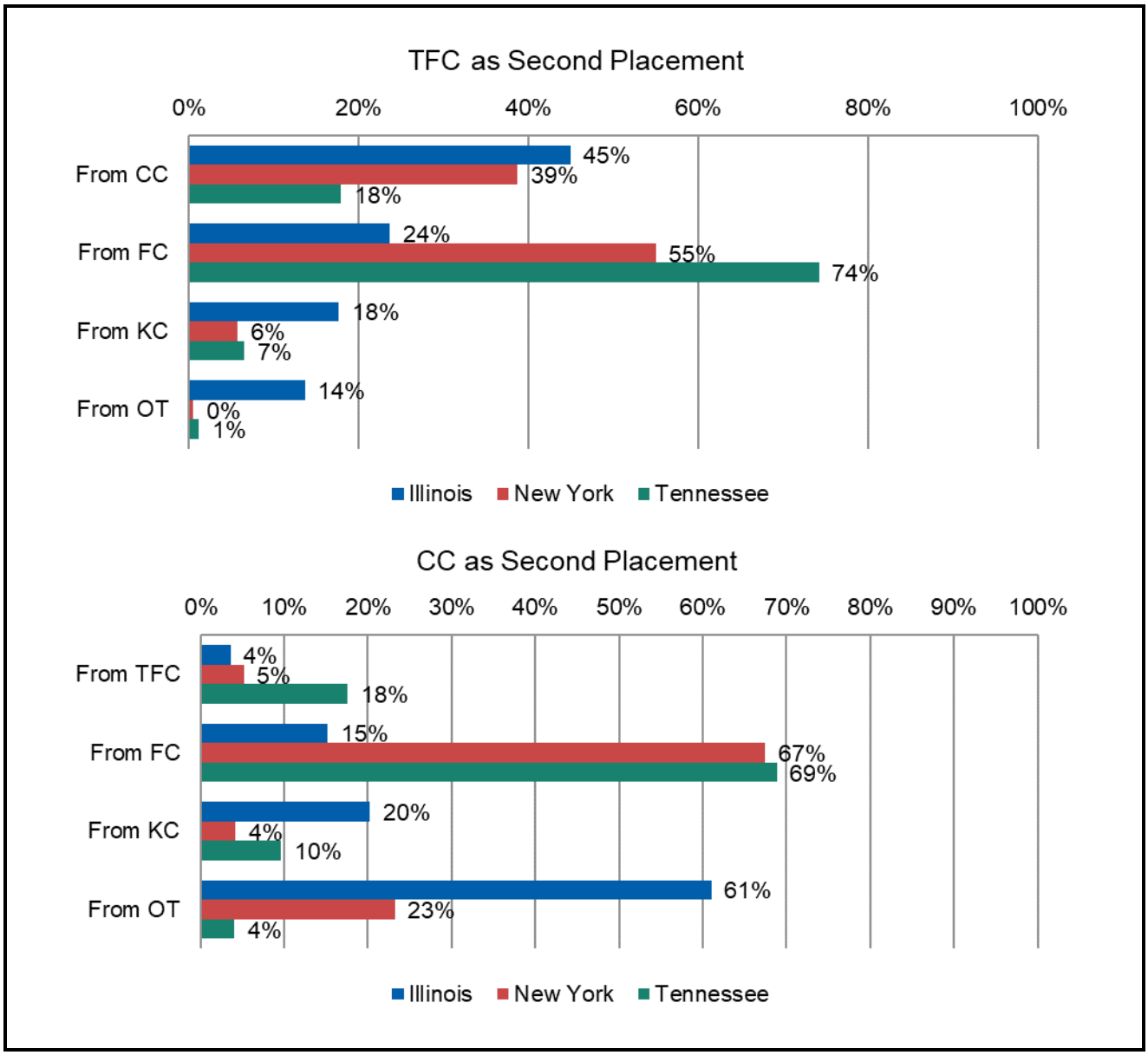
Figure 3. Number of Children Placed in TFC and Congregate Care as a Second Placement, 2008–2015



CC = congregate care, FC =non-kin foster care; KC = kinship foster care; TFC = treatment/therapeutic foster care.

In comparing across placement types in Figure 4, data indicate that a relatively high percentage of children with TFC as a second placement are initially placed in congregate care. This suggests that TFC is used as a step-down placement from congregate care. Conversely, a relatively low percentage of children with congregate care as a second placement are from TFC. This suggests that fewer children step up to congregate care from TFC and can be served appropriately in a TFC placement. The exception to this pattern is Tennessee. In Tennessee, the percentage of children in TFC as a second placement from congregate care is equal to the percentage of children in congregate care as a second placement from TFC (18 percent).

Figure 4. Initial Placement Type for Children with TFC and Congregate Care as a Second Placement Type, 2008–2015



CC = congregate care; FC = non-kin foster care; KC = kinship foster care; OT = other; TFC = treatment/therapeutic foster care.

Note: There are 2,639 second placements in TFC in Illinois, 1,503 second placements in TFC in New York, and 3,207 second placements in TFC in Tennessee. There are 1,228 second placements in CC in Illinois, 1,197 second placements in CC in New York, and 1,655 second placements in CC in Tennessee.

Youth and Caregiver Assessed Needs:

The levels of care provided to children in different placement types reflect, in part, the different emotional, behavioral, and medical needs of the children. The CANS instrument is used upon initial placement to assess these needs across several key domains. CANS data for Illinois and Tennessee in Tables 2 and 3 show that children with higher CANS scores, and therefore higher needs, receive higher intensity levels of care. Children spending the predominant amount of their time (80 percent or more during first episode of care) in congregate care have the most actionable items or mean score, indicating high needs while children spending the predominant amount of time in the traditional/kinship care placement type have the fewest actionable items and lowest mean scores, indicating low needs.

Table 2. Number of CANS Actionable Items: Illinois

CANS Domain	Congregate Care	Foster Care		Mixed Placements
		Therapeutic	Traditional and Kinship	
Child Risk (11 items)				
Mean number of actionable domain items	2.4	0.55	0.10	0.90
Traumatic Stress (5 items)				
Mean number of actionable domain items	1.12	0.66	0.37	0.87
Behavioral/Emotional Needs (13 items)				
Mean number of actionable domain items	3.49	1.46	0.48	1.91

CANS = Child and Adolescent Needs and Strengths assessment.

Note: Mixed placement means a child spent less than 80 percent of his or her time in any single given placement type in the first out-of-home episode.

Table 3. Mean CANS Score: Tennessee

CANS Domain	Congregate Care	Foster Care		Mixed Placements
		Therapeutic	Traditional and Kinship	
Externalizing Behavior (10 items)				
Mean score for the domain	1.17	0.58	0.27	0.74
Physical and Developmental Needs (3 items)				
Mean score for domain	0.30	0.26	0.18	0.25
Caregiver Needs (15 items)				
Mean score for domain	0.67	0.92	0.91	0.91

CANS = Child and Adolescent Needs and Strengths assessment.

Note: Mixed placement means a child spent less than 80 percent of her time in the first out-of-home episode in any given placement type.

Sociodemographic Factors:

Differences in demographic distributions across placement type may directly reflect different policies and resource constraints. For example, differences in age distributions may reflect policies to place younger children in family settings. Differences may also raise issues that suggest further investigation. Figures 5, 6 and 7 show different sociodemographic patterns for children in different placement types. Figure 5 reflects that relative to other types of placement, children placed initially in TFC and congregate care are generally older. Also, children in congregate care as a first placement are generally older than children placed in TFC. In each state, the proportion of children in the 13 to 17 years age group is higher for congregate care than for TFC, with the finding particularly pronounced in Tennessee. In all three states, traditional foster care and kinship foster care typically include more younger children.

Figure 5. Age Distribution for Placement Type by State: Initial Placement During First Out-of-Home Care Episode, Entry Year 2015

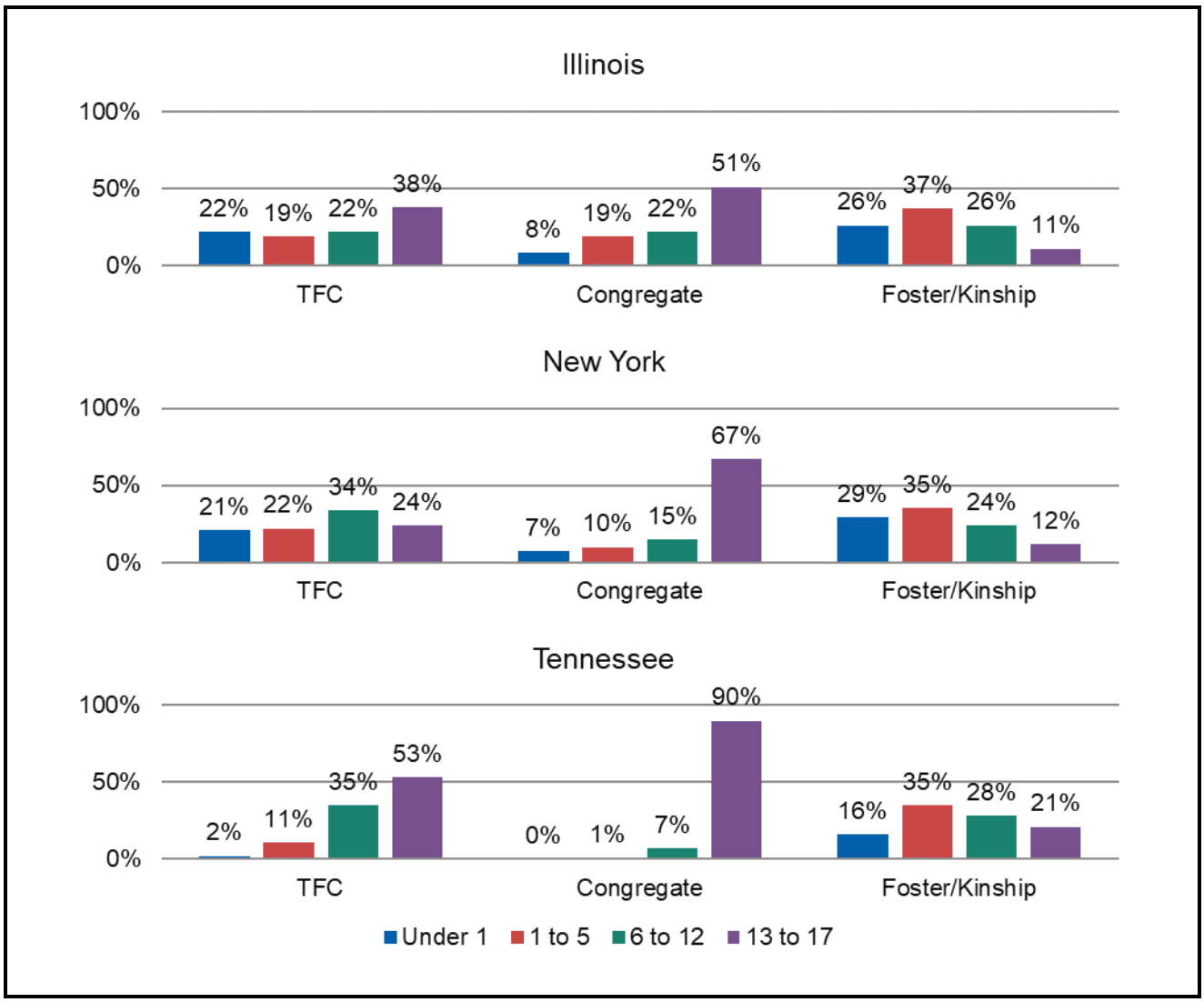


Figure 6. Gender Distribution for Placement Type by State: Initial Placement During a First Out-of-Home Care Episode, Entry Year 2015

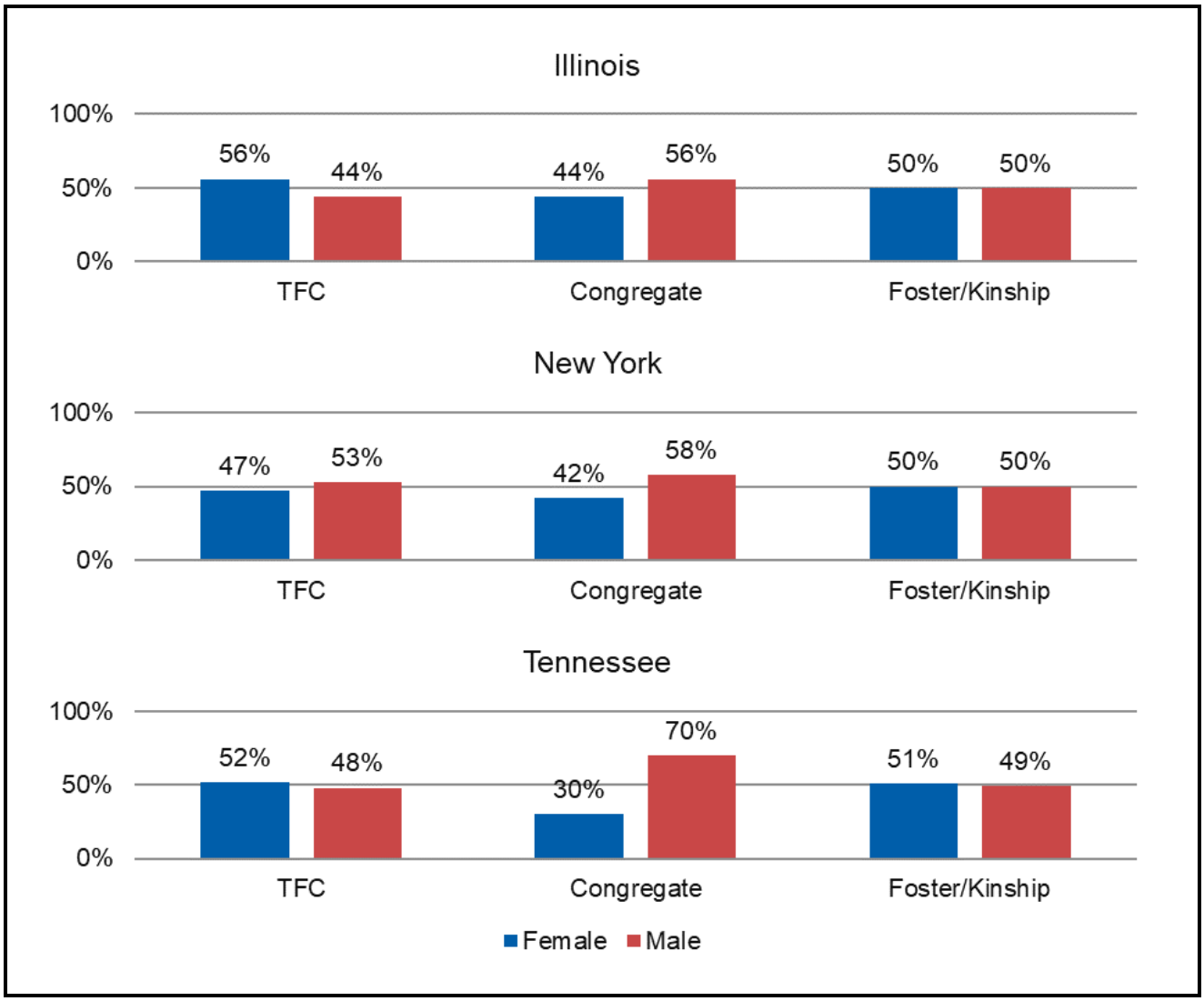


Figure 6 shows that the gender distribution for initial placement in TFC is similar across the states. Among children initially placed in TFC, a slightly larger proportion is girls than boys in Illinois (56 percent are girls, 44 percent are boys) and Tennessee (52 percent and 48 percent), whereas there are fewer girls than boys initially in TFC in New York (47 percent girls, 53 percent boys). In all three states, a higher proportion of initial placements in congregate care are boys.

Figure 7. Race/Ethnicity Distribution for Placement Type by State: Initial Placement During a First Out-of-Home Care Episode, Entry Year 2015

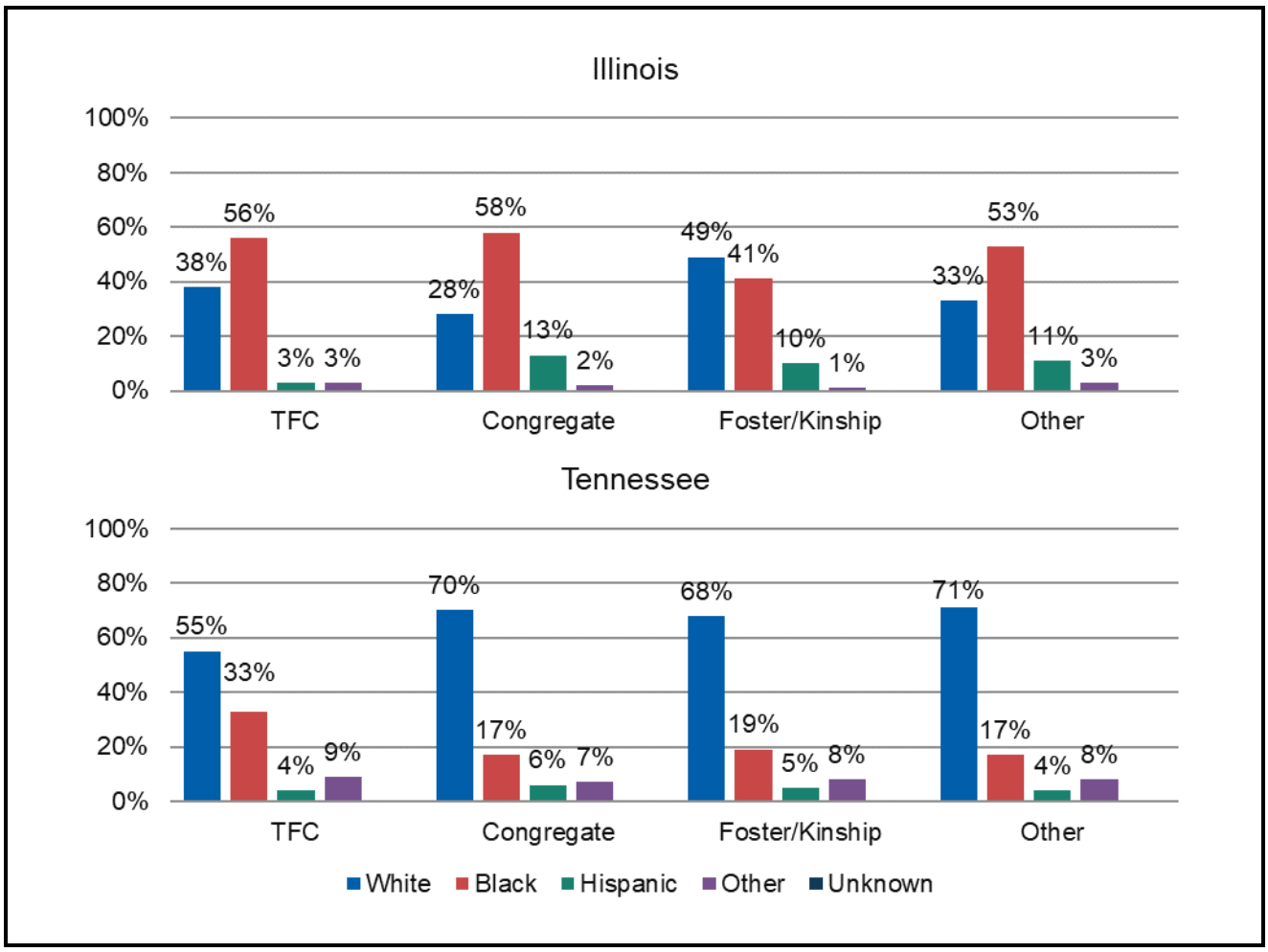


Figure 7 shows the race/ethnicity of children initially placed in TFC in Illinois and Tennessee. Data limitations prevent such a breakout for New York. In Illinois, most children initially placed in TFC or congregate care as their initial placement are black, 56 percent and 58 percent respectively, whereas the overall percentage of black children in the first out-of-home-care episode is 44 percent. In Tennessee, just over half of children initially placed in TFC are white (55 percent) and 33 percent are black. This can be compared to the overall percentages of white and black children in the first out-of-home care episode, 64 percent and 21 percent respectively.

Discussion

TFC can be a vital service for children with significant behavioral and emotional needs who require out-of-home placement. TFC can also be a strategy for states to ensure that children with intensive needs are not placed in congregate care unnecessarily, remain in a community setting, live in a family home, and participate in typical childhood experiences.

In this brief we provide analyses of administrative data from the Chapin Hall Multistate Foster Care Data Archive describing the characteristics and care trajectories of children in the Illinois, New York, and Tennessee child welfare systems. As many studies have shown improved outcomes in TFC compared to those in congregate care, this brief portrays how some states are currently using TFC and congregate care and whether TFC could be a replacement for congregate care in order to help states meet the requirements of the FFPSA. Data shown in this brief identifies some promising patterns showing that states may have already begun using TFC as a substitute for congregate care. However, other patterns point to a need for additional support for increased TFC resources.

Data suggests that additional support for TFC could be pursued to allow more children to access TFC as well as allow more children to access TFC earlier in their out-of-home episodes. However, the data presented here are for three states only, and assessment data was available for only two states. Even among these three states, TFC is used very differently. Findings suggest that states should examine their own data as they determine whether expanding TFC is a strategy that would support their systems and child welfare populations.

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Appendix

Child Welfare Data Descriptions

Table A1. CANS Question Items by Domain for Tennessee and Illinois

Tennessee		Illinois	
Domain	**Question Item**	**Domain**	**Question Item**
Trauma	Adjustment to trauma	Traumatic stress	Adjustment to trauma
Externalizing behavior	Other self-harm		Re-experiencing
	Danger to others		Avoidance
	Delinquent behavior		Numbing
	Substance use		Dissociation
	Impulsivity/hyperactive	Behavioral and emotional needs	Psychosis
	Oppositional		Attention/impulse
	Conduct		Depression
	Anger control		Anxiety
	Social functioning		Oppositional
	Recreational		Conduct
Physical and developmental needs	Developmental		Substance abuse
	Medical health		Attachment
	Physical		Eating disturbances
Caregiver needs	Supervision		Affect dysregulation
	Care involvement		Behavior regressions
	Knowledge		Somatization
	Organization		Anger control
	Natural supports	Risk behavior	Suicide risk
	Residential stability		Self-mutilation
	Problem solving		Other self-harm
	Cultural identity		Danger to others
	Legal		Sexual aggression
	Physical		Runaway
	Mental health		Delinquency
	Substance use		Judgment
	Developmental		Fire setting
	Safety		Social behavior
	Acculturation: Language		Sexually reactive behaviors