

RESEARCH ABSTRACT

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Maryland Science to Service for Children's Mental Health A Study of Treatment Foster Care in Maryland

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Introduction

In Maryland, and nationwide, providers of services to children with intensive needs have struggled to implement effective practices. With funding from the National Institute of Mental Health, the Maryland Mental Hygiene Administration, and the University of Maryland, Baltimore, worked with other collaborators to conduct a study of implementation of Treatment Foster Care (TFC) in the state. The ultimate goals of this "Maryland Science to Service" project were to determine ways to improve service delivery for this population, and to create a learning community around providing high-quality care for children and their families.

The study used interviews with program administrators, focus groups with program staff and treatment parents, and a collection of outcomes data from provider organizations in order to: (1) assess implementation of TFC, (2) determine adherence to evidence-based practice standards, and (3) explore outcomes achieved by programs.

Aim 1: Assessing TFC Implementation

The primary goal of the Maryland Science to Service project was to conduct an intensive assessment of the "real world" implementation of TFC across the state. To do so, researchers constructed an interview to be administered to program administrators in charge of the state's approximately 40 active TFC providers. The survey was based largely on the Standards Review Instrument (SRI) developed by Betsy Farmer and colleagues from Duke University (Farmer, Burns, Dubs, & Thompson, 2002), which consisted of open-ended questions that assessed conformance to national TFC standards set by the Foster Family-based Treatment Association (FFTA). The FFTA *Program Standards for Treatment Foster Care* include Program Standards, TFC Parent Standards, and Youth and Family Standards. Though there are over 100 FFTA standards, the Maryland Science to Service interviews chose 43 core standards to assess. Based on information provided by program administrators, interviewers coded conformance to standards as Full (score = 2), Partial (score = 1), or No conformity (score = 0).

Results found that TFC providers in Maryland scored much higher than providers assessed in a statewide implementation study in North Carolina in 1998. Maryland providers scored, on average, at 83% of the total possible score for all 43 standards, compared to 67% for the same standards as assessed for providers in North Carolina. Maryland providers also scored higher for each of the three

standards areas. Despite these overall higher scores, however, Maryland programs' scores on the standards varied considerably. Programs scored as low as 52% and as high as 96% on the standards. Ten programs scored significantly below average, while 11 others scored significantly above average. Results across individual standards also revealed many interesting findings:

- Caseload sizes for supervisors ranged from 1:1 to 8:1, with a mean of 3:1 (the FFTA Standard is 5:1).
- Case worker caseloads ranged from 2:1 to 22:1, with a mean of 8.5:1 (the FFTA standard is 8:1). Only 45% of programs were fully conforming to this standard.
- Caseworkers visited treatment families 3.3 times per month, on average, with programs ranging from 1-20 visits, on average, per month. Only 50% of programs fully met the standard of weekly contact with treatment families.
- Case workers visited the biological families of enrolled youth on average 2.5 times per month. However, 22 of 31 programs reported that biological family visits were “not applicable” for their program. The average percent of youth with contact with their biological families was only 53%, with one-third of programs reporting that fewer than 30% of their youth had contact with their biological families.
- Treatment parent stipends averaged \$1,158 across the 31 programs assessed. However, stipends ranged from \$550 to \$2,700 per treatment parent.
- Respite care, a cornerstone of evidence-based TFC programs and a best practice standard, was provided regularly by only 55% of programs. The median number of hours provided per month was found to be 48 (Range = 24 to 96 hours per month).

Aim 2: Conformance to the Evidence-based Model for TFC

The above results demonstrate that Maryland TFC providers have achieved conformance to many of the core standards for TFC quality set by the FFTA. However, previous research has shown that conformance to these standards is not necessarily related to outcomes (Farmer et al., 2002). To assess conformance to the Oregon Social Learning Center (OSLC) TFC model shown to produce superior outcomes (Chamberlain, 2002), we asked several questions about whether programs incorporated specific features of this model, including:

1. Higher treatment parent stipends;
2. Intensive training and ‘in-vivo’ training of treatment parents;
3. Active support from the program to implement a behavior plan, including use of points and level systems;
4. Daily telephone contact from program staff;
5. “24-7” access to program staff; and
6. Planned respite for treatment parents on a regular basis.

Results of interviews revealed that there was little evidence of consistent use of most of these model components among Maryland TFC programs. Though most programs made arrangements for 24-7 access to program staff, virtually none had the intensive (e.g., daily) contact used in studies of TFC that showed more positive outcomes. Though most TFC programs pay better stipends to treatment parents than for regular foster parents, the range of stipends across programs is great, and one-third of programs pay less than \$800 per month, on average. Approximately one-half of the programs had any

planned respite. In addition, the cornerstone of the OSLC model, program-supported behavioral assessment and planning and use of points and level systems, was used infrequently. In sum, though Maryland providers showed more consistent conformance to FFTA standards, incorporation of elements of evidence-based TFC was inconsistent. In fact, when asked, fewer than half of program administrators reported any type of specific model upon which their TFC programming was based.

Aim 3: Compiling Outcomes Data for TFC Programs

During the course of the study, we worked with eight provider organizations to compile data from their own data systems on several core outcomes. Some core findings included the following.

- Over 65% of youth served by Maryland TFC programs are coming from more restrictive placements, such as child psychiatric hospitals and residential treatment centers.
- Maryland TFC programs, on average, discharge 60% of enrolled children and youth to less restrictive and more community-based care settings. This result is nearly identical to a review of several studies nationally of other systems of care.
- There is a great diversity of the demographics of youth served across TFC programs, with some programs serving primarily young children, others older youth. Similarly, some programs serve a primarily Caucasian population while others serve 100% African-American children. Overall, among the eight programs included in analyses, 75% of the enrolled children and youth were male, and 70% were African-American.
- There is also a great range in the lengths of stay (LOS) of enrolled youth, as well as in the average lengths of stay for individual programs. Only 36% of enrolled children and youth in the eight programs were discharged within 18 months of enrollment. Across the programs, average LOS ranged from 1.89 to 7.78, with the average across all youths being 2.76 years.

This last finding about lengths of stay in the evidence-based TFC model is an important one, and demonstrates the difference between “evidence-based” TFC and TFC as implemented in Maryland and most “real world” systems of care. Evidence-based TFC as promoted and researched by OSLC (Chamberlain, 2002), is intended to be a short-term (6-12 months) model aimed at stabilizing challenging behaviors and transitioning youth to their biological families. Clearly, given long lengths of stay and the absence of contact with the biological family for many youths, TFC, as implemented by many Maryland programs, is being used to address different needs of youth and families than in the studies of the OSLC model.

Discussion

The Maryland Science to Service project yielded a range of interesting findings and potential areas for future action. The major finding of the study was that TFC providers in Maryland are capable of high quality TFC provision, and meet the national FFTA standards of care for this service model at a rate that far surpasses any previous statewide study. As a result, providers seem to be achieving a reasonable level of success for core outcomes, such as successful transitioning from higher to lower levels of residential restrictiveness.

At the same time, results showed that the TFC model being implemented varies greatly from program to program, and some critical components are often missing in service delivery. Of particular interest, the TFC programs surveyed typically did not incorporate characteristics of the evidence-based TFC model that has been shown to produce positive outcomes for youth with serious behavioral problems in

Oregon. Such findings from the implementation survey were corroborated by focus groups with treatment parents, who often expressed frustration with the apparent lack of effective treatments for the behavioral problems of the youths in their care.

One reason for the lack of systematic implementation of specific TFC models is that the population being served by the providers in the state is extremely diverse. It is clear that many providers are meeting a range of child and family needs via TFC. In addition, they are experiencing many basic challenges to program administration, such as recruiting adequately qualified staff and treatment parents. Without additional support and policy direction, these factors make adoption of an intensive, evidence-based TFC model for youth with serious emotional problems unlikely.

Implications for Practice

It is encouraging that Maryland's system of TFC providers are governed by specific Code of Maryland (COMAR) regulations based on best practice standards. As a result, TFC programs achieve conformance to FFTA standards at a relatively high rate. At the same time, only one-half of the FFTA Standards are reflected in COMAR regulations, and, perhaps as a result, several key best practice standards are met inconsistently across programs. These areas demand future attention and resources to support better practice, including:

- Lower case worker-to-treatment parent caseloads;
- More consistent availability of respite, and encouragement (or mandates) to treatment parents to use it, to ensure less burnout and greater retention;
- Greater effort to find and engage biological family members, and involve them in planning and implementation of services for enrolled youths; and
- Greater support to treatment parents to manage challenging behaviors, including consultation with behavioral specialists and greater intensity of contact with program staff.

A second major recommendation from the study centers around implementation of specific TFC models with potential for greater impact. Clearly, most Maryland TFC providers are not currently in a position to use the 'evidence-based' TFC model. Such models require significant resources to implement, and are not intended for use with all children and youth currently enrolled in TFC programs. At the same time, the majority of administrators report that their TFC program is primarily aimed at serving youth with serious emotional and behavioral challenges, and who have experienced past abuse, neglect, and trauma. For these youth, "hybrid" models of TFC that blend characteristics of the OSLC evidence-based model with components aimed at serving the needs of youth in the "real world" should be considered (e.g., Farmer, 2005). If strategically applied and well-supported, such models hold the promise to achieve better outcomes at lower costs than long-term group care.

Finally, results of the current study yielded lessons about the benefits of research and implementation assessments. The process of designing study methods, collecting data, and interpreting results has elevated awareness of the potential importance of best practice standards, the existence of evidence-based models, and what kinds of outcomes are being proposed and achieved in Maryland. In addition, eight provider programs representing over one-half of the estimated 3,000 youth being served by TFC programs statewide are now in the process of implementing outcomes monitoring systems to inform

their practice. Clearly, the TFC Coalition in Maryland is a strength of the state's system of care for youth with intensive needs. With support and direction from Maryland policymakers, these programs are well-positioned to elevate their standards of care and potentially implement evidence-based models for targeted populations of children and youth who would benefit from them.

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