Briefing Paper

Treatment Foster Care and the Foster Family-based Treatment Association

Prepared by: Jay A. Berlin, Ph. D., President
Foster Family-based Treatment Association

Executive Director, Alternative Family Services, Inc.
25 Division Street, Suite 201
San Francisco, CA 94103

Telephone: (415) 626-2700
Fax: (415) 626-2760

Executive Summary

Treatment foster care (TFC) is a method of caring for vulnerable populations, principally children as an alternative to more intensive residential treatment utilizing family-based placements surrounded by intensive professional supports. It is being used with an increasing number of target population groups, facilitates family preservation, and is finding its place within the managed care environment. It is largely publicly funded. The Foster Family-based Treatment Association is the professional association that represents TFC in the U.S. and Canada. TFC provides a partial solution to the escalating cost of residential care for vulnerable populations and provides better care in the process. It can make significant contributions to improving the current publicly operated foster care system.

Part I: Treatment Foster Care

Definition of Treatment Foster Care: The Foster Family-based Treatment Association (FFTA) formally defines treatment foster care as:

> a program for children, youth and their families whose special needs can be met through services delivered primarily by treatment foster parents trained, supervised and supported by agency staff. Each of the key persons and components identified in this statement is essential to any application of treatment foster care as a service model or program type.[1]

Essentially, TFC is a model of caring for vulnerable populations, predominantly children, outside of their home that combines the strengths and technology of residential treatment with the benefits of family-based placement. Treatment foster care is distinguished from traditional foster care by:

- more stringent requirements of foster parents
- more intense, required pre-service and ongoing training of foster parents
- higher reimbursement payments to foster parents based on the comprehensiveness of the treatment program and the skills required of the foster parents to carry it out
- intensive supervision of foster homes by highly qualified (usually Master's level) social workers with small caseloads

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[1] Foster Family-based Treatment Association, (1991). *Program Standards for Treatment Foster Care.* New York: Foster Family-based Treatment Association.

- highly individualized treatment planning for each child often accompanied by an agency-implemented treatment program according to a particular clinical modality

- intensive therapeutic supports and specialized services to children, foster and primary families provided by agency professional staff, available on a 24-hour, 7-day per week basis

- more intensive attention paid to the questions of permanency in the child's life, attention to primary family, and follow-through in achieving the goals of the treatment plan

- the fact that most, but not all, treatment foster care is delivered by private, community-based agencies, usually, though not always, not-for-profit corporations. Most traditional foster care is directly operated by state or local government

The Place of Treatment Foster Care in the Continuum of Services: By and large, treatment foster care has been used as an alternative to residential treatment. It is considerably less expensive, though not necessarily less treatment intensive than the residential treatment it is designed to replace. The economic advantage of the modality is due to the absence of physical plant costs and to the relatively low cost of foster parent reimbursement (particularly considering the 24-hour nature of their commitment) compared to salaries for shift staff in a residential treatment setting. Research to date shows the results to be as good, if not better than residential treatment.[2] Placing one or two children per home allows for a much more individualized treatment plan than is possible in group settings, without the danger of contamination from other disturbed children. The typical child in a treatment

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[2]Fanshel. D., Finch, S., & Grundy (1990), *Foster Children in a Life Course Perspective.* New York: Columbia University Press.

Colton, M. (1988). *Dimensions of substitute child care.* Aldershot, England: Avebury.

Hawkins, R., Almeida, C. & Samet, M. (1989) Comparative evaluation of foster-family-based treatment and five other placement choices: A preliminary report. In A. Algarm, R. Friedman, A. Duchnowski, K. Kutash, S. Sliver, & M. Johnson (Eds.) *Children's Mental Health Services and Policy: Building a Research Base* (pp.98-119). Proceedings of the 2nd Annual Research Conference, Research and Training Center for Children's Mental Health, University of South Florida, Florida Mental Health Institute, Tampa, FL.

Chamberlain, P., & Reid, J. (1991) Using a specialized community treatment model for children and adolescents leaving the state mental hospital. *Journal of Community Psychology,* 19, 266-276.

Chamberlain, P. (1990). Comparative evaluation of specialized foster care for seriously delinquent youths: A first step. *Community Alternatives,* 2, 21-36.

foster home has two foster parents, a caseworker, a therapist, and a variety of other agency staff in his/her life. Thus the child is surrounded by health, supervision and role models, rather than pathology. Furthermore, children are socialized to live in more normal, caring, non-restrictive settings rather than institutions. Put another way, advocates claim that a child can only learn family values as part of a family.

Treatment foster care is more intensive and *seemingly* more expensive than traditional foster care due to the higher staff to foster family ratio required to deliver the necessary support and supervision and due to the higher payment made to foster parents. However, the true cost of traditional foster care is difficult to calculate. Traditional foster care is usually delivered by county or state government. A fair estimate of the full cost of traditional foster care would factor in the cost of local welfare and probation department personnel and the program's share of governmental overhead. Public sector social workers are often paid higher salaries and receive higher benefits, especially retirement benefits, than their private sector counterparts.

Developments in the Field: There are three trends discernable in the current development of TFC - increasing diversity of target populations; accommodation to and blending with family preservation; development of TFC as a "step-down" option for seriously disturbed children in a managed care environment.

> **Target Populations:** As mentioned, TFC developed originally as an alternative to residential treatment within the child welfare, mental health, and juvenile justice systems. As the model proliferated, it has been adapted to specialized subsets such as pregnant teens/teen moms; medically fragile children; children needing short-term emergency shelter; and adjudicated juvenile delinquents. An increasing use of TFC has been with developmentally delayed children. Some FFTA members offer TFC to developmentally delayed adults, adults with brain injuries (as an alternative to rehabilitation facilities) and to geriatric populations (as an alternative to board and care/rest homes). An interesting adaptation currently being experimented with in some agencies is "whole-family" or "shared-family" care wherein the entire family, parents and children are taken into care and placed with a foster family. This modality has been applied in drug treatment situations (as a means of keeping parents and children together while the parents undergo drug treatment); and homelessness prevention (instead of removing the children of homeless adults and placing them into foster care and leaving the adult on the street, the family unit is kept intact, placed with a foster family, and given services to help the family get on its feet).
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> **Family Preservation:** Direct work with the primary family typically begins as soon as the child enters treatment foster care. Many FFTA members have found that the supports they provide to their treatment foster families are

identical to those utilized by primary families in family preservation programs. This provides an entree for programming that helps children exit the foster care system. Support staff to foster parents can "go home" with the children when they are reunified. The continuity of care helps to ensure that the reunification is successful. Conversely, the presence of staff who work with the primary family has made placement-oriented staff more willing to support family reunification.

Managed Care Step-down: Intensive and often restrictive residential treatment programs serving seriously emotionally disturbed children have begun adding TFC programming as a response to pressure from managed care companies that they shorten stays in the more expensive facilities. This services allows children to be "stepped-down" into foster homes with high levels of in-home support. As the child improves, the support can be withdrawn gradually as appropriate, without interfering with the bond between the child and foster parent. This aspect of TFC may be the fastest growing part of the field, and is of increasing interest to large proprietary, hospital corporations and managed care companies.

The Funding of Treatment Foster Care: The vast majority of treatment foster care is publicly funded. Funding and rates paid vary among the states. With regard to federal funds, nearly all publicly funded programs take some Title IV-E funds. An increasing number of agencies fund large portions of their programs with Title XIX Medicaid dollars, particularly in those states electing the Rehab Option, though the manner and mechanisms vary dramatically. Some programs have been able to access EPSDT, though this is more the exception than the rule. In addition to local match, many programs augment with private foundation and voluntary dollars.

Part II: The Foster Family-based Treatment Association

The Foster Family-based Treatment Association (FFTA) was founded in 1988. It has grown rapidly and now is comprised of 312 agencies that operate treatment foster care programs. Two hundred eighty-six of these agencies are located in the United States, twenty-six in Canada. Members represent a wide spectrum of agency profiles from small agencies providing homes to ten children, to large multi-state agencies with program capacity in the hundreds of beds. Similarly, some Association members offer treatment foster care only, while others are multi-service agencies offering a continuum of services including residential treatment, family preservation, day treatment, on-grounds school, and a full range of related mental/behavioral health services.

The purpose of the association is to promote and enhance the provision of treatment foster care services to children; set professional standards for the delivery of these services; encourage the development of programming expertise, including an

emphasis on research, evaluation and outcome measurement; offer resources and support to the providers of treatment foster care services; and act as the North American voice in behalf of treatment foster care.

Much of the Association's efforts in its early years was dedicated to the development of written practice standards for treatment foster care. The primary intent of this effort was to ensure the quality of programming by concretely specifying the nature and intensity of services required for a program to be able to call itself Treatment Foster Care. The secondary intent was to provide a measure of continuity in the field to assist policy development on the state, provincial and federal levels in U.S. and Canada. The development process took almost three years and involved extensive contributions from the rank and file through a series of local meetings held all over North America feeding back to a centralized process. Standards of practice were published in 1991. The first revision of these standards are due to be published this year. The Association operates a national conference annually, and publishes a quarterly newsletter for its members.

Within the past three years the Association has undertaken the formation of local chapters for the purpose of delivering training to members and promoting advocacy in behalf of treatment foster care. Currently FFTA operates chapters in California, New Mexico, Minnesota, Nebraska, Illinois, Michigan, Indiana, Ohio, Kentucky, West Virginia, Maryland, Pennsylvania, Delaware, District of Columbia, Virginia, New York, Alberta and Ontario.

Part III: Public Policy Issues

Most Important Global Issue: Maintain the open ended entitlement for foster children. These children have been made children-of-government by court action. Government's responsibility to these children is fundamentally different than it is toward other constituencies as it has assumed the role of parent and legal guardian. Funding for foster care needs to be recognized as the health and safety issue it is, not a welfare issue as some would have it. To us, a carve-out for dependent children from welfare reform and block grant is not dissimilar to the "except for rape and incest" carve-out that even the most adamant pro-lifers were usually willing to put in their anti-abortion bills. That is, protecting vulnerable dependent children should be advanced as a bi-partisan principle of fundamental humanitarianism.

Privatizing Foster Care, Outcome Monitoring, and Permanency For Children: While a full evaluation of the public sector foster care system is beyond the scope of this paper, the advantages the private sector has in efficiency, flexibility, and accountability are generally recognized. Currently, public agencies both contract with for services and compete with the services they contract with. A less conflicted arrangement would have the public agencies continue to be responsible for case

management, court reporting, and holding the direct service providers accountable, while the private sector handled the direct provision of services. Thus, privatization would enhance the prospect of "outcomes monitoring" (i.e. measuring status of child/family at discharge) which could be required as part of the private agency's contract. Accountability of outcome is particularly difficult to mandate in the public, civil service environment. The goal of these contemplated changes would be to achieve permanency for children, reduce the number of children in the system, increase the number of adoptions. Aggressive efforts on the federal level would be helpful in achieving this goal.

Blended and Flexible Funding: Current funding follows the "system" that identifies the child. If the child comes through child welfare, access to IV-E/IV-A is easy, and this is the way most TFC is funded. Access to mental health funding is more available to children identified by the mental health system. Jurisdictional licensing and certification rules complicate service delivery. It would be enormously useful if funding that is now restricted to children could be applied to the child's family, or that IV-E funding could be expanded beyond "care and supervision" to include treatment services. While some states have taken the initiative to blend funding streams so that services can be targeted to children and their families based on assessment of need rather than the label - "runaway," "delinquent," "dependent," "patient," "student," etc, federal leadership is needed to spotlight decategorization efforts that are working, provide technical assistance and consultation, and most importantly clear away the red tape.

Managed Care: Inasmuch as managed care is providing a needed impetus to rely more on innovative service delivery and less on inpatient care, managed care is a fresh wind blowing out the cobwebs of institutional care. It holds promise not only for cutting costs of mental health treatment, but also for demystifying and normalizing the mental health delivery system. The threat, however, is in the fact that managed care companies focus on acute interventions (a holdover from the hospital culture) and don't like to consider the needs of longer-term populations. In the coming years there will probably be a move to include traditional child welfare services into the managed care arrangements that states and counties are embracing for health and mental health care. When the Health Care/Insurance Reform is enacted, statutory and regulatory protection must ensure that children are not disqualified for services because of their chronicity (i.e. they are kids and it takes time to grow up); and that community-based facilities are allowed in as service providers.

Problems with Medicaid: To date, TFC still is not well recognized as a valid modality. Many jurisdictions require discrete TFC service components to be billed in 15 minute units. In some jurisdictions MA funding requirements have distorted the TFC concept by requiring certified mental health professionals to intervene in the homes when they were not really needed to provide the treatment. TFC is *not* a

traditional foster care bed with periodic mental health services patched in. That is like saying residential treatment should be funded for bed-cost only with staff intervention billed by the minute. In actuality, both residential treatment and TFC are *programs* of services (including staff requirements, training, technology, etc.). Medical assistance works well for TFC when is allows for a "bundled" or generic TFC rate based on an average set of service costs.