TREATMENT FOSTER CARE IN TEXAS

A MIXED METHODS DESCRIPTIVE ANALYSIS

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tacfs TEXAS ALLIANCE OF CHILD AND FAMILY SERVICES
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EXECUTIVE SUMMARY

Treatment foster care (TFC; or professional foster care) is a type of out-of-home placement provided by foster parents who receive specialized training to care for children and with intensive emotional or behavioral needs.

Treatment foster care is intended to maintain high needs children in family settings to reduce the need for more restrictive placements such as residential treatment centers (RTCs), psychiatric hospitals, or other group care settings. TFC placements are limited in length, typically 6 to 9 months, with the goal of stabilizing the child and subsequently placing them in a less restrictive home setting.

Recent changes in federal child welfare policy through the Family First Prevention Services Act (FFPSA) place a strong emphasis on reducing reliance on group residential settings for children in foster care. With the FFPSA potentially decreasing the number of facilities that provide residential group care for high-needs children, family-like alternatives providing treatment services may become an even more important placement option in the continuum of substitute care.

In 2017, the Texas Legislature appropriated funding to implement Treatment Foster Care through contracts with three providers: CK Family Services, Arrow Child and Family Ministries, and the Bair Foundation.

In September 2020, the Texas Center for Child and Family Studies partnered with these three provider agencies to conduct a mixed-methods descriptive study to examine characteristics of children in TFC, the restrictiveness of pre- and post-TFC placements, and TFC implementation in Texas.

A few of the most relevant findings in the report are highlighted below:

- As of September 2020, 233 children had been served in a TFC setting through one of these agencies. Of these 97 were still[1] in a TFC placement, and 136 had been discharged.
- Children in TFC have high levels of need. Ninety-four percent of children have had at least one mental health diagnosis. The most common diagnosis is ADHD. The majority of children (86%) have at least one active medication prescription. The mean number of active prescriptions 3.3. The large majority of children (82%) have at least one prescription for a psychotropic medication.
- Children came into TFC placements from a variety of immediately prior placements. Just over half (52%) "stepped up" from a foster family home into TFC, while 41 percent "stepped down" into TFC from a psychiatric facility (14%) or an RTC or other group residential setting (27%).
- Children who have discharged from a TFC placement spent an average of 197 total days (just over 6 months) in TFC, including any extensions granted by DFPS.

Treatment foster care may also be referred to as treatment family foster care or professional foster care

TFC parents get on average between 10-15 additional hours of training compared to traditional foster parents

TFC placements are limited in length, typically 6 to 9 months

- The majority of children who have discharged from TFC "stepped down" into a less restrictive setting immediately following their TFC placement. Regardless of their placement setting immediately prior to TFC, 76% of children discharged to a less restrictive placement after TFC.
- The length of time that children spend in TFC correlates with less restrictive post-TFC placements. While 76 percent of all discharged children exited TFC to a less restrictive placement, 81 percent of children who spent at least three months in TFC exited to a less restrictive placement.

In addition to these figures, in-depth interviews with providers and foster parents produced helpful findings that give context to the study.

- Organizations found the paid rate for TFC to be sufficient to hire qualified staff and parents. The rate, however, does not consider health insurance and paid respite for the foster parents between placements.
- The foster parents interviewed for the study felt that the 10-15 additional hours of TFC training adequately prepared them for their role. They often referred back to their training materials when attempting to stabilize a child in their care.

- Providers take concrete steps to ensure that they are implementing TFC with fidelity to the model. Foster parents and staff both play important roles in ensuring the TFC model works in the home as it should. Providers promote fidelity through recruitment of high quality foster homes, paying attention to the language foster parents use to describe children in their care, using internal documents to track performance, and conducting regular monitoring checks and assessments within the home.

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The findings from this study produced several recommendations for strengthening TFC in Texas:

- Be flexible with part-time, non-restrictive employment for foster parents. The rate paid for TFC, which requires one parent who is unemployed, does not take into account loss of stability in income and benefits such as health insurance.

1 Throughout this report of findings, "currently" refers to as of September 2020, when the data were collected.

- Increase investment in TFC to promote recruitment and retention of foster parents. Additional investment would allow for paid respite to support placement stability, and a respite stipend between placement to support retention and a healthy home environment.
- Improve transition planning with DFPS to help ensure subsequent placements are successful. Additional planning would further allow subsequent placements to prepare for a post-TFC placement and identify needed supports.
- Extend or provide flexibility with the six-to-nine month time limit for TFC. The rigid limits on length of stay can make it difficult to find an appropriate placement post-TFC, which may hinder children's success in less restrictive placements. At times, an extension may be necessary to support children long enough to see positive gains.
- Support ongoing rate investment into TFC to provide a strong child welfare workforce that can support the child and family, identify stressors, track outcomes, and work to meet the needs of each unique placement. Direct care staff, therapists, and child welfare professionals all contribute to the success of TFC. Ensuring that organizations and their staff have the tools they need is critical for ongoing success.

While determinations about whether TFC is more effective than traditional foster care at preventing more restrictive placements cannot be made within the scope of this study, these initial findings offer a snapshot of the current state of TFC implementation in Texas. Further research should use methods that allow for causal inference so that decisions about future investment in TFC can be based on evidence of whether it is more effective than other placement options at achieving the goals of meeting children's therapeutic needs and preventing restrictive placements.

This study provides promising indications that TFC is working as intended to stabilize high-needs children in family-like settings. Continued development of TFC in Texas is in line with the goals and values of keeping children safe in the most nurturing, least restrictive placements possible.

INTRODUCTION

Treatment foster care (TFC; also called professional foster care) is a type of out-of-home care provided by foster parents who receive specialized training to care for children with intensive emotional or behavioral needs. Treatment foster care is intended to maintain high-needs children in family settings to prevent the need for more restrictive placements such as residential treatment centers (RTCs), psychiatric hospitalization, or other group care settings.

The requirements for TFC homes are more intensive than the requirements for traditional foster homes. At least one parent in a TFC home must stay at home full time, and each home may only care for one or two children at a time. Foster parents in TFC homes also receive more services, support, and specialized training to develop specific expertise in meeting the treatment needs of children who need the intensive care provided in a TFC setting. Further, TFC foster parents are treated as members of the child's treatment team. Because TFC requires a high level of foster parent qualification and at least one stay-at-home parent, this model of foster care is paid at a higher rate than traditional foster care.

Treatment foster care is a temporary placement, typically six to nine months, meant to help stabilize children so they can be maintained in a less restrictive setting. Placements in TFC can reflect "stepping down" or "stepping up" toward the goal of preventing group residential placements. When used as a step-down, TFC is an intermediate placement between a group residential setting or hospital to prepare for placement into a traditional foster home or another less restrictive setting. When used as a step-up, TFC helps regulate children who are at risk of placement into a group residential facility, so that children may return to a traditional foster home or other less restrictive setting. Whether children are stepping up or stepping down, TFC is the stabilizing center between traditional foster care and residential care facilities or psychiatric hospitalization.

Table 1 summarizes key differences in the purposes of traditional foster care, TFC, and residential group care.

Table 1: Purposes of Various Placement Settings

Traditional Foster Care	Treatment Foster Care	Group Residential Care
A placement in family setting with kinship caregivers or unrelated caregivers for children who are removed from their parents because of neglect or abuse. Focus: 1. Care and protection of children who must be placed outside their homes 2. Basic foster parent training	A placement in a family setting with unrelated caregivers, where there is a focus on a therapeutic family environment with active and structured treatment. Provides individualized therapeutic treatment for children who might otherwise be placed in group residential settings. Focus: 1. Care and protection of children who must be placed outside their homes 2. Clinical treatment of child's emotional, behavioral, and medical problems in a specialized setting 3. Basic foster parent training plus intensive training on mental & behavioral health	A residential care facility where staff, rather than foster parents, care for children. Intended as short-term placements for children with intensive behavioral needs. Focus: 1. Youth have movement restricted 2. Mental, emotional, and behavioral health, and educational services are dependent on each separate facility/program 3. Services provided within institutional setting, with staff caring for children rather than foster parents or relatives.

PRIOR RESEARCH ON TFC

With the Families First Prevention Services Act (FFPSA) potentially decreasing the number of facilities that provide residential group care for high-needs children, TFC homes may become an even more important placement option in the continuum of out-of-home care. Despite the potentially increased demand for TFC homes, there is limited evidence about whether it is effective at preventing more restrictive placements and promoting better child outcomes.

FAMILY FIRST PREVENTION SERVICES ACT

Family-like alternatives to group residential settings that provide therapeutic services, such as TFC, may become an even more important placement option in the continuum of substitute care as Texas nears implementation of FFPSA

Congress passed FFPSA in February 2018, which seeks to shift the focus of child welfare toward preventing the removal of children into foster care. For a number of reasons, Texas chose to delay implementation until September 2021.

The three major objectives of FFPSA include reducing the use of congregate care in favor of family-like settings, preventing entries to substitute care through funding for family services and strengthening kinship care.

Outcomes Associated with TFC

As TFC's primary target population is children and youth with high emotional, behavioral, or psychiatric needs, most research evaluating the intervention has focused on outcomes related to mental health and functioning. Some prior research has found that TFC placement is associated with improved control of emotions,[1] better internalizing behavior,[2] increased resiliency skills,[3] and improvements in day-to-day functioning.[4,5,6] Beyond individual psychological wellbeing, TFC has also been evaluated for its impact on families, with previous research finding that TFC was associated with reduced caregiver stress[7] and higher perceived levels of caregiver empathy.[8] Compared to other placement settings such as group care,[9] TFC has also been linked to better foster care outcomes,[10] including an increased likelihood of reunification,[11,12] greater placement stability,[13] and a reduction of future interactions with the child welfare system.[14]

Populations Studied

TFC has been studied in two distinct systems: child welfare and juvenile justice. As the populations served by the child welfare system and the juvenile justice system fundamentally differ, strong caution is warranted in assuming any research findings can be generalized from one population to the other. Within the juvenile justice system, TFC has been most strongly associated with a reduction in violent[15] and delinquent[16,17,18] conduct among participants, particularly when compared to group placements. Among juvenile justice populations TFC is also associated with a decreased chance of being placed in more restrictive settings.[19,20]

Qualitative evidence also supports the potential benefits of TFC, with one study finding that youth and parents were more likely to describe TFC interventions as "preventative," whereas group care interventions were described as "reactive."[40]

Within the child welfare system, existing research has compared TFC to both group residential placements and traditional foster care. Although early studies supported the conclusion that TFC was associated with improved outcomes when compared to group placements,[21,22] more recent studies have produced mixed findings. Some research suggests that TFC is associated with worse outcomes compared to group residential placements,[23] or that it has no long-term comparative benefits.[24] A limited body of evidence has also compared TFC to traditional foster care and found that TFC may be linked to increased retention of foster parents and a decreased number of unplanned exits from care.[25]

Demographics of Children and Youth in TFC

Findings from prior research have varied regarding participant demographics. To date, the large majority of TFC studies have focused on adolescents, with very few studies examining TFC outcomes among younger children. Among the research focusing on younger children in TFC, results have been mixed, with some research supporting the effectiveness of TFC as an intervention for children as young as pre-school[26] and other studies finding inconclusive results.[27] At the time of the study, DFPS-contracted TFC programs are limited to children 10 and younger, caution is warranted in generalizing research findings to children in TFC in Texas. Research has also found differential results by gender, with some evidence suggesting that females are less likely than males to see benefits from TFC.[28,29] Further, recent research has found that Black and Hispanic youth and youth with more severe behavioral problems may be more likely to be placed in traditional foster care[30] or group settings[31] when compared to other groups, so findings may be not be fully comparable across all racial/ethnic populations.

TFC Models and Fidelity

Another important consideration regarding the effectiveness of TFC is that there are different treatment models, such as Pressley Ridge TFC and TFC-Oregon. There are substantial differences in how these programs are designed and implemented, yet the large majority of existing studies of TFC do not specify which model is being examined. Further, some research has found significant differences in outcomes between different models of TFC,[32,33] highlighting the importance of understanding which TFC model is being utilized.[2]

Research suggests that fidelity to TFC model standards is associated with more positive outcomes for children and their families,[34] yet most studies do not address fidelity to TFC standards or agency protocols when evaluating TFC programs. Research that has examined model fidelity indicates that most TFC programs do not follow model standards.[35,36] Low rates of fidelity also raise questions about the validity of comparing results of different TFC studies, as different programs may have used dissimilar models, or did not implement models to fidelity. When implementing TFC in Texas in 2018, DFPS selected and implemented the TFC model developed by the Foster Family Based Treatment Association (FFTA) in 1989. The FFTA model targets any children with behavioral or emotional disturbance who would otherwise be placed in a group residential setting. None of the studies available for review specified that FFTA model was the model that was studied.

In sum, there is limited prior research on TFC, and research that does exist shows mixed findings and varies widely in the focus population and the treatment model. Although some TFC research has moderately supported its effectiveness at promoting better youth outcomes, other research is inconclusive[37,38] or does not support the effectiveness of the intervention.[39] Most prior studies of TFC are focused on adolescents. Since DFPS-contracted TFC in Texas is limited to children 10 and younger, research on adolescents may not apply to a younger population. Further, much of the prior research on TFC examines outcomes in juvenile justice populations rather than child welfare populations. Another difficulty in using prior research to determine TFC effectiveness is that there are multiple models, or approaches, to TFC, some of which are not articulated in prior studies.

2 A matrix outlining the different models of TFC can be found in Appendix A.

STUDY PURPOSE AND METHODS

Evaluating the effectiveness of TFC in Texas is important to understand how well the program is working to achieve its intended goals and to inform decisions on potential expansion and further investment in TFC throughout the state. While determinations about whether TFC is more effective than traditional foster care cannot be made within the scope of this study,[3] we conducted a mixed-methods descriptive analysis to address the following questions examining how TFC is functioning in Texas:

1. What are the characteristics of children placed in TFC homes?
2. What proportion of children are placed in less restrictive settings after exiting TFC placements?
3. What is the average length of time children stay in a TFC placement?
4. How do CPAs who operate TFC homes perceive its effectiveness at meeting children's clinical needs and promoting positive outcomes?
5. What are the benefits and challenges of implementing a TFC program?
6. What are the recruitment experiences for finding TFC homes?
7. How do TFC foster parents perceive its effectiveness at meeting children's needs?
8. What are the benefits and challenges of being a TFC foster parent?

STUDY PARTICIPANTS INCLUDED:

- Administrative and direct care personnel from each provider
- TFC foster parents from each provider

DFPS has contracted with three TFC provider agencies – Arrow Child and Family Ministries, the Bair Foundation, and CK Family Services – whose work began on September 1, 2018. As of September 2020 (when data collection for this study took place), 233 children had been served in a TFC setting through one of these agencies.

For the quantitative component of the study, we obtained de-identified data from each of the three providers on all children who are currently in TFC, or who were previously placed in a TFC home and already discharged to a subsequent placement. Requested data elements included demographics (age, race, gender), mental health diagnoses, medication information, level of care, the placement or exit type immediately before TFC, the placement or exit type immediately after TFC (for those who already exited), and duration of TFC stay (for those who already exited).

The qualitative component of the study entailed interviews with administrative personnel from each provider (e.g., program directors who operate the TFC homes), focus groups with TFC foster parents from each provider agency, and a review of documents such as TFC training protocols, manuals/handbooks, and DFPS procurement documents.

For interviews and focus groups, we created semi-structured, in-depth interview guides. We conducted a conceptual analysis on interview and focus groups transcripts to identify major themes, subthemes, and conceptual categories. For document review, we extracted targeted data from written sources and analyzed these data using content analysis to understand critical information, including the specifics of the TFC model used by the provider, minimum standards requirements for TFC foster parents, recruitment strategies, pre-service training requirements, and in-service/ongoing training requirements.

3 Only experimental studies can determine the effectiveness of an intervention. A retrospective and cross-sectional study such as this can only produce correlational findings, not causal findings.

Further, the sample size for this study was fairly small, which leads to high variability in findings. With a larger sample size, it is possible that the race/ethnicity distribution of children in TFC would more closely match the population of all children in care.

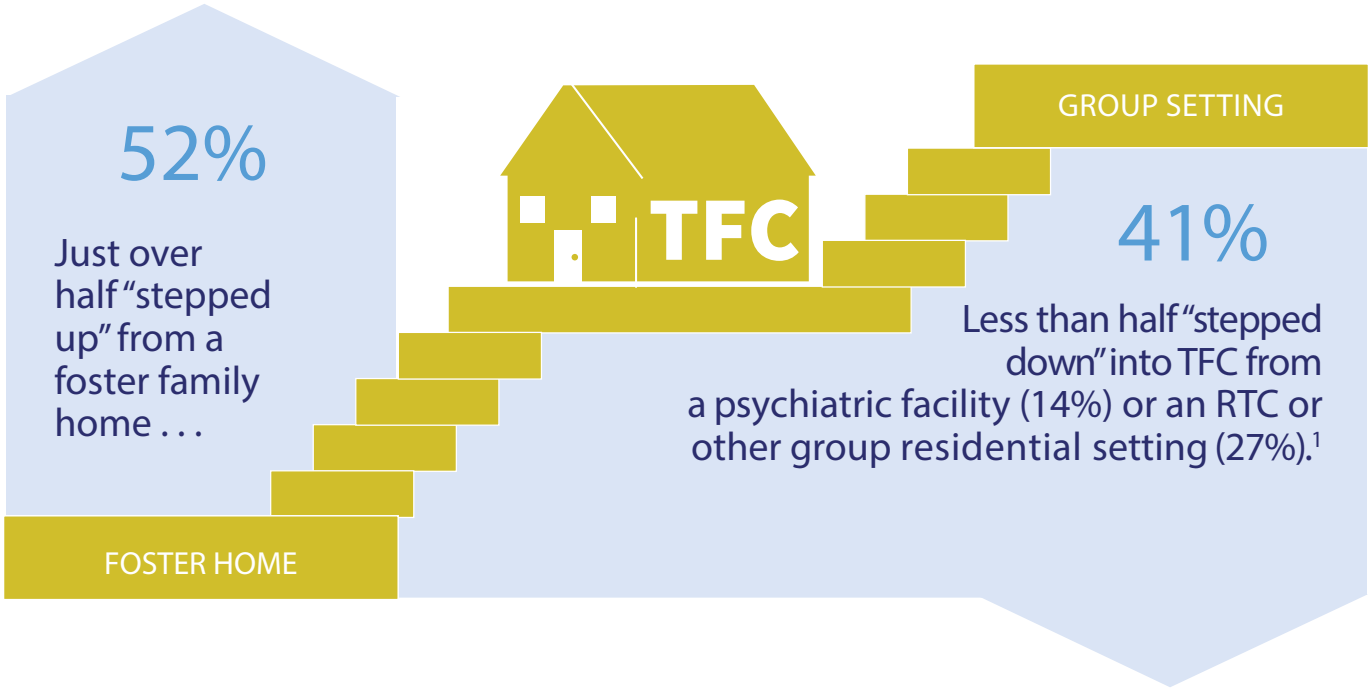
QUANTITATIVE FINDINGS

All Children in TFC (Active and Discharged)

Among all children served by TFC through the three DFPS-contracted agencies to date (N=233), 97 are currently[4] in a TFC placement, and 136 have been discharged.

The three agencies that provided data for this study are contracted with DFPS to provide TFC. Those agencies, however, also provide TFC through contracts with Single Source Continuum Contractors (SSCCs). Among children who are or have been in TFC, the majority (71%) were served through a DFPS contract, while the remainder were served through contracts with OCOK (13%), Saint Francis Ministries (9%), Family Tapestry (4%), or 2INgage (2%).

Children came into TFC placements from a variety of immediately prior placements



Level of care for children entering TFC was distributed across categories, as shown in Table 2.[5] There are some differences in children's level of care when comparing DFPS-contracted placements and SSCC-contracted placements.[6] Children placed through DFPS contracts were more likely to be at a

4 Throughout this report of findings, "currently" or "to date" means as of September 2020, when the data were collected.

5 The "unknown" responses were all from a single agency.

6 For context, please see the discussion on page 17 (Levels of Care in TFC) related to why so many children have lower or missing levels of care.

specialized or unknown level of care compared to children placed through SSCC contracts.[7]

Table 2: Levels of Care for Children Placed in TFC

Level of care	All placements combined	DFPS-contracted placements	SSCC-contracted placements
Basic	21%	20%	22%
Moderate	14%	13%	18%
Specialized	42%	44%	35%
Intense	9%	6%	16%
Unknown	15%	17%	9%
Total	100%[8]	100%	100%

The age range of children (at the time of TFC placement) was 2 to 19. The mean age was 8.9. The gender breakdown was 46 percent female and 54 percent male. The race/ethnicity breakdown of children in TFC shows disproportionate representation among groups in TFC compared to the full population of children in substitute care. For example, Black children and white children are overrepresented among children in TFC compared to the population of all children in conservatorship (CVS), while Hispanic children are substantially underrepresented (Table 3).

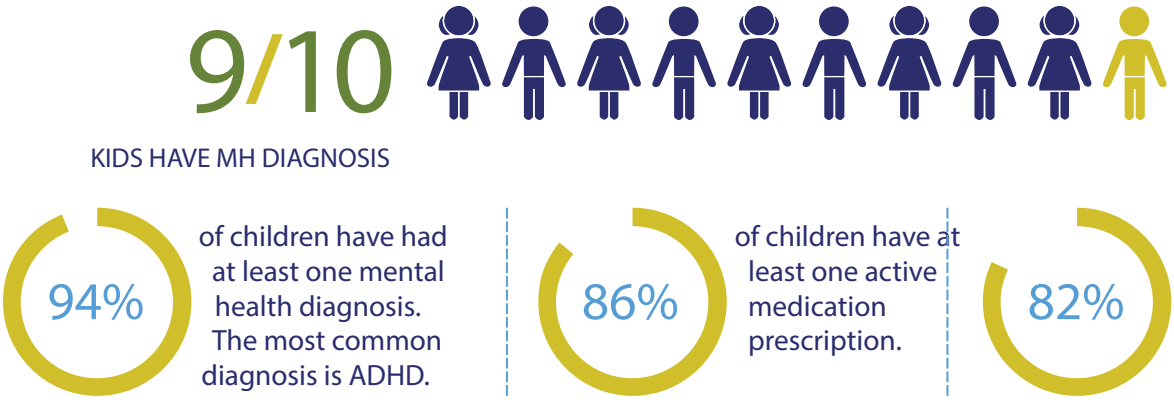
Table 3: Race/Ethnicity of Children in TFC Compared to All Children in Substitute Care

Race/ethnicity	Percent in TFC population	Percent in CVS population
Black	28%	21%
Hispanic	27%	42%
White	38%	30%
Asian	0.4%	0.3%
Native American	0%	0.1%
Other/unknown	0.9%	6%

Interpreting these disproportionate figures is challenging. Some might argue that overrepresented groups are receiving a level of substitute care that is commensurate with their level of need to avoid more restrictive placements. Others might argue that overrepresented groups are being disproportionately placed in environments that are more restrictive than is warranted. Without knowing how individualized needs are distributed across racial and ethnic groups, it is not possible to know what the "correct" representation of TFC should look like, or whether it should exactly match the full population of children in substitute care.

7 The only statistically significant difference is in the intense category; only 6 percent of DFPS placements were an intense level of care, compared to 16 percent of SSCC placements.

8 The sum of this column's percentages equals slightly over 100% due to rounding.



Ninety-four percent of children in TFC had at least one mental health diagnosis. The most common diagnosis was ADHD. The majority of children (86%) who are or have been in TFC had at least one active medication prescription. The number of active prescriptions per child ranged from zero to 11, and the mean was 3.3. The large majority of children (82%) were prescribed at least one psychotropic medication.

Children Who Have Discharged from TFC

Out of all children in TFC placements with a DFPS-contracted provider to date, 136 (58%) have been discharged.

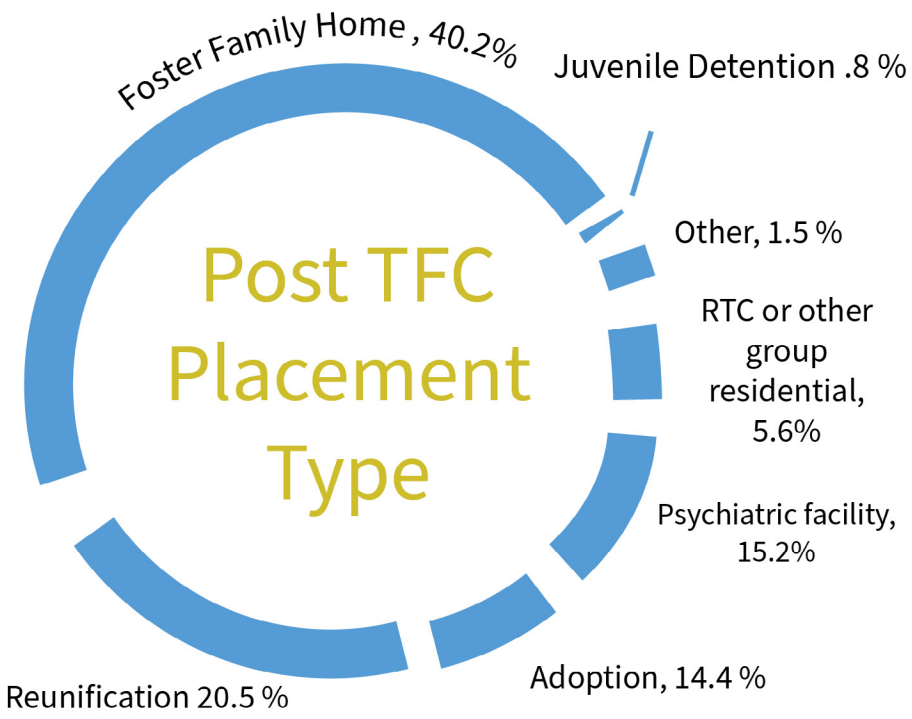
Children who discharged from TFC spent an average of 197 total days (just over 6 months) in a TFC placement, including any extensions granted by DFPS.[9] The median number of days children spent in TFC was similar, at 184 days. Children who started in a less restrictive placement and stepped up into TFC spent more days on average in the TFC placement (mean=218 days) than children who started in a more restrictive placement and stepped down (mean=175 days).

Immediately following TFC discharge, more than three-quarters of children (76%) went into a less restrictive placement, including 35 percent who were reunified or adopted (Table 4). Roughly a quarter (23.5%) of children stepped up into a more restrictive placement immediately following TFC.[10]

> "Kids in TFC have complex emotional and behavioral needs. TFC is often a space for children to regulate, explore dosages, and try alternatives to their medication for mental health diagnoses in a trained, regulated, and safe environment."
> TFC Agency Personnel

9 An important caveat is that the mean masks variation in the number of days any given child spends in TFC. The range spanned from a child who was in TFC for 4 days to a child who was in TFC for 658 days (likely due to more than one separate TFC placement episodes).

10 Though the goal of TFC is to prevent more restrictive placements, it is important to acknowledge that "step-up" placements are not necessarily negative by definition. Psychiatric facilities and residential care facilities are important options on a full continuum of care for serving all children. For example, a psychiatric placement is not a bad outcome if a child is in need of acute or life-saving mental health treatment.



Since the purpose of TFC is to provide a stabilizing setting to prevent more restrictive placements, understanding the overall trajectories of children from pre-TFC to post-TFC sheds light on the placement outcomes associated with TFC.[11]

197 Total Days Average length of stay in TFC placement

76% of all discharged children and . .

81% of children who spent at least three months in TFC exited to a less restrictive placement

The length of time that children spend in TFC correlates with less restrictive post-TFC placements.

84% Of children who started in a less restrictive placement and stepped up into TFC, 84 percent had a positive trajectory, going back down into a less restrictive placement after TFC.

67% Of children who started in a more restrictive placement and stepped down into TFC, 67 percent had a positive trajectory, stepping down again into a less restrictive placement after TFC.

11 It is critical to note again that this study cannot speak to the cause of any outcomes. Without a control group, we cannot say that TFC is the reason for any changes from pre- to post-TFC placements. We can only observe correlations, which does not tell us what we might have seen in the absence of TFC.

QUALITATIVE FINDINGS

The research team conducted a qualitative analysis to gather first-hand information from DFPS, provider agencies, and TFC foster parents. The findings from the qualitative portion of the study provide an in-depth look at the requirements for TFC homes, the processes through which children are placed in TFC, and stakeholders' perceptions of the effectiveness of TFC at achieving the intended goals. The key findings are summarized below.

Child Referral Characteristics

During the qualitative data collection process, the research team explored the characteristics of children that make them a good candidate for TFC. Although organizations emphasized that the referrals are somewhat subjective and children's behaviors are considered for TFC on a case-by-case basis, there are some key indicators for a child that might do well in a TFC home.

1. The source of the referral. DFPS and the SSCCs have different ideas and flexibilities regarding good fit for TFC. SSCCs can more flexibly refer children over 10 to TFC, while DFPS has more rigid guidelines in their contracts that limit the age to 10 and under. Also, because SSCCs usually know their community needs more intimately than DFPS, they can place children in TFC that might not be referred by DFPS based on local capacity and the behavioral interventions that are available to the child. Children over the age of 10 are in significant need of stabilizing placements. SSCCs tend to focus less on age as a referral factor and more on providing a placement for children who are hard to place.
2. Dangerous or violent behaviors. A child might exhibit behaviors that are too intense for a traditional foster care home and would be better supported in TFC. Any child at risk for going into a residential treatment center is usually a good candidate for TFC.
3. Child dysregulation. A child that is highly dysregulated and cannot function in school or at home might be a good candidate for TFC. This could be a child that needs to stabilize before entering a traditional foster home. Further, if a child is actively psychotic or has a significant mental health diagnosis, they are probably not ready to be in a less restrictive setting.
4. Medication regulation. If a child's medication needs adjustment or alteration, they might be a good fit for a TFC placement.
5. One-on-one attention. Some children need more focused attention than a traditional foster home or residential care facility is able to give them.

Levels of Care in TFC

When a referral is made to a CPA for TFC, it is not sent as a traditional foster care referral. Therefore, organizations do not have to record children's level of care in their case file when they come into a TFC placement. There is a unique TFC rate that the state pays to organizations, so level of care is not as important when children first enter TFC. Eventually, the CPA works with Youth for Tomorrow (YFT; the agency that contracts with the state to assess level of care) to determine a service level for each child before they leave the TFC placement, because the child may be going back into traditional foster care where the service level is tied to a specific paid foster care rate. As a result, children in TFC may have a missing level of care or a default "basic" level of care recorded at the time of placement. Considering the previously

discussed behaviors and circumstances that make a good TFC referral, it is highly probable that children entering TFC have high mental, physical, and behavioral health needs that do not represent a basic level of care. Children who have recently entered substitute care may not yet have a level of care assigned before they start showing severe behaviors that warrant being moved to a TFC home. Further, some children can be placed straight into TFC as their first placement after removal. One provider described this as a child that "go[es] 0-100 and jump[s] to TFC quickly instead of it being a progression."

Traditional Foster Care vs. Treatment Foster Care Processes

Table 5: Placement Process Difference between TFC and traditional foster care.

The research team used coded interview transcripts to assess the placement process differences between TFC and traditional foster care, as summarized in Table 5.[12,]

TFC Process	Traditional Fostercare Process
1. Foster parents are recruited, evaluated, and hired on as TFC parents. They must complete the same training as other foster parents, but in many cases take an additional 12 hours of TBRI Training. All TFC foster parents are trained in Together Facing the Challenge in addition to TBRI. 2. Child is assigned a DFPS caseworker. 3. DFPS' Centralized Placement Unit (CPU) sends a TFC referral to the Child Placing Agency (CPA) or will send general referrals to SSCCs to determine which kids need TFC placements. 4. The CPAs assess whether the child is a good fit for their TFC program based on foster parent capacity and family fit. Process usually takes 1-2 days. 5. CPAs do a case consult with the TFC caseworker, DFPS caseworker, and the TFC parent so the parent can ask questions about the child before placement.	1. Foster parents are recruited, evaluated, and hired. They must complete the standard foster parent training. 2. Child is assigned a DFPS caseworker. 3. DFPS' Centralized Placement Unit (CPU) or SSCCs send a referral to the Child Placement Agency (CPA) 4. CPA checks for available foster homes based on foster parent capacity and family fit. 5. Child is placed in the foster home.

12 Both the TFC and traditional foster care processes include basic Minimum Standards requirements, such as building education plans, 3-in-30 requirements, other testing requirements, and safety plans. Since these actions are mandatory for all children, they do not appear in the processes outlined here.

6. Pre-placement: Child meets with the foster family (sometimes with an overnight visit) and is either placed or referred elsewhere.
7. Family works with a staff member to build a service plan for the child.
8. Child is assigned a caseworker from the CPA in addition to their DFPS caseworker, a therapist, and a qualified behavioral health specialist or a behavioral support specialist to help the family and the child. In some programs, the child is also assigned a Wrap-around therapist.
9. Parents receive TFC coaching about every 2 weeks.
10. Staff do additional assessments specific to TFC like sensory profiles to determine sensory seeking and avoiding behaviors
11. During the first 2 months, the CPA works with DFPS to line up an appropriate post-TFC placement for the child. If permanency placement is identified, they are invited to all team meetings.
12. A supervisor comes into the home every other week (in person or virtual) to verify gains children are making in the home.
13. The child's team creates a treatment plan in addition to a crisis plan for the child in the first 2 months.
14. Every month, the child's team goes over their plan of care and modifies it to the child's needs.
15. The child's team repeats monthly and weekly check-ins until a subsequent placement is confirmed.
16. Redo the CANS at 60 days to measure progress
17. After 90 days, another treatment plan meeting is held.
18. The subsequent placement has the plan in place and has attended the meetings to understand the child's needs.

6. Family works with a staff member to build a service plan for the child.
7. Child is assigned a caseworker from the CPA in addition to their DFPS caseworker.
8. The caseworker visits the home once per month.

Support for Children in TFC and Traditional Foster Care

Figures 1 and 2 display the professional supports that children receive in TFC and in traditional foster care.

Figure 2: Professionals Supporting Children in Traditional Foster Care

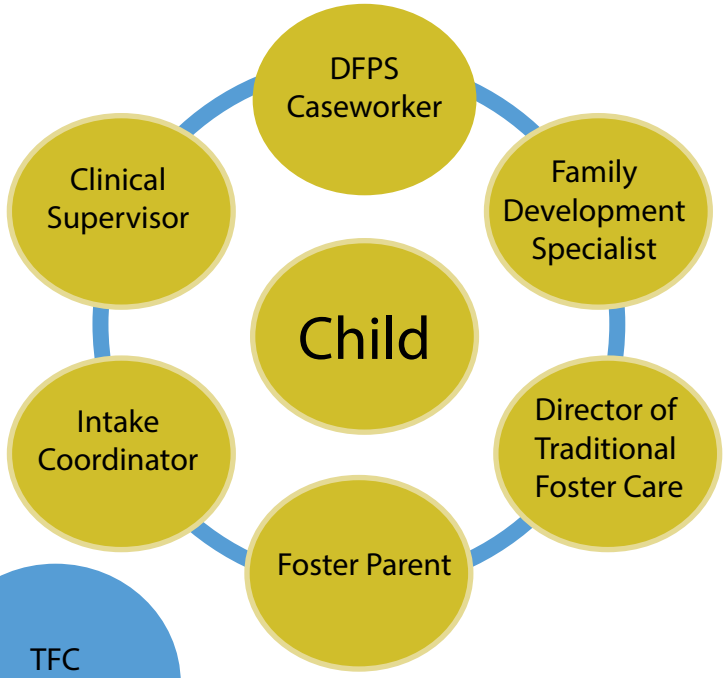
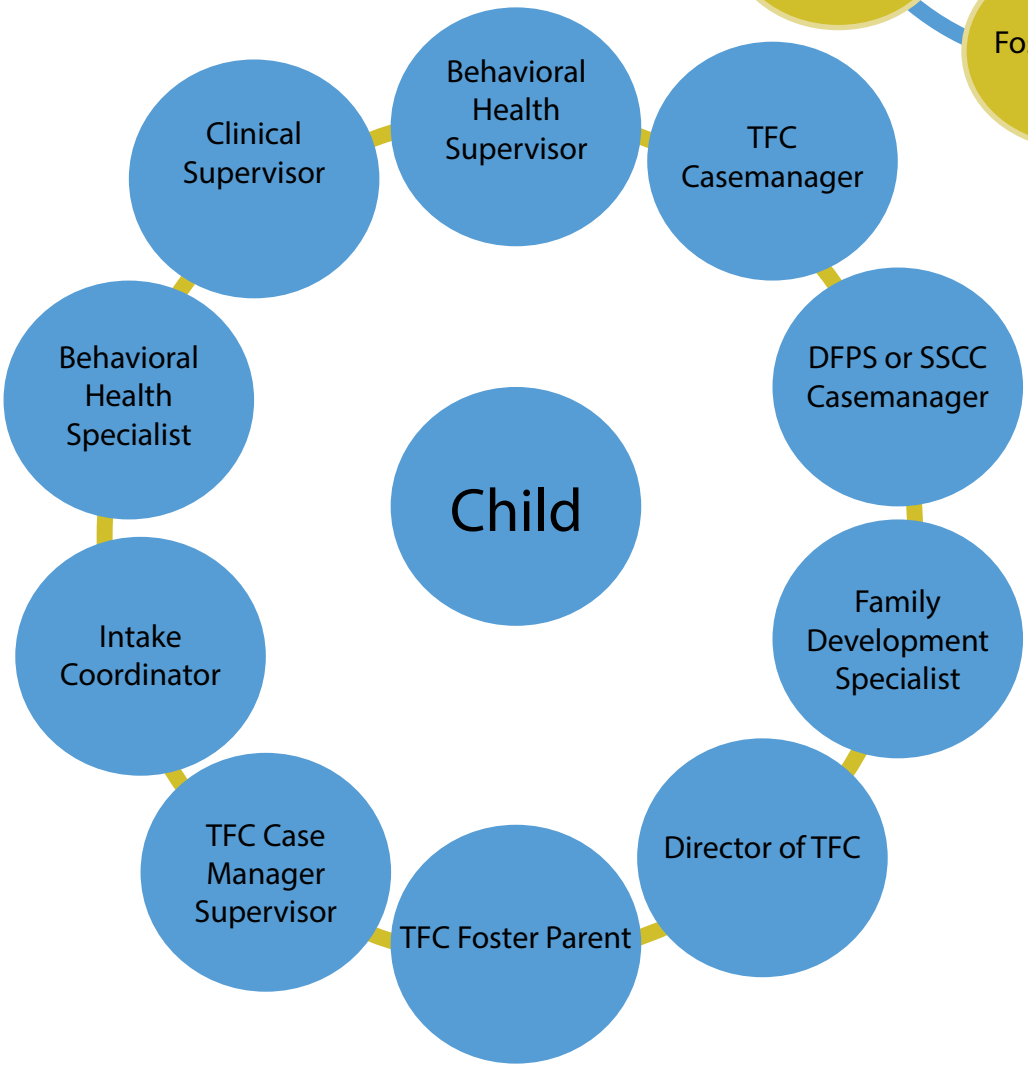


Figure 1: Professionals Supporting Children in TFC



TFC Program Comparisons

All TFC programs currently offered in Texas are not identical. There are many similarities how TFC is operated across providers, including staff structure, modalities used in the program, recruitment strategies, and fidelity checks. There are, however, differences in implementation. Table 6 displays the similarities and differences between TFC programs.[13]

Table 6: Comparisons of TFC Implementation Across Provider Agencies

	Organization A	Organization B	Organization C
Modalities Employed	• Trust-Based Relational Intervention • NWIC Wraparound Model • Together Facing the Challenge • Nurturing Parenting • Seeking Safety	• Trust-Based Relational Intervention • Together Facing the Challenge	• Trust-Based Relational Intervention • Trauma-Focused Cognitive Behavioral Therapy • Together Facing the Challenge • Promoting Placement Stability • Promoting Resiliency
Key Staffing	• Director of TFC • Family Development Specialist • TFC Case Manager • Wraparound Treatment Coordinator • TFC Parent • Behavioral Health Supervisor • TFC Case Management Supervisor	• Regional Director • TFC Therapist • Behavioral Support Specialist • Regional Intake Coordinator • Therapist Case Manager • Clinical Supervisor • TFC Parent	• Clinical Director • Clinical Supervisor • TFC Therapist • Treatment Coordinator • TFC Parent

TFC Foster Parent Recruitment and Retention

Foster parents in TFC homes may need a break between placements because of how difficult the role is. Once a child leaves the TFC placement, foster parents need to recuperate after the intensity of providing care for a high-needs child. Foster parents are not paid for this respite between placements. Though the rate for TFC parents is higher than the rate for other foster home placements, they receive no health care or other benefits, so these expenses must be absorbed as part of the paid rate.

13 See Appendix B for notes describing modalities and key staffing positions listed in Table 6.

Due to the behaviors of children in TFC these homes are more likely to be investigated by the state for standards violations, so many foster parents are nervous about starting or continuing in a TFC role.

When an investigation is initiated, foster parents have to wait until the investigation is complete before being able to continue.

These issues make recruiting and retaining foster parents challenging and may contribute to low supply of TFC foster homes in the state.

Foster Care Rate

Organizations found the rate for TFC homes to be sufficient to hire qualified staff and parents. However, the rate does not provide health insurance for the foster parents, and parents are not paid when taking respite between placements (time off that is beneficial for their self-care and foster parent retention).

Foster Parent Training

Foster parents in TFC homes receive, on average, 10-15 additional hours of training compared to traditional foster parents. The TFC foster parents interviewed for this study felt adequately prepared for their roles and mentioned how often they referred back to their training materials when attempting to stabilize a child in their care.

CPA Employee Retention

In our interviews, foster parents stated that there was significant turnover among children's therapists. During our interviews with provider organizations, however, they shared that the paid rate for TFC helped them hire and, most importantly, retain qualified clinical staff. This contradictory finding needs further exploration.

TFC Program Fidelity

Foster parents are the key ingredient to ensuring the TFC model works as it should. However, staff in provider organizations also play an influential role in ensuring program fidelity. We briefly list the processes organizations take to ensure TFC is running effectively and smoothly in the home. These items were all verified for accuracy with foster parents and provider agencies.

1. Fidelity begins with parent recruitment: The arduous processes of TFC recruitment and training act as an initial selection process for finding parents who are a good fit for the TFC program. Starting with hiring the right people is key.
2. Identifying language used in the home: When doing fidelity checks in the home, professionals pay close attention to the language parents use to describe the children in the home to make sure there are not any sudden, negative shifts in language.
3. Clinical services and processes: Organizations use internal measurements and documents to track and ensure program fidelity in the home, including:

    a. Treatment plans
    b. Case manager notes
    c. Coaching visits

d. Wraparound services and documentation
e. Crisis plans
f. Parent check-ins/coaching

4. Assessments and evaluations: Providers administer child assessments and evaluate homes for performance using some of these indicators:
    g. Clinical service notes
    h. Weekly/biweekly monitoring of the home environment to ensure child safety
    i. Daily monitoring of incident reports
    j. The Child and Youth Resilience Measure (CYRM)
    k. Case conceptualizations
    l. Yearly family performance evaluations
    m. Risk Prevention Management Committee and the National Continuous Quality Improvement (CQI) Council Meetings

LIMITATIONS

All research studies have limitations to consider alongside the findings. The quantitative data used in the analysis is retrospective and cross-sectional and has a relatively small sample size. It is a snapshot of TFC at the specific point in time when the study was conducted; results may have been different if the sample were larger, if the program had been in operation longer, or if there were more than three providers included. There are also limits to the information that was available for the analysis. For example, we were only able to obtain data on the next placement immediately following TFC discharge. We were not able to look at any placements beyond the one that occurred immediately post-TFC, so we do not have a way to know whether children were maintained in less restrictive settings after discharge from TFC.

Qualitative interview participants mostly included foster parents who were satisfied, in general, with TFC. Therefore, the themes and recommendations are centered in overwhelmingly positive experiences. Considering the turnover rate and difficulty recruiting TFC parents, future research on TFC will need to include more diverse and balanced perspectives, including parents who might have served as a foster parent in TFC and left the program.

DISCUSSION AND RECOMMENDATIONS

Prior research on the effectiveness of TFC is limited and, though there are some findings suggesting improved outcomes across several domains, somewhat inconclusive. Assessing the effectiveness of TFC in Texas is further challenging because most prior research focuses on older children in juvenile justice populations rather than younger children in foster care populations, and there are no known prior studies specifically examining the model of TFC used in Texas.

Though this study cannot produce rigorous evidence of TFC effectiveness, this analysis found some promising indicators that the program is operating as intended. Children placed in TFC have high levels of need, as evidenced by the fact that 94 percent of children in TFC have a mental health diagnosis, children are prescribed an average of 3.3 medications, and the overwhelming majority (82%) are prescribed at least one psychotropic medication. Even with these indicators of high need, the majority of children placed in TFC are discharged to a less restrictive placement. Further, foster parents and provider organizations perceive that TFC is working to move children into less restrictive settings and to manage and minimize challenging

behaviors for high-needs children.

Providers and foster parents provide extra levels of support and services to stabilize children's behavioral and emotional needs so that they can be maintained in less restrictive settings after TFC. Several recommendations emerged from this analysis that may strengthen TFC in Texas and inform decisions on expanding the program's capacity:

Contract Recommendations

- Based on input from providers and foster parents, the state should consider flexibility with the requirement that one parent must not have employment outside the home, even if it is part-time employment.
- Expanding the eligible age past 10 for children referred by DFPS would allow this placement option to reach more children in need of family-like stabilizing settings.
- Consider allowing extensions of TFC placements beyond the current 60-90 day window. This would help providers find the best possible post-TFC placement and would allow foster parents to build and maintain rapport with the children long enough to optimize positive gains.

TFC Model Recommendations

- Through training and care coordination, equip caregivers in post-TFC placements to manage children's behaviors so they can see continued success.
- Streamline and standardize the TFC placement process so it is as consistent as possible across providers.
- Training CPS placement workers on the purpose and goals of TFC may result in more referrals to TFC and better placement transitions.
- Continue to invest in TFC by providing additional paid respite for TFC families.
- Equip providers with the skills and resources to track the overall performance of their TFC program with logic modeling or other program evaluation processes.

Barriers to Building TFC Capacity

- Parents feel adequately prepared and supported in their roles as caregivers; however, retention and building capacity remains difficult. "The requirements of somebody who stays at home that's unemployed is prohibitive."
- The TFC Rate does not consider loss of stability in income and benefits, such as health insurance. Be flexible with part-time, non-restrictive employment.
- Respite care, and/or the support of a mentor or paraprofessional is important to both the family and the child in care. Increased investment to provide for respite care or a paraprofessional to support ongoing placement stability. Respite may be necessary between placements, but many families cannot afford the loss of income. Additional investment could support a "respite stipend" to support family retention and a healthy home environment.

Focusing on Youth in Care

- Child serving organizations and parents providing direct care for children in TFC are seeing improvements with behavioral concerns and the ability to successfully step down into a less restrictive setting.

- Additional planning would further allow subsequent placements to prepare for a post-TFC placement and identify any additional support or planning needs. Furthermore, in some instances, children are not able to step down into a less-restrictive setting if a home is not available. Improved transition planning is needed with DFPS to ensure a successful subsequent placement and to better equip caregivers for continued success.
- The rigid length of stay for a child in TFC can make it difficult to find an appropriate placement post-TFC and may cause a child step back up into care. At times, an extension may also be needed to continue to support the child long enough to see positive gains. Extend or provide additional flexibility with the program's 6-9 month time limited services requirement.

Strong Child Serving Workforce

- Direct care staff, therapists, and child welfare professionals support the success of TFC. Hiring, retaining and, supporting staff of TFC programs is critical for ongoing success.
- Experienced and skilled staff can: assist in the recruitment of parents that are a good fit for TFC, and identify and support changing home dynamics.
- Organizations are critical in supporting kids in TFC programs through: tracking progress and outcomes such as treatment plans, clinical and case manager notes, coaching visits, wraparound services, crisis plans, and more.
- Ongoing assessments are key and include: frequent monitoring of home, daily monitoring of incidents, ongoing risk management, and family performance evaluation.
- Support ongoing rate investment into TFC to provide a strong child welfare workforce that can support the child and family, identify stressors, track outcomes, and work to meet the needs of each unique placement.

In addition to these program recmmendations, rigorous research is needed to determine whether this model of TFC is effective for the population being served by TFC in Texas. This will allow the state to make decisions about investment in TFC that are based on empirical evidence of whether it is more effective than other placement options at achieving the goals of meeting children's therapeutic needs and preventing restrictive placement settings.

APPENDIX A: MATRIX OF TFC MODELS

Model	Proprietary?	Population	Purpose	Description	Prevalence
Standard TFC[14] -Developed by: Foster Family-Based Treatment Association (FFTA) in 1989	Yes, agencies can become members and pay dues for support in implementing TFC[15]	-Any behaviorally challenged and/or severely emotionally disturbed child who would otherwise be placed in an institutional setting	-To keep youth out of restrictive, institutionalized care -To provide them with specialized support to promote behavioral and emotional wellbeing	- TFC parents are trained specifically to meet the needs of challenging children -TFC parents are treated as full-fledged members of the treatment team -TFC parents are compensated at a higher rate than traditional foster parents -Treatment families receive respite and support services -Care is provided in a private home	-FFTA has 470 member agencies located all over United States and Canada[16] - FFTA member agencies provide treatment foster care services to more than 50,000 children and youth each year.

14 First standardized by the Foster Family-Based Treatment Association (FFTA) in 1989 (Dore & Mullin, 2006).
15 https://www.ffta.org/page/Benefits
16 https://www.ffta.org/page/TheNewFFTA

Treatment Foster Care Oregon (TFCO)— Previously known as Multidimensional Treatment Foster Care (MTFC)[17] -Developed in 1983 following research trials at Oregon Social Learning Center (OSLC).	Yes; use of the model name 'Treatment Foster Care Oregon'™ and its abbreviation, 'TFCO' ™ is restricted to programs that are certified or are receiving clinical supervision from TFC Consultants, Inc.[18]	-Any behaviorally challenged and/or severely emotionally disturbed child who would otherwise be placed in an institutional setting -Originally developed as an alternative to residential placement for serious juvenile offenders -Has been modified for use in the child welfare system and is still used in the juvenile justice system -For children ages 3-17 -Generally for youth with problems with chronic antisocial behavior, emotional disturbance, and delinquent behavior -Has been adapted as TFCO-Adolescents[19] and TFCO-Preschoolers[20] for children 12-18 and 3-6 respectively	Main goals: - To create opportunities for youth to successfully live in a family setting - To help parents (or other long-term family resource) provide corrective and therapeutic parenting.	- 6-9 month program - Three components of the intervention that work in unison to treat the youth: TFC Parents, the child's Family, and the agency-based Treatment Team (which includes therapists, psychiatrists, case managers, and daily callers). - Draws on social learning theory and cognitive-behavioral approaches	14 certified sites and 21 developing sites in United States, Australia, Sweden, Norway, Denmark, The Netherlands, United Kingdom, and New Zealand.

17 https://www.tfcoregon.com/about/
18 https://www.tfcoregon.com/implementation/
19 https://www.cebc4cw.org/program/treatment-foster-care-oregon-adolescents/
20 [https://www.cebc4cw.org/program/treatment-foster-care-oregon-for-preschoolers/

APPENDIX B:

Notes for Table 6: Comparisons of TFC Implementation Across Provider Agencies

Trust-Based Relational Intervention: Rated by the California Evidence-Based Clearinghouse (CEBC) as Promising Research Evidence in Resource Parent Training Programs.

NWIC Wraparound Model: Rated by the CEBC as Promising Research Evidence in Placement Stabilization Programs.

Together Facing the Challenge: Rated by the CEBC as Supported by Research Evidence in Resource Parent Recruitment and Training Programs.

Director of Treatment Foster Care: Responsible for clinical oversight, providing support and leadership, and managing the direction of the program.

Development Specialist: The foster family's first point of contact and responsible for the application process, the home study, and organizing orientations and trainings.

TFC Case Manager: The family's second point of contact who supports the treatment foster child through the provision of support and case management to the treatment foster parent. (1:10 client ratio)

Wraparound Treatment Coordinator: High Fidelity Wraparound Facilitator – Youth and Family Training Institute; Facilitates and coordinates the provision of treatment services for TFC children. (1:10 client ratio)

Behavioral Health Supervisor: 1:7 staff ratio

TFC Case Management Supervisor: 1:3 staff ratio

Regional Intake Coordinator: Interviews children, collects documentation, and helps match them with a home.

Clinical Supervisor: Provides clinical oversight, ensures documentation is up to standards, provides guidance, on-call backup for clinicians, assists in training and development of TFC families.

TFC Therapist: Provides therapy for children on two Treatment Coordinators' caseloads; 1:12 therapist to client ratio; collaborates with coordinators on diagnosis, interventions, and treatment plan; completes therapy notes.

Treatment Coordinator: Treatment coordination ratio 1:6; weekly face-to-face contact with TFC parent (minimum of 2 visits/month); coordinates monthly treatment plan meetings; tracks goals; coaches family on interventions.

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