Quarterly

How can foster care help vulnerable children?

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THINKING OF THE WORLD

THIS ISSUE

NEXT ISSUE
Intervening after intimate partner violence
Many children are exposed to their caregivers perpetrating or being victimized by intimate partner violence. We examine interventions that can help those who experience this particularly common form of child maltreatment.

How to Cite the *Quarterly*

We encourage you to share the *Quarterly* with others and we welcome its use as a reference (for example, in preparing educational materials for parents or community groups). Please cite this issue as follows:

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Supporting our most vulnerable children

I go into those phases … where I wanna be a kid again. But reality quickly snaps me back. My friends, they have a lot of family support, so they're making those mistakes … they have their family to back them. I don't have the luxury of making those types of mistakes. — Youth in foster care[1]

Try to put yourself in their place. Sometimes when I would get frustrated sometimes I would just step back and I would put myself in their place and think, well, you know, had I gone through that I'd probably act the same way. — Foster parent[2]

All children deserve to be raised in safe homes, surrounded by loving families and communities. Fortunately most families and most communities are able to ensure this. When they cannot, child protection agencies must intervene. Once anyone — teacher, doctor or other community member — reports concerns about a child's safety, protection workers typically conduct an assessment, following processes outlined in provincial or territorial legislation.[3] If the child's risk of harm from remaining in the family home is deemed greater than their risk from going into care, a safe placement must be found.[4] When extended family is not available, foster care is typically preferred over group homes and residential centres, because foster care better approximates family settings.

Maltreatment — including neglect, emotional abuse, physical abuse and sexual abuse — is the most common reason for children being in foster care.[5] And recent data suggest that many children experience maltreatment. A survey of Canadian child welfare agencies found substantiated maltreatment occurring for approximately 1,400 of every 100,000 children (or nearly 1.5%) — which is thought to be an underestimate given that many cases go unreported.[6] Children may also enter foster care if their parents are unable to provide care as a result of illness or incarceration.[4]

How many children are living in foster care?

Determining the exact number of children living in foster care is challenging because each province and territory defines "children in care" slightly differently. For example, some jurisdictions include children placed with extended family members while others do not.[7] Definitions of children in care can also vary according to length of time a child is in protective care.[8] Researchers have nevertheless estimated that as many as 67,000 Canadian children may be placed

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in protective care each year, which is an estimated 920 of every 100,000 children (or nearly 1%).[8]

The BC rates are similar. In 2011, nearly 8,200 children were living in protective care, which is an estimated 910 of every 100,000 children.[9] But there are striking imbalances in the populations affected. In BC, Aboriginal children are 15 times more likely to be in protective care than other children (6.1% versus 0.4%, respectively).[9] Furthermore, most Aboriginal children in protective care — 53% — are placed in non-Aboriginal homes.[10]

When the challenges continue

Once children enter foster care, many often continue to face significant obstacles. A recent systematic review found that foster children had substantially higher rates of developmental delays and mental disorders, including attention-deficit/hyperactivity disorder, conduct disorder, depression and substance abuse, compared to non-maltreated peers.[5] Recent BC data also suggest that children in protective care make significantly more suicide attempts than children in the general population.[10] As well, BC data suggest that these children are significantly less likely to finish high school.[9] However, it remains unclear whether these poorer outcomes stem from the family difficulties that brought children into protective care in the first place, experiences within the system, or a combination of these and other factors.[11] It is nevertheless very clear that children who "graduate" from foster care typically face numerous challenges in adulthood, including higher rates of incarceration, homelessness, unemployment and reliance on public assistance.[12]

Good data is a click away

To learn more about the foster care system in Canada, please visit the Canadian Child Welfare Research Portal (www.cecw-cepb.ca). The portal is designed to provide child welfare professionals, researchers and the public with access to research publications that include information about provincial, territorial, Aboriginal and national child welfare policies, legislation and programs.

Non-profit group gives youth a voice

In 1993, a group of young people dedicated to improving the lives of children and youth in government care created the Federation of BC Youth in Care Networks. This youth-driven non-profit organization gives young people with current and past experiences in the care system:

- opportunities to meet and engage with other young people in or from government care within their own communities
- individual support, including advocacy, referral services, support plans and bursaries
- educational resources, including detailed information about the rights of children in care
- a united voice to create positive changes within the care system

Their website — available at http://fbcyicn.ca — also provides links to other resources for Canadian children in care.

Fostering hope

Adults and communities share a collective responsibility to ensure that all children are protected. Part of this obligation includes preventing child maltreatment wherever possible, thereby averting the need for foster care. To this end, in our previous issue on <u>Preventing and Treating Child Maltreatment</u>, we identified a number of prevention programs with solid evidence of success. One program with particularly robust outcomes is the <u>Nurse-Family Partnership</u>, which involves providing intensive nursing services to vulnerable first-time mothers.[13] However, until prevention programs are more widely available, the need for high-quality protective care is unlikely to decline substantially.

When children do need protective care, risks can nevertheless be mitigated. In particular, permanency planning is helpful for children. This includes not moving children without a compelling reason and maintaining the same protection workers so children experience continuity in their relationships.[14] As well, there is evidence that children have better developmental and mental health outcomes when they are placed with family members — in "kinship care" — rather than in traditional foster care.[11]

There is also growing evidence that children's outcomes are better when the foster care they receive is specialized and therapeutic. We explore the evidence for treatment foster care in the following review. ✋

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Can foster care be therapeutic?

Ideally, foster care would always be nurturing, consistent and developmentally appropriate, ensuring stability and good outcomes for some of society's most vulnerable children. In reality, many children in foster care do not experience stability or good outcomes.[14, 15] One suggested remedy is to provide an enriched form of foster care — or treatment foster care (TFC) — wherein children are cared for by foster parents who have specialized training and who themselves receive ample support.

The fundamentals of treatment foster care

While there are variants of TFC, all share the common goal of providing children with stable placements and reuniting them with their families of origin whenever possible.[16] As well, TFC usually aims to serve children at risk for having multiple placements or more restrictive placements (such as residential centres) due to their complex emotional and behavioural needs.[16] With TFC, children access specialized foster family settings and receive personalized treatment with clear goals, documented methods for achieving goals and a process for evaluating outcomes.[16]

TFC also provides intensive training and enhanced supports for foster parents, such as 24-hour crisis intervention services. Additionally, foster parents typically have no more than two children in their homes so they can deliver high levels of care. These foster parents are also fully recognized as treatment team members.[16]

Assessing the evidence

Researchers MacDonald and Turner set out to determine whether TFC actually improves children's outcomes. To do this, they conducted a systematic review of randomized controlled trials (RCTs) of TFC's effectiveness. (Our methods for appraising and selecting this review are detailed in the Appendix.) Because MacDonald and Turner's review was limited to RCTs published up to January 2007, we conducted our own systematic search for RCTs published after this date. We found one follow-up publication (regarding an RCT included in MacDonald and Turner's review), plus one entirely new evaluation (which is highlighted in the sidebar on page 10.)

Variants of treatment foster care share the common goal of providing children with stable placements and reuniting them with their families of origin whenever possible.

What's in a name?

Treatment foster care (TFC) is the term used to describe foster family-based interventions that provide children with individually tailored programs in homes with highly skilled and well-supported foster parents. The forms of TFC featured in this review include the *Fostering Individualized Assistance Program*,[21] *Multidimensional Treatment Foster Care* (regular and "light" versions)[17, 19, 23, 25] and *Specialized Foster Care*.[20]

MacDonald and Turner identified five RCTs that met their inclusion criteria. These five RCTs evaluated four types of TFC: 1) *Multidimensional Treatment Foster Care* (covered in two separate evaluations — one for boys and one for girls);[17, 18] 2) *Multidimensional Treatment Foster Care* "Light";[19] 3) *Specialized Foster Care*;[20] and 4) the *Fostering Individualized Assistance Program*.[21] Table 1 describes the four programs and the children who participated in the five evaluations of them.

Table 1: Child and Intervention Characteristics[16]			
Age (Gender)	**Presenting Problem**	**Program Participants and Roles**	**Comparison Condition**
4–7 yrs (39% male)	Maltreatment	***Multidimensional Treatment Foster Care "Light"***[19] *Case manager:* Supporting foster parents with 3x weekly phone calls + weekly group meetings	Typical foster care
7–15 yrs (61% male)	Maltreatment	***Fostering Individualized Assistance Program***[21, 22] *Case manager:* Conducting assessments, facilitating monthly planning meetings,* coordinating services,** tracking progress, teaching self-advocacy skills to children + their caregivers *Child:* Participating in therapy as needed *Family of origin:* Participating in therapy as needed	Typical foster care
9–18 yrs (40% male)	Severe emotional disorder	***Specialized Foster Care***[20] Case manager: Supporting + supervising foster parents with daily phone calls + weekly group meetings, monitoring treatment plan *Child:* Participating in weekly individual therapy *Foster parent:* Participating in 8-hr behaviour management training, applying daily behavioural point systems	Residential centre (e.g., juvenile corrections), hospital or extended family home
12–17 yrs (100% male)	Chronic delinquency	***Multidimensional Treatment Foster Care***[17] *Case manager:* Supporting + supervising foster parents with daily phone calls + weekly group meetings; coordinating services *Child:* Participating in weekly individual therapy *Family of origin:* Participating in weekly family therapy *Foster parent:* Participating in 20-hr behaviour management training, implementing individualized behavioural plans	Group home
13–17 yrs (100% female)	Chronic delinquency	***Multidimensional Treatment Foster Care***[18] See above	Group home
* Facilitation gradually transferred to parent or other relative when possible. ** Including community services such as Big Brothers as well as individual services such as supplying refrigerators for parents or bicycles or tutoring for children.			

Children participating in these programs resided in Oregon and Florida. They needed foster care as a result of maltreatment, severe emotional disorders or chronic delinquency. The programs geared to maltreated children — *Multidimensional Treatment Foster Care* "Light" and the *Fostering Individualized Assistance Program* — had the youngest participants, ranging from four to 15 years. *Specialized Foster Care,* serving children who had been psychiatrically hospitalized, was delivered to both children and adolescents. Finally,

Multidimensional Treatment Foster Care was delivered to adolescents with chronic delinquency problems.

All four programs included a case manager who supported the foster parents. The case manager also supervised foster parents in the two *Multidimensional Treatment Foster Care* trials and the *Specialized Foster Care* trial. In the *Fostering Individualized Assistance Program,* case managers played an even more comprehensive role: conducting assessments, coordinating services and teaching self-advocacy skills to children and their caregivers.

Therapy was available to children in four of the evaluations. In the two *Multidimensional Treatment Foster Care* trials, youth participated in weekly individual therapy focused on skill building.[17, 23] As well, youths' families of origin participated in weekly family therapy focused on parent management training.[17] In *Specialized Foster Care,* children participated in weekly individual therapy, typically focused on problem-solving, self-control strategies and communication skills.[20] In the *Fostering Individualized Assistance Program* a variety of therapies were available, on an as-needed basis, including family systems therapy, joint sibling therapy and grief counselling.[21]

How well does treatment foster care work?

MacDonald and Turner reported on a range of children's outcomes — from mental health to school success to placement stability. We present these outcomes in Table 2, along with more recently published data on substance use reported in the follow-up *Multidimensional Treatment Foster Care* study with adolescent boys.[24]

Most forms of TFC produced statistically significant beneficial outcomes. *Multidimensional Treatment Foster Care* proved to be effective for adolescents with delinquency problems, reducing incarceration rates for both boys and girls. Boys in this program also had less criminal offending according to official and self-reports, along with less substance use than comparison boys. As well, fewer boys in the program ran away from their placements. Similarly, girls in *Multidimensional Treatment Foster Care* had fewer behaviour problems and better school attendance. These outcomes were also clinically meaningful (demonstrating at least moderate effect sizes when such calculations were possible).

A less intensive version of this program — *Multidimensional Treatment Foster Care* "Light" — showed one promising outcome for young children who had been maltreated. Children in this program were significantly more likely to remain with their original foster parent than to be placed in a different foster home or in residential care.

Most forms of treatment foster care produced statistically significant beneficial outcomes.

Table 2: Treatment Foster Care Outcomes[16]					
Interventions	**Multidimensional Treatment Foster Care "Light"**[19]	**Fostering Individualized Assistance Program**[21,22]	**Specialized Foster Care**[20]	**Multidimensional Treatment Foster Care**[17,24]	**Multidimensional Treatment Foster Care**[18]
Participants	4–7-year-old boys + girls	7–15-year-old boys + girls	9–18-year-old boys + girls	12–17-year-old boys	13–17-year-old girls
Outcomes assessed (post-baseline)	3 months	42 months	7 months	19, 25 + 31 months*	12 + 24 months
Behavioural					
↑ social skills	—	○	○	—	—
↓ problem behaviours	—**	○	○	—	●
↓ substance use	—	—	—	●	—
↓ criminal offending	—	○	—	●	○
↓ incarceration	—	●	—	●	●
Emotional					
↓ emotional problems	—	○	—	—	—
↓ disturbance severity	—	—	○	—	—
School					
↑ attendance	—	○	—	—	●
↑ homework completion	—	—	—	—	●
↓ dropping out	—	○	—	—	—
↓ suspensions	—	○	—	—	—
Placement stability					
↓ placement disruptions	●	—	○	◉	—
↑ in permanent placement	—	●	—	—	—
↓ running away	—	●	—	●	—

● Statistically significant (p < .05)
◉ Statistically significant for some but not all measures
○ Not statistically significant (p > .05)

— Not assessed/Not applicable
* Timeframes are approximate
** Measure of statistical significance not reported

The other program evaluated with maltreated children also documented some significant benefits. Young people receiving the *Fostering Individualized Assistance Program* had reduced incarceration rates and fewer episodes of running away compared to those in typical foster care. As well, by final follow-up, intervention children were twice as likely to be living with parents (either biological or adoptive), with other relatives or in independent situations. However, the *Fostering Individualized Assistance Program* did not achieve success for most assessed outcomes.

Specialized Foster Care produced less promising results for children needing placements following psychiatric hospitalization. Children in this program neither remained in their placements longer nor achieved better mental health outcomes compared to controls. However, children in the program were placed in foster homes significantly more quickly than control children. In addition to these children benefiting by entering less restrictive settings more quickly, their earlier departure from hospital resulted in average cost savings of US$10,280 per child (in 1988).[20]

Building on success

MacDonald and Turner's review highlighted evidence supporting treatment foster care as "a promising intervention" for children and youth experiencing emotional and behavioural problems and in need of protective care. However, forms of TFC provided to children who had been maltreated and to children who had been psychiatrically hospitalized achieved only modest benefits. In contrast, American youth with serious delinquency problems showed multiple gains in two evaluations of *Multidimensional Treatment Foster Care*. Given new findings from a recent Swedish study (highlighted in the sidebar), there is now evidence that this program also works with adolescents outside of the United States.

Notably, however, while *Multidimensional Treatment Foster Care* is the one form of TFC being offered in Canada (in Sault Ste. Marie, Ontario), the program has yet to be evaluated in this country, according to MacDonald and Turner's review. Therefore, we strongly recommend a Canadian outcome evaluation before widespread dissemination is considered in this country. ✋

Benefits beyond American borders

Results from the first RCT evaluation of treatment foster care outside the United States were published in 2011.[25] This landmark study tracked the outcomes for conduct disordered Swedish youth. Although *Multidimensional Treatment Foster Care* was not significantly better than regular services at reducing youth's emotional problems over a two-year period, it did reduce behaviour problems. And the gains did not stop there. Mothers of these youth had significantly less severe mental health symptoms in general, and significantly fewer depressive symptoms in particular, than did mothers of youth receiving regular care. Notably, all of these improvements were statistically *and* clinically significant, suggesting that gains resulted in meaningful differences in the lives of these young people and their families.

Increasing our acceptance

To the Editors:

In the last *Quarterly*, you identified several ways to reduce the stigma associated with mental disorders. Given that increasing knowledge can encourage understanding and compassion, could you identify any mental health resources for school counsellors, teachers, physicians and families — to help them in working with children and youth?

Hazel Neill
Coquitlam, BC

We agree that increasing knowledge can be a helpful first step in reducing stigma and increasing understanding and compassion for children. The following table lists several websites that provide comprehensive information on a variety of children's mental health topics pertinent to your question. ✋

Increasing knowledge can be a helpful first step in reducing stigma.

Table 3: Children's Mental Health Resources

Audience	Resources	Organization
Families, practitioners	• Factsheets on topics ranging from infant mental health to children's mental disorders to grief • Practical resources, including self-help workbooks	*Kelty Mental Health Resource Centre* (BC Children's Hospital) www.keltymentalhealth.ca
Youth	• Factsheets on anxiety, depression, psychosis, substance use and managing stress • Lists of treatment resources, including self-help workbooks	*Mindcheck* (Consortium of BC Healthcare Providers) www.mindcheck.ca
Youth, families, general public, practitioners	• Factsheets on topics ranging from daycare to healthy development to childhood mental disorders	*American Academy of Child and Adolescent Psychiatry* www.aacap.org
Practitioners	• Suicide prevention guide	*Child and Youth Mental Health* (Ministry of Children and Family Development) www.mcf.gov.bc.ca/suicide_prevention/for_practitioners.htm

Contact Us

We hope you enjoy this issue. We welcome your letters and suggestions for future topics. Please email them to chpc_quarterly@sfu.ca or write to the Children's Health Policy Centre,

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Research methods

To identify the best systematic reviews on the topic of treatment foster care, we adapted methods from the *Cochrane Collaboration*.[26] We first searched the following databases (without date limiters):

- Campbell Collaboration Library
- Cochrane Database of Systematic Reviews
- Medline
- PsycINFO

Using this approach, we identified two systematic reviews. We accepted the one that met all the inclusion criteria detailed in the table below.

Table 4: Inclusion Criteria
Basic Criteria
• Peer-reviewed articles published in English about children aged 0 to 18 years
• Articles relevant to treatment foster care
Systematic Reviews
• Methods clearly described, including database sources and inclusion criteria
• Original study designs described
• Contains at least two original studies meeting criteria listed below
Original Studies
• Randomized controlled trial (RCT) methods used
• Attrition rates below 20% at final evaluation
• Outcomes measures assessed using two or more informant sources
• Reliability and validity of all primary measures documented
• Levels of statistical significance reported for primary outcomes

Because searches in the accepted review stopped in January 2007, we conducted our own systematic search to identify any new studies published since, using the same search terms. We applied criteria for assessing original studies as detailed in the table above. This new search yielded one follow-up to an original study included in the systematic review. We also identified one new RCT. These new studies were incorporated into our findings. ✋

BC government staff can access original articles from BC's Health and Human Services Library (www.health.gov.bc.ca/library/).

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