OVERVIEW
Supporting our most vulnerable children

REVIEW
Can foster care be therapeutic?

LETTERS
Increasing our acceptance

How can foster care help vulnerable children?
Supporting our most vulnerable children

Children living in foster care typically face numerous obstacles, from instability in their living situations to high rates of mental disorders. We identify typical issues that bring children into foster care and strategies for improving outcomes.

Can foster care be therapeutic?

Treatment foster care places high-risk children in the homes of specially trained and highly supported foster parents. But does it make a difference? We present findings from a systematic review to answer this question.

Increasing our acceptance

Improving knowledge about children’s mental disorders can help fight the stigma associated with them. We respond to a reader’s request for educational resources suitable for a range of audiences.

How can foster care help vulnerable children?

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

How to Cite the Quarterly

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

Supporting our most vulnerable children

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

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

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

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

How many children are living in foster care?

Determining the exact number of children living in foster care is challenging because each province and territory defines “children in care” slightly differently. For example, some jurisdictions include children placed with extended family members while others do not. Definitions of children in care can also vary according to length of time a child is in protective care. Researchers have nevertheless estimated that as many as 67,000 Canadian children may be placed in protective care each year.
in protective care each year, which is an estimated 920 of every 100,000 children
(or nearly 1%).

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

**When the challenges continue**

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

**Non-profit group gives youth a voice**

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

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

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

**Good data is a click away**

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

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

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

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

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

The fundamentals of treatment foster care

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

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

Assessing the evidence

Researchers MacDonald and Turner set out to determine whether TFC actually improves children’s outcomes. To do this, they conducted a systematic review of randomized controlled trials (RCTs) of TFC’s effectiveness. (Our methods for appraising and selecting this review are detailed in the Appendix.) Because MacDonald and Turner’s review was limited to RCTs published up to January 2007, we conducted our own systematic search for RCTs published after this date. We found one follow-up publication (regarding an RCT included in MacDonald and Turner’s review), plus one entirely new evaluation (which is highlighted in the sidebar on page 10.)
MacDonald and Turner identified five RCTs that met their inclusion criteria. These five RCTs evaluated four types of TFC: 1) Multidimensional Treatment Foster Care (covered in two separate evaluations — one for boys and one for girls);17, 18 2) Multidimensional Treatment Foster Care “Light”;19 3) Specialized Foster Care;20 and 4) the Fostering Individualized Assistance Program.21 Table 1 describes the four programs and the children who participated in the five evaluations of them.

<table>
<thead>
<tr>
<th>Age (Gender)</th>
<th>Presenting Problem</th>
<th>Program Participants and Roles</th>
<th>Comparison Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>4–7 yrs (39% male)</td>
<td>Maltreatment</td>
<td>**Multidimensional Treatment Foster Care “Light”**17</td>
<td>Typical foster care</td>
</tr>
<tr>
<td>7–15 yrs (61% male)</td>
<td>Maltreatment</td>
<td><strong>Fostering Individualized Assistance Program</strong>19, 22</td>
<td>Typical foster care</td>
</tr>
<tr>
<td>9–18 yrs (40% male)</td>
<td>Severe emotional disorder</td>
<td><strong>Specialized Foster Care</strong>20</td>
<td>Residential centre (e.g., juvenile corrections), hospital or extended family home</td>
</tr>
<tr>
<td>12–17 yrs (100% male)</td>
<td>Chronic delinquency</td>
<td><strong>Multidimensional Treatment Foster Care</strong>17</td>
<td>Group home</td>
</tr>
<tr>
<td>13–17 yrs (100% female)</td>
<td>Chronic delinquency</td>
<td><strong>Multidimensional Treatment Foster Care</strong>16</td>
<td>Group home</td>
</tr>
</tbody>
</table>

* Facilitation gradually transferred to parent or other relative when possible.
** Including community services such as Big Brothers as well as individual services such as supplying refrigerators for parents or bicycles or tutoring for children.

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

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

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

**How well does treatment foster care work?**

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

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

A less intensive version of this program — *Multidimensional Treatment Foster Care* “Light” — showed one promising outcome for young children who had been maltreated. Children in this program were significantly more likely to remain with their original foster parent than to be placed in a different foster home or in residential care.
The other program evaluated with maltreated children also documented some significant benefits. Young people receiving the *Fostering Individualized Assistance Program* had reduced incarceration rates and fewer episodes of running away compared to those in typical foster care. As well, by final follow-up, intervention children were twice as likely to be living with parents (either biological or adoptive), with other relatives or in independent situations. However, the *Fostering Individualized Assistance Program* did not achieve success for most assessed outcomes.

<table>
<thead>
<tr>
<th>Interventions</th>
<th><em>Multidimensional Treatment Foster Care “Light”</em>&lt;sup&gt;19&lt;/sup&gt;</th>
<th><em>Fostering Individualized Assistance Program</em>&lt;sup&gt;21, 22&lt;/sup&gt;</th>
<th><em>Specialized Foster Care</em>&lt;sup&gt;23&lt;/sup&gt;</th>
<th><em>Multidimensional Treatment Foster Care</em>&lt;sup&gt;17, 24&lt;/sup&gt;</th>
<th><em>Multidimensional Treatment Foster Care</em>&lt;sup&gt;18&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participants</td>
<td>4–7-year-old boys + girls</td>
<td>7–15-year-old boys + girls</td>
<td>9–18-year-old boys + girls</td>
<td>12–17-year-old boys</td>
<td>13–17-year-old girls</td>
</tr>
<tr>
<td>Outcomes assessed (post-baseline)</td>
<td>3 months</td>
<td>42 months</td>
<td>7 months</td>
<td>19, 25 + 31 months*</td>
<td>12 + 24 months</td>
</tr>
<tr>
<td>Behavioural</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>↑ social skills</td>
<td>—</td>
<td>◌</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>↓ problem behaviours</td>
<td>—**</td>
<td>◌</td>
<td>—</td>
<td>—</td>
<td>◌</td>
</tr>
<tr>
<td>↓ substance use</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>◌</td>
<td>—</td>
</tr>
<tr>
<td>↓ criminal offending</td>
<td>—</td>
<td>◌</td>
<td>—</td>
<td>◌</td>
<td>◌</td>
</tr>
<tr>
<td>↓ incarceration</td>
<td>—</td>
<td>◌</td>
<td>—</td>
<td>◌</td>
<td>◌</td>
</tr>
<tr>
<td>Emotional</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>↓ emotional problems</td>
<td>—</td>
<td>◌</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>↓ disturbance severity</td>
<td>—</td>
<td>—</td>
<td>◌</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>School</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>↑ attendance</td>
<td>—</td>
<td>◌</td>
<td>—</td>
<td>—</td>
<td>◌</td>
</tr>
<tr>
<td>↑ homework completion</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>◌</td>
</tr>
<tr>
<td>↓ dropping out</td>
<td>—</td>
<td>◌</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>↓ suspensions</td>
<td>—</td>
<td>◌</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Placement stability</td>
<td>◌</td>
<td>—</td>
<td>◌</td>
<td>◌</td>
<td>—</td>
</tr>
</tbody>
</table>

* Statistically significant (p < .05)
* ◌ Statistically significant for some but not all measures
* ○ Not statistically significant (p > .05)
* — Not assessed/Not applicable
* * Timeframes are approximate
* ** Measure of statistical significance not reported
Specialized Foster Care produced less promising results for children needing placements following psychiatric hospitalization. Children in this program neither remained in their placements longer nor achieved better mental health outcomes compared to controls. However, children in the program were placed in foster homes significantly more quickly than control children. In addition to these children benefiting by entering less restrictive settings more quickly, their earlier departure from hospital resulted in average cost savings of US$10,280 per child (in 1988).

Building on success

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

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

Benefits beyond American borders

Results from the first RCT evaluation of treatment foster care outside the United States were published in 2011. This landmark study tracked the outcomes for conduct disordered Swedish youth. Although Multidimensional Treatment Foster Care was not significantly better than regular services at reducing youth’s emotional problems over a two-year period, it did reduce behaviour problems. And the gains did not stop there. Mothers of these youth had significantly less severe mental health symptoms in general, and significantly fewer depressive symptoms in particular, than did mothers of youth receiving regular care. Notably, all of these improvements were statistically and clinically significant, suggesting that gains resulted in meaningful differences in the lives of these young people and their families.
To the Editors:
In the last Quarterly, you identified several ways to reduce the stigma associated with mental disorders. Given that increasing knowledge can encourage understanding and compassion, could you identify any mental health resources for school counsellors, teachers, physicians and families — to help them in working with children and youth?

Hazel Neill
Coquitlam, BC

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

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

**Contact Us**

We hope you enjoy this issue. We welcome your letters and suggestions for future topics. Please email them to chpc_quarterly@sfu.ca or write to the Children’s Health Policy Centre,  
Attn: Jen Barican, Faculty of Health Sciences  
Simon Fraser University, Room 2435, 515 West Hastings St.,  
Vancouver, British Columbia V6B 5K3  
Telephone (778) 782-7772
To identify the best systematic reviews on the topic of treatment foster care, we adapted methods from the Cochrane Collaboration. We first searched the following databases (without date limiters):

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

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

**Table 4: Inclusion Criteria**

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

Because searches in the accepted review stopped in January 2007, we conducted our own systematic search to identify any new studies published since, using the same search terms. We applied criteria for assessing original studies as detailed in the table above. This new search yielded one follow-up to an original study included in the systematic review. We also identified one new RCT. These new studies were incorporated into our findings. 📦
BC government staff can access original articles from BC's Health and Human Services Library (www.health.gov.bc.ca/library/).


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22. Clark, H. B., Prange, M. E., Lee, B., Steward, E. S.,
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    M. H. Epstein & K. Kutash (Eds.), *Outcomes for children
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    families* (pp. 513–542). Austin, TX: PRO-ED.

    with delinquent peers: Intervention effects for youth in
    the juvenile justice system. *Journal of Abnormal Child
    Psychology, 33*, 339–347.

    Preliminary support for Multidimensional treatment
    foster care in reducing substance use in delinquent boys.
    *Journal of Child & Adolescent Substance Abuse, 19*,
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    Multidimensional treatment foster care (MTFC): Results
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    Therapy, 33*, 20–41.

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    5.0.2 [updated September 2009]*. Chichester, UK: John
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2012 / Volume 6
2 – Treating Anxiety Disorders
1 – Preventing Problematic Anxiety

2011 / Volume 5
4 - Early Child Development and Mental Health
3 - Helping Children Overcome Trauma
2 - Preventing Prenatal Alcohol Exposure
1 - Nurse-Family Partnership and Children’s Mental Health

2010 / Volume 4
4 - Addressing Parental Depression
3 - Treating Substance Abuse in Children and Youth
2 - Preventing Substance Abuse in Children and Youth
1 - The Mental Health Implications of Childhood Obesity

2009 / Volume 3
4 - Preventing Suicide in Children and Youth
3 - Understanding and Treating Psychosis in Young People
2 - Preventing and Treating Child Maltreatment
1 - The Economics of Children’s Mental Health

2008 / Volume 2
4 - Addressing Bullying Behaviour in Children
3 - Diagnosing and Treating Childhood Bipolar Disorder
2 - Preventing and Treating Childhood Depression
1 - Building Children’s Resilience

2007 / Volume 1
4 - Addressing Attention Problems in Children
3 - Children’s Emotional Wellbeing
2 - Children’s Behavioural Wellbeing
1 - Prevention of Mental Disorders