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Family Involvement in Treatment Foster Care

Dannia G. Southerland, Ph.D.¹, Barbara J. Burns, Ph.D.¹, Elizabeth M.Z. Farmer, Ph.D.², H. Ryan Wagner, Ph.D.¹, and Ashley M. Simpson, MSW³

¹Department of Psychiatry and Behavioral Sciences, Duke University School of Medicine, Durham, North Carolina

²School of Social Work, Virginia Commonwealth University

³School of Social Work, University of North Carolina at Chapel Hill

Abstract

Child mental health policy and practice has increasingly embraced family-driven practice which promotes family involvement in all aspects of planning and service delivery. While evidence for positive outcomes related to family involvement is mounting in traditional residential treatment, there is little information about family involvement in treatment foster care. This study provides data on family involvement in a statewide randomized trial of treatment foster care. The types of family involvement, factors associated with such involvement, and placement outcomes were examined. Nearly eighty percent of youth experienced recent family contact and/or family participation in treatment planning. Implications for research, policy, and practice to increase understanding the role of family involvement are discussed.

Keywords

Family Involvement; Treatment Foster Care; Placement Outcomes

The notion that youth in residential placements should be kept away from their families has been largely abandoned in child welfare and child mental health agencies. Instead, there has been a shift to understanding the importance of relationships between the child and family, family functioning, and family involvement, especially for long-term recovery goals (Jenson & Whittaker, 1987; Davis, Landsverk, Newton, & Ganger, 1996; Pierpont & McGinty, 2004). This shift has led to a focus in child mental health policy and practice on developing family-driven models which promote family involvement in all levels of planning and service delivery in residential care (Arbuckle, 2005; Chance, Dickson, Bennett, & Stone, 2010; Hoagwood, 2005). In addition to this shift in focus to greater family participation in treatment, there have been parallel efforts to identify ways in which residential treatment

Address correspondence to Dr. Farmer at 1001 W. Franklin St., Richmond, VA 23284-2027. efarmer4@vcu.edu.

Dr. Southerland is a former Postdoctoral Fellow in the Department of Psychiatry and Behavioral Sciences at the Duke University School of Medicine; Dr. Farmer is Professor in the School of Social Work at Virginia Commonwealth University; Dr. Burns is Professor in the Department of Psychiatry and Behavioral Sciences and Director of the Services Effectiveness Research Program at the Duke University School of Medicine; Dr. Wagner is Associate Professor in the Department of Psychiatry and Behavioral Sciences at the Duke University School of Medicine; Ms. Simpson was a Research Assistant for the Services Effectiveness Research Program in the Department of Psychiatry and Behavioral Sciences at the Duke University School of Medicine during the preparation of this paper; she is a recent graduate of the School of Social Work at the University of North Carolina at Chapel Hill.

and community-based services and supports could be better integrated (Duchnowski & Kutash, 2007). The convergence of these efforts places a strong emphasis on incorporation of family members in the child's treatment while in out-of-home care, including treatment planning, visits with family members, family involvement in discharge planning, and clear plans for after-care services and supports (Blau, et al., 2010; Walter & Petr, 2008). The American Association of Children's Residential Centers has been developing policy statements on family-driven care since 2005 and more recently in 2009 (AACRC, n.d.).

Evidence is accumulating that family involvement is associated with successful outcomes for children receiving intensive mental health services, including residential care (Affronti & Levison-Johnson, 2009; Knorth, Harder, Zandberg, & Kendrick, 2008; Pierpont & McGinty, 2004). In a review of research on residential care, Hair (2005) found that family involvement is the strongest predictor of continued gains after discharge. Research on specific models of family involvement have shown that parental involvement is associated with shorter stays in residential care, discharge to less restrictive settings, greater likelihood of receipt of aftercare services, and more stable discharge placements (Landsman, Groza, Tylre, & Malone, 2001; Knecht & Hargrave, 2002; Stage, 1999). Sunseri (2001) reported that for youth in residential care, home visits were significantly associated with both positive outcomes while in treatment and for treatment completion. Despite these encouraging findings, a national survey of 293 residential treatment facilities revealed that only 12% of providers regularly apply the principles of family-driven practice (Brown, et al., 2010).

While evidence for positive outcomes related to family involvement is mounting in traditional residential treatment, there is a paucity of information about family involvement in treatment foster care (TFC). TFC is a community-based residential treatment option for youth with emotional and/or behavioral problems in need of out-of-home care. TFC is the only community-based residential treatment option for youth for which there is a substantial evidence base (Chamberlain, 2003; Farmer, Compton, Burns, & Robertson, 2002; Fisher & Chamberlain, 2000; Farmer, Burns, Wagner, Murray, & Southerland, 2010). In this paper, the types of family involvement found in usual care TFC in one state are described, with a focus on factors associated with family involvement.

Since the 1970s, TFC, variously called "therapeutic foster care," "family-based treatment," or "specialized foster care," has emerged as an alternative form of community based out-of-home care for youth with serious emotional and behavioral disorders (Chamberlain, 2002; Curtis, Alexander, & Lunghofer, 2001; Duchnowski, Kutash, & Friedman, 2002; Farmer, Dorsey, & Mustillo, 2004). TFC programs serve youth referred by multiple agencies, especially youth identified as having disruptive behavior disorders, youth discharged from psychiatric hospitals, and youth "stepping down" from other more restrictive residential care (Baker & Curtis, 2006; Farmer, Wagner, Burns, & Richards, 2003). Youth in TFC generally have one or more psychiatric diagnoses, combined with numerous psychosocial adversities, including histories of maltreatment and trauma, previous out-of-home placement, involvement with juvenile justice, and family risk factors (Curtis, et al., 2001; James et al., 2006; Turner & Macdonald, 2011). TFC is unique in that it provides a least-restrictive treatment-oriented residential placement, and allows for family-based living and community-based opportunities for learning and development (Chamberlain, 2003; Farmer,

et al., 2003). A key feature of TFC is that the treatment parents, trained paraprofessionals, provide care and treatment for troubled youth in their home on a 24/7 basis. The treatment parent in TFC fulfills dual roles: (1) the parent role of nurturing and taking care of the youth's basic needs; and (2) the treatment role, directly implementing treatment interventions with the youth (Wells, Farmer, Richards, & Burns, 2004; Southernland, Mustillo, Farmer, Stambaugh, & Murray, 2009).

The Foster Family-Based Treatment Association (FFTA) has developed a set of standards of care for TFC (FFTA, 2004; Farmer, Burns, Dubs, & Thompson, 2002). In alignment with the SAMHSA Building Bridges Initiative (Blau, et al., 2010; Bullard, 2006), these standards call for family participation on treatment teams in deciding on goals and treatment plans for their child and ongoing involvement with the family while the child is in TFC. In spite of these efforts, there is little empirical evidence to inform an understanding of what family involvement looks like in usual care TFC. Some older studies that examined the issue of family involvement in TFC noted little evidence of either actual involvement of biological families or practices to facilitate such involvement (Hudson, Nutter, & Galaway, 1994; Wells & D'Angelo, 1994). In interviews with TFC providers about the involvement of biological families, Jivanjee (1999a) found that although providers and professionals espoused values and attitudes supportive of family involvement, practices that encouraged or facilitated such involvement were highly varied if they existed at all. Jivanjee (1999b) also interviewed family members about their experiences of involvement with a child in TFC. Barriers to involvement mentioned by families included difficulties with transportation, scheduling problems for meetings, and a lack of follow-through from the provider agency. A meta-review of existing studies of TFC reported additional organizational barriers to involvement, such as large caseloads, burdensome paperwork, the impact of multiple and disconnected service providers, a lack of commitment to families by the provider agency, and lack of training on specific strategies for family involvement (Redding, Fried, & Britner, 2000).

The study reported here addresses this gap in the literature regarding family involvement in TFC. We explored how families are involved with youth while in usual care TFC along two dimensions, (1) contact between family members and the youth, and (2) participation of family members in treatment planning while the youth is in TFC. These dimensions are operationally described in detail below. Because there is such a paucity of empirical data on family involvement in TFC, this analysis is guided by a set of exploratory research questions:

1. What types of family involvement, measured as contact with family members and family member participation in treatment planning, occurred in a sample of usual care TFC agencies?
2. How are characteristics of youth related to family involvement?

Methods

Setting and Sample

The sample for this study of family involvement with youth in usual care TFC comes from baseline data for a randomized trial testing the effectiveness of an enhanced TFC model in “usual care” agencies. This sample of youth receiving TFC is largely referrals from mental health and child welfare systems that required either a higher level of care than biological, foster, or kin parents could provide, or as a step-down from a higher level of placement to address continuing behavioral health needs. The intervention, *Together Facing the Challenge*, was developed (Murray, et al., 2007) from a combination of best practices from a prior descriptive study of TFC in usual care (Farmer, et al., 2003) and selected elements from evidence-based interventions (e.g., Chamberlain, 2002; Chamberlain, 2003; Clark & Davis, 2000). All data are from baseline, face-to-face interviews with treatment parents of youth enrolled in the study before intervention with any agencies or families. Youth in the intervention and control conditions were comparable at baseline on all covariates. While family involvement measures were not a focus of the intervention, all variables were measured prior to the experimental intervention; to take potential intervention effects into consideration, study condition (intervention vs. control) was included in the descriptive analyses. As specified by IRB protocol, written informed consent was obtained from each youth’s parent/legal guardian for the youth’s participation, and written consent was obtained from each participating respondent.

Measures

Information about family involvement, operationalized as family contact and family member participation on a treatment team, was obtained from questions in the study baseline interview that asked the treatment parent about involvement between the youth and his/her family in the two months preceding the baseline interview. Family contact was operationalized as any contact with any family members (including in-person visits, telephone calls, or letters). Measures of family participation in treatment planning were derived from a question that asked the treatment parent about whether any family members participated in treatment team meetings. Family was defined as parents, brothers and sisters, and other relatives of the child that he/she considered important to him/her (extended family). This distinguished the child’s biological or natural family of origin from the TFC family.

Variables related to youth and system covariates were grouped into four domains: youth demographics, clinical/behavioral status, psychosocial risk/protective factors, and service system involvement. Youth demographics include age, ethnic/racial group, and gender. Clinical and behavioral status included measures of (a) clinical severity, measured by the Strengths and Difficulties Questionnaire (SDQ; Bourdon, Goodman, Rae, Simpson, & Koretz, 2005; Goodman, 2001); (b) problem behaviors, measured by the Parent Daily Report (PDR; Chamberlain & Reid, 1991); and (c) strengths and competencies, measured by the Behavioral and Emotional Rating Scale (BERS; Epstein, Mooney, Ryser, & Pierce, 2004).

The SDQ is a 25-item questionnaire designed for general behavioral health screening. Responses to 20 of the items generates a “total difficulties” score, based on subscale scores for emotional symptoms, conduct problems, hyperactivity, and peer problems. Scores for the SDQ total difficulties scale used in the current analysis range from 0 – 40. Scores 14–16 are in the borderline clinical range, while scores 17 and above are in the clinical range (Bourdon, et al., 2005). The total difficulties score was used in all analysis. The PDR obtains information about the number of types of problematic behavior displayed in a previous 24-hour period. Scores range from 0 to 34, with higher scores indicating more problems; an average of 5 ‘daily problems’ has been previously cited as the ‘norm’ for youth in a TFC setting (Chamberlain, et al., 2006). The BERS is a 52-item scale including five subscales (Mooney, Epstein, Ryser, & Pierce, 2005). It also provides a summary score of the overall behavioral and emotional strengths of the youth, the Strength Index, which was used in the current analyses. Higher scores on the BERS Strength Index represent better functioning; the measure has a general population mean normed at 100 ($SD = 15$).

Psychosocial risk/protective factors included history of maltreatment and the quality of the therapeutic relationship between the treatment parent and youth. Prior exposure to maltreatment was assessed using a modified version of the Posttraumatic Stress Disorder Reaction Index (UCLA PTSD-RI) (Pynoos, 2004; Steinberg, Brymer, Decker, & Pynoos, 2004). While the full index assessed 10 types of trauma, current analysis used only those items related to maltreatment exposure: sexual abuse, physical abuse, and neglect. The Trusting Relationship Questionnaire (TRQ) assesses the affective quality of the relationship between youth and their adult caregivers in residential settings (Vance & Sanchez, 1997) and has been validated (Mustillo, Dorsey, & Farmer, 2005; Southerland, et al., 2009). The caregiver report version of the TRQ consists of 18 items designed to assess the quality of the relationship with the youth based on the caregiver’s perceptions. The items are coded on a Likert scale from 1 to 5. The TRQ score is the mean of the items completed. Higher scores denote better relationships; in previous studies of youth in TFC, the mean score was 3.6 ($SD = .7$).

The system involvement domain included dichotomous variables indicating whether the youth had been living in an out-of-home placement immediately prior to their TFC placement, an indicator for whether the youth was in state custody, and length of stay of the youth in their TFC placement at baseline, calculated in months.

Data Analysis

Descriptive statistics of all study variables are presented in tabular format. Additional analysis assessed associations between the two dimensions of family involvement, family contact and participation in treatment planning, as well as an aggregate variable that combined both types of involvement and youth characteristics.

Results

Sample Description

Ages of youth in this sample ranged from 2 to 21 years old at baseline, with a mean age of 13 years. Almost half of the sample (47.4%) was between the ages of 11 and 15. The distribution of gender was approximately equal (45.3% female). One-third of the cohort (33.2%) was identified as white, a little over half was identified as African American (56.7%), and the remaining youth were identified as another racial or ethnic category (10.1%). Of those, four youth were identified as Hispanic (1.6%), fourteen as biracial (5.7%), three as American-Indian (1.2%), two as Asian (.8%), and for two (.8%) race was listed as "other." Race/ethnicity was dichotomized for use in analytic models (White = 1; African American/Other = 0).

The clinical/behavioral profile of the study cohort resembled previously studied TFC populations (Chamberlain & Smith, 2005; Farmer, et al., 2003). The mean SDQ score, a measure of clinical severity, was 16 ($SD = 6.9$), which is in the borderline clinical range. The mean of problem behaviors, measured by the PDR, was 5.6 ($SD = 4.4$). The BERS had a mean of 86.9 ($SD = 15.7$), approximately a standard deviation below a population-based sample and typical of a sample of youth with serious emotional and behavioral disorders (Buckley & Epstein, 2004; Chamberlain, 2003; Farmer, et al., 2005). Based on treatment parent reports, two-thirds of the cohort (65.6%) had a history of abuse or neglect. The mean rating of relationship quality between the treatment parent and youth was 3.7 ($SD = .6$) which is consistent with previous TRQ ratings for youth in TFC populations (Southerland, et al., 2009). Three quarters of youth (76.3%) had been in another out-of-home placement immediately prior to entering their current TFC placement. The average length of stay in the current TFC placement at the time of study entry was just under two years (20.1 months; $SD = 25.1$). The majority youth (86%) in this sample were in state custody.

Description of Family Involvement in Usual Care TFC

The distribution of types of family involvement are shown in Table 2 and described here. The majority of youth (78.5%) in this usual care sample some type of family involvement, either contact, treatment team participation or both. A little over a third of youth (38%) only had contact with their family, but no participation in treatment planning. A little over a quarter of all youth (28%) had family member participation on a treatment team. Kinds of family contact reported were in-person contact (visits), telephone contact (phone), and letters. Of youth with any contact, most (63.9%) had a combination of all three kinds of contact. Almost a quarter (21.7%) had only in-person visits, and the remaining (13.9%) had only phone or letter contacts (e.g. no in-person visits). One youth (.5%) reported contact only via letters.

Associations between Family Involvement and Youth Characteristics

Table 3 provides a comparison of characteristics of most of the youth who experienced some family involvement in contrast to over a fifth with no contact. These two groups differ somewhat across the variables reported. However, there were no statistically significant

differences between them on demographic characteristics, measures of strengths and functioning, or maltreatment history, maltreatment, or prior out-of-home placements.

Significant differences observed for a more favorable relationship with the therapeutic foster parent and double the tenure (34.3 versus 17.1 months) in TFC are meaningful and partially explained by higher proportion (+p.1) in state custody for youth with no family involvement.

Discussion

To our knowledge, this is the first study of family involvement in usual care TFC. It marks an important starting point for understanding what family involvement looks like in this community-based residential setting. Three key aspects of family involvement in usual care TFC emerge from these findings. First, it is clear that the majority of youth (nearly 80%) have some kind of involvement with their family. Second, of those youth with family contact, a majority (63.9%) had in-person contact with family members. Third, family member participation on the youth's treatment team was fairly modest. It appears that in this sample of usual care TFC, while there was a considerable amount of contact with family members, there was less evidence of family member involvement in treatment-related activities.

Several findings present less clear implications. The finding that shorter lengths of stay are associated with family involvement is encouraging. This finding is possibly a proxy for a set of factors related to families with youth in TFC who have longer lengths of stay (e.g., termination of parental rights, reunification not viewed as viable, etc.). It is reasonable to extrapolate that youth in these types of situations simply stay in TFC for longer periods of time for lack of an appropriate post-discharge placement, but additional empirical evidence is necessary to make this conclusion. It is also possible that these data are pointing to a time-dependent relationship in which agencies stop trying to facilitate family involvement in treatment planning or that parents lose interest in their child's treatment needs when they are in TFC for long term placement. The implications of this association need to be further explored.

The counterintuitive finding that a higher quality relationship score with the treatment parent was associated with less likelihood that the youth would have family involvement suggests another area in need of further research. This finding was explored with a post-hoc analysis testing the correlations between relationship quality and other youth covariates. The TRQ was significantly positively related to a history of maltreatment; youth who had experienced abuse/neglect had a significantly higher quality of trusting relationships with their treatment parents. Such youth also had longer lengths of stay in their current TFC placement. Interpretation of such a finding in cross-sectional data is difficult. Are longer lengths of stay reducing family contact/involvement? Or does lack of family contact/involvement serve as a proxy for a variety of factors that increase length of stay? Do issues of maltreatment reduce likelihood of family reunification and, indirectly, increase lengths of stay and opportunities for relationship development between youth and treatment parents? Competing hypotheses for this set of findings are impossible to discern from current data. However, from a developmental perspective, the finding that these youth were forming positive relationships

with nurturing adults may be an indicator of both resiliency and potential for a positive adult-child relationship to positively influence future development.

Study Limitations

The primary limitation of this study is that since family involvement was not a primary focus of the randomized study, the opportunity was missed to ask more detailed questions that might have provided greater insight into the nature and extent of family involvement observed. For instance, in future work, it will be important to assess the amount and quality of involvement, satisfaction of the youth and family with the involvement, perceptions of the quality of the relationship between the youth and family, and the perceptions of treatment parents and families about family involvement. Perhaps the biggest limitation in the current study is the paucity of data on the youth's family. It would have been very informative to know about risk factors and strengths of the family members involved with these youth. Equally important would be to understand the limitations, obstacles, and opportunities that the family members faced in their ability to be in contact with their youth or be involved with their youth's treatment (Kruzich, Jivanjee, Robinson, & Friesen, 2003). Further, assessing a broader array of options for family involvement would enhance future research (see Walter & Petr, 2008). In spite of these limitations, this study represents a significant addition to the empirical evidence about the role of the youth's biological or natural family while they are in TFC, and provides guidance for future research.

Conclusion and Implications

This examination of family involvement in usual care TFC provides an important starting place for more in-depth exploration of this important aspect of residential treatment. It is clear from the findings that most youth have some contact with their family, and that many youth have families involved in the treatment process. This finding suggests that there are many opportunities for TFC agencies to work with parents and/or extended family members. To take advantage of those opportunities, a better understanding of the wishes and intentions of families of youth in TFC is needed. What are their perceptions of involvement (or lack thereof) with their youth while he/she is in TFC placement? In particular, what facilitates or hinders involvement? A better understanding about what the involvement with family looks like (both quality and quantity) is also needed. More information about the nature of attitudes and the interactions among the TFC agency, the treatment parents, and the family would inform where to focus future interventions. Empirical research on policy and practice related to a family-driven focus in TFC is needed. Future research could be designed to assess the impact of family involvement on both the gains while in TFC, outcomes for youth who return to the community, and those who were placed in a more restrictive setting subsequently.

Youth who do not have involvement with their family while in TFC suggest another critical area of attention. About one-fifth of the youth in this TFC sample did not have any recent involvement with their family. Among the youth with no family involvement ($n = 53$; 20.5%), termination of parental rights had occurred for over half (59.6%). These youth remained in TFC longer and appeared to have developed positive relationships with their treatment parents. This level of stability in placement and apparent success of the

relationship suggest that these TFC families may be filling basic “family-like” needs for this subset of youth. While these youth appear to be doing well in their current TFC placement, is long-term TFC viable from a financial and system-level perspective? What avenues exist for support for these youth beyond their placement? What are the implications of this type of attachment for the future transitions when the youth ages out of their placement?

These findings present an initial glimpse at family involvement for youth in TFC. Additional work is necessary to more fully understand this set of issues and to improve practice and outcomes related to families and youth. From the current findings, it appears that there is tremendous opportunity for TFC agencies to engage families in youths’ lives and treatment. It also appears that there are two distinct groups of youth who may require quite different foci to maximize the potential opportunities of TFC. For the larger group, those with substantial family involvement, it is critical to understand the nature of this involvement, the ways that agencies can work with families to maximize benefits of such involvement, and to develop approaches that integrate families’ and youth’s perspectives, strengths, and needs into the TFC process and practice. For youth without family involvement, the factors associated with it need to be more fully understood and viable sustainable approaches to providing long-term caregivers/supports and appropriate placement for these youth need to be identified.

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Table 1

Sample Description of Youth Characteristic N=247

Demographics	M(sd) or %
Age (range = 2–21)	12.9(3.8)
5	6.5%
6–10	17.4%
11–15	47.4%
16+	28.7%
Gender (% Female)	45.3%
Race/Ethnicity	33.2%
White	
African American	56.7%
Other	10.1%
Clinical/Behavioral Status	
Strengths and Difficulties Questionnaire (SDQ)	16.3(6.9)
Parent Daily Report (PDR)	5.6(4.4)
Behavioral and Emotional Rating Scale (BERS)	86.9(15.7)
Maltreatment History	65.6(228)
Trusting Relationship (TRQ)	3.7(.64)
System Involvement	
In State Custody	86.0%
Prior Out of Home Placement	76.3%
Time in TFC (months)	20.1(25.1)
Study Condition	
Control	44.9%
Experimental	55.1%

Table 2

Description of Family Contact

	N	%
Types of Family Involvement		
Any Family Involvement	194	78.5%
Family Contact Only	93	38%
Family Participation on Treatment Team	69	27.9%
Kinds of Contact		
Combination Phone, In-Person and/or letter	124	63.9%
In Person	42	21.7%
Phone Only or Phone and Letter	27	13.9%
Letter only	1	.5%

Table 3

Family Involvement and Selected Characteristics

	Any Involvement (N = 194 78.5%)	No Involvement (N = 53 21.5%)
	Mean (SD) or %	Mean (SD) or %
Age	13.0 (3.8)	12.6 (4.0)
Gender (Female)	46.9%	39.6%
Race (White)	32.5%	35.8%
Strengths/Difficulties	16.2 (6.8)	16.7 (7.5)
Problem Behaviors (PDR)	5.5 (4.6)	6.8 (5.5)
Behavioral and Emotional Rating Scale	86.8 (15.9)	86.5 (14.8)
Maltreatment History	65.1%	75.5%
Therapeutic Relationship (TRQ)	3.6 (0.6)	3.8 (0.6) *
In State Custody	82.3%	92.3% +
Prior Out of Home Placement	75.1%	80.8%
LOS in TFC (months)	17.1 (23.1)	34.3 (29.5) **
Study Condition (Experimental)	55.7%	52.8%

⁺
p<.1

^{*}
p<.05

^{**}
p<.01