Family Based Treatment Analysis
Presented to
Children's Mental Health Coalition

By

Weiskopf Consulting Services
26 Crestwood Drive
Clifton Park, New York 12065
Tel: (518) 339-6990
www.weiskopfconsulting.net

September 2nd 2005

This report was written by Gary Weiskopf of Weiskopf Consulting Services (WCS). WCS is located in Clifton Park, New York. It specializes in public policy analysis, program evaluation and organizational studies. It was established to provide government and not-for-profit decision makers with information and analysis necessary to make informed public policy decisions.

Overview of Family Based Treatment

In New York State, the Office of Mental Health refers to Therapeutic Foster Care as Family Based Treatment. According to the Surgeon General[1], "Therapeutic Foster Care is considered the least restrictive form of out-of-home therapeutic placement for children with severe emotional disorders. Care is delivered in private homes with specially trained foster parents. The combination of family-based care with specialized treatment interventions creates 'a therapeutic environment in the context of a nurturant family home' (Stroul & Friedman, 1988). These programs, which are often funded jointly by child welfare and mental health agencies, are responsible for arranging for foster parent training and oversight. Although the research base is modest compared with other widely used interventions, some studies have reported positive outcomes, mostly related to behavioral improvements and movement to even less restrictive living environments, such as traditional foster care or in-home placement."

Therapeutic Foster Care programs vary considerably but have some common features:

- Children are placed with foster parents who are trained to work with children with special needs;
- Usually, each foster home takes one child at a time, and caseloads of supervisors in agencies overseeing the program remain small;
- Therapeutic foster parents are given a higher stipend than that given to traditional foster parents;
- Foster parents receive extensive pre-service training and in-service supervision and support;
- Frequent contact between case managers or care coordinators and the treatment family is expected; and
- Additional resources and traditional mental health services may be provided as needed.

Benefits of Family Based Treatment

According to the Surgeon General's 1999 study, Therapeutic Foster Care is an evidence based practice. At the time of this report, the Surgeon General found four efficacy studies, each with randomized, controlled designs.

- In the first study, 20 youths who had been previously hospitalized were assigned to either Therapeutic Foster Care or other out-of-hospital settings, such as residential treatment centers or homes of relatives. Youths in Therapeutic Foster Care showed more improvements in behavior and lower rates of reinstitutionalization, and the costs were lower than those in other settings (Chamberlain & Reid, 1991).
- Another study concentrated on youths with histories of chronic delinquency.
    - Those in Therapeutic Foster Care were incarcerated less frequently and for fewer days per episode than youths in other residential placements.
    - At 2-year followup, 44 percent fewer children in Therapeutic Foster Care were incarcerated (Chamberlain & Weinrott, 1990).

[1] U.S. Department of Health and Human Services. Mental Health: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999. Chapter 3: Children and Mental Health Services Interventions.

- In a third study, outcomes for children in Therapeutic Foster Care were compared with those of children in standard foster care. Children in Therapeutic Foster Care were less likely during a 2-year study to run away or to be incarcerated and showed greater emotional and behavioral adjustment (Clark et al., 1994).
- In the most recent study in the report, Therapeutic Foster Care was compared with group care. Children receiving the former showed significantly fewer criminal referrals, returned to live with relatives more often, ran away less often, and were confined to detention or training schools less often (Chamberlain & Reid, 1998).

All four studies of treatment effectiveness showed that youths in Therapeutic Foster Care made significant improvements in:

- Adjustment;
- Self-esteem;
- Sense of identity; and
- Aggressive behavior.

Gains were sustained for some time after leaving the therapeutic foster home (Bogart, 1988; Hawkins et al., 1989; Chamberlain & Reid, 1991).

The Surgeon General concluded that "Therapeutic Foster Care produces better outcomes at lower costs than more restrictive types of placement."

Family Based Treatment in New York State

In New York State, OMH has stated that children's priority populations include children diagnosed with a severe emotional disturbance who are currently in or at risk for out-of-home treatment and children who are victims of trauma.[2] According to OMH, a consistent evidence base currently exists in some but not all areas of children's services. The research evidence linking services to positive outcomes is strongest in several areas including:

- Home-based services, including Multi-systemic Family Therapies;
- Therapeutic foster care;
- Case management;
- Cognitive-behavioral therapies for some disorders;
- Pharmacotherapy for some disorders; and
- Specific family educational or supportive interventions.

However, OMH's priority set of evidence based practices for children and families does not include therapeutic foster care. It does include:

- Home-Based Crisis Intervention (HBCI);
- Intensive Case Management (ICM);
- Cognitive Behavioral Therapies for Childhood Trauma; and
- Functional Family Therapy (FFT).

New York State expanded funding for Family Based Treatment in the year 2000 as part of the Governor's New Initiatives. Funding was added for 125 new Family Based Treatment beds.

[2] http://www.omh.state.ny.us/omhweb/ebp/children.htm Evidence-Based Practices for Children and Families

According to New York State CAIRS (Child and Adolescent Integrated Reporting System) the state now has a Family Based Treatment capacity of 485 beds which includes the new 125 beds. However, as the data in Table 1 shows, the utilization rate for these beds has only experienced a slight upward trend since 2002, ranging from a quarterly low of 56.9% in Quarter 2 of 2002 (276 filled beds) to a high of 64.3% in quarter 1 of 2005 (312 filled beds).

Family Based Treatment Capacity, Census, Age, Gender by Quarter

Table 1

Data from CAIRS Family Based Treatment *Family Indicator Report*

Census	Year													
	2005		2004				2003				2002			
Indicator	Q1	Q2	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Age <13	118	116	132	123	122	117	149	149	148	141	149	143	154	152
Age >17	21	23	10	14	13	15	14	11	7	7	5	9	10	14
Age 13-17	173	171	170	171	176	175	130	143	147	157	130	124	117	123
Capacity	485	485	485	485	485	485	485	485	485	485	485	485	485	485
Census	312	310	312	308	311	307	293	303	302	305	284	276	281	289
Utilization Rate (%)	64.3	63.9	64.3	63.5	64.1	63.3	60.4	62.5	62.3	62.9	58.6	56.9	57.9	59.6
Female	121	117	111	109	119	119	117	112	109	108	115	114	113	114
Male	191	193	201	199	192	188	176	191	193	197	169	162	168	175

OMH Program Requirements for Family Based Treatment[3]

New York State has established a variety of requirements for Family Based Treatment. Among these are the following:

1. Professional families, including respite parents, meet together on a regular basis (ranging from weekly to monthly) and develop a cohesive network that provides social and emotional support for its members:
2. Professional parents are recognized as the most important part of the treatment, and are an integral part of the professional program staff;
3. Professional parents are specifically recruited to work with children and youth with serious emotional disturbances; they receive a stipend above and beyond the money paid to regular foster parents for their participation in the program;
4. Professional parents receive special training in working with children with serious emotional disturbances before a child is placed, and intensive training while the child(ren) is in placement;
5. A mental health professional with a small caseload works closely with the child, the professional parents, and the child's family or goal environment;
6. Only one child or adolescent is placed with each professional family at any time.

[3] OMH Family Based Treatment Program Description.

7. When clinically appropriate, a waiver can be requested and approved by the Office of Mental Health to place two children or siblings in one home; [4]
8. OMH guidelines include requirements for space and fire safety. OMH also requires that parents document fire safety inspections. OMH allows a home to be an apartment or a house. However they will not allow mobile homes or modular homes;
9. OMH requires parents in family based care to maintain records on Medicaid reimbursable services that they are administering; and
10. Anticipated average length of stay for youth entering Family Based Treatment is 18 months to two years. Data from CAIRS in Table 4 on page 12 shows that average length of stay has varied but remains at between one and two years.

Family Based Treatment Target Population[5]

According to OMH, the children and adolescents admitted to the program require individualized, intensive treatment and rehabilitation services and usually exhibit a range of mental health diagnoses and characteristics. They are those who have the potential of functioning in the community and do not need the restrictiveness of a campus or facility type environment. They are able and willing to accept the responsibilities of being integrated into a family unit and will be capable of sustaining the close one-on-one relationship or a family environment.

Participants should be children and youth from 5 through 18 years who have serious emotional and behavioral difficulties. A child may remain in Family Based Treatment for one year past his/her 18th birthday if deemed medically appropriate and necessary.

The child must meet the criteria for a DSM-IV-R psychiatric diagnosis.[6] He/she must have experienced functional limitations due to emotional disturbance over the past 12 months, and meet criteria for ratings of 50 or less on the Children's Global Assessment Scale OR meet criteria for current impairment in functioning with severe symptoms.

Referral Source

According to OMH, admissions to Family Based Treatment should come from the following sources:

1. 30% referred from children’s inpatient programs;
2. 20% RTF related youth including RTF[7] eligible youth waiting placement and those referred from RTFs; and
3. 50% from the community to include but not be limited to parents, committees on special education-related referrals, local departments of social services, Office of Children and Families (Juvenile Justice Division), Community Mental Health Centers, and Intensive Case Management programs and voluntary agencies.

Actual data on referral source and living situation are presented in the Table 2 below.

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[4] http://www.omh.state.ny.us/omhweb/policy/594amend.htm Amendment to Part 594 Regulations, Family-Based Treatment Program (FBTP)
[5] OMH Family Based Treatment Program Description.
[6] DSM-IV - Diagnostic and Statistical Manual of Mental Disorders - Fourth Edition.
[7] RTF – Residential Treatment Facility.

Family Based Treatment Admissions Information

Table 2[8]

		Census									
		2002				2004				2005	
Category	**Indicator**	**Q4**	**Q3**	**Q2**	**Q1**	**Q4**	**Q3**	**Q2**	**Q1**	**Q2**	**Q1**
Admissions	Admissions	38	49	35	41	28	53	29	31	33	38
Custody Status Prior to Admissions	Juvenile Justice							1			
	OCFS	18	13	13	17	7	16	9	6	4	3
	Other	1	2	1	4	4	6		1	8	1
	Other Family	1	7	4	4	7	8	3	2	3	4
	Parent	18	27	17	16	10	23	16	22	18	30
Custody Status Total		38	49	35	41	28	53	29	31	33	38
Living Situation Prior to Admissions	Family	82	76	67	70	90	92	90	89	N/A	N/A
	OCFS FC	29	31	35	35	22	24	25	22	N/A	N/A
	OCFS Residence	15	16	16	15	13	12	10	12	N/A	N/A
	OCFS/ DRS		0	1	1		0			N/A	N/A
	OMH Residence	126	117	112	115	141	141	141	147	N/A	N/A
	Other/Miss	15	14	13	12	14	16	16	15	N/A	N/A
	Psych Inpatient	22	27	32	36	27	26	26	27	N/A	N/A
Living Situation Total		289	281	276	284	307	311	308	312	N/A	N/A
Medication	Medication No	28.9%	23.5%	31.4%	27.6%	19.4%	15.0%	13.5%	16.6%	9.6%	18.4%
	Medication Yes	72.1%	72.4%	65.7%	72.4%	76.4%	85.0%	84.0%	80.4%	79.5%	81.7%
Referral Source	Article 28	1		2	5			1			
	DFY		2					1	1		2
	Emergency				1	2					
	Family/Guardian	7	18	6	13	3	6		5	3	7
	OCFS	15	13	11	10	4	7	5	5	3	1
	OMH	7	16	15	9	1	6	5	3	5	4
	Other	14	9	8	9	21	35	18	23	25	21
	School	1	1	1	3		3	1	1		1
Referral Source Total		45	59	43	50	31	57	31	38	36	36

Challenges Facing Family Based Treatment Providers

Based on discussions with Family Based Treatment providers, it appears that providers are concerned about several issues as follows:

Low utilization of beds: Despite the additional funding in 2000 for 125 new Family Based Treatment beds, few additional beds are occupied. As shown in Table 3 below, there were 316 filled Family Based Treatment beds on August 11, 2000 compared to 323 filled beds on August 11 2005. In contrast, filled crisis beds increased by 406% during the same time period.

[8] Data in Table 2 from two CAIRS reports: (1) *Management Indicator Report – Admissions* and (2) *Living Situation Prior to admission*.

Census Data by Program Type[9]

Table 3

Program Census	Program Type[10]				
Date	Crisis	CRs	FBT	RTF	TFH
11-Aug-05	172	189	323	547	28
11-Aug-04	163	179	332	539	24
11-Aug-03	145	176	326	538	22
11-Aug-02	64	153	294	528	21
11-Aug-01	28	154	304	527	24
11-Aug-00	34	154	316	498	19

As the data in Table 1 on page 5 show, the utilization rate for Family Based Treatment beds has only experienced a slight upward trend since 2002, ranging from a quarterly low of 56.9% in Quarter 2 of 2002 (276 filled beds) to a high of 64.3% in quarter 1 of 2005 (312 filled beds).

***Recruiting and Retaining Parents**:* Several providers indicated that they have trouble recruiting and retaining parents. This in turn makes it more difficult to match children who would like to enter the Family Based Treatment program. OMH has also reached this conclusion. According to OMH, Family-Based Treatment program (FBTP) providers have experienced increasing difficulties over the past several years in recruiting a sufficient number of Professional Parents to operate their programs at full capacity.[11] Several possible reasons for this exist including:

- *One child per home*: One of the principal reasons for recruitment difficulties, "according to providers who were surveyed by OMH in late 1999 and early 2000, is the inability of FBTP recruiters to compete with recruiters from Therapeutic Foster Home Programs (OCFS-funded) where foster parents are permitted to work with more than one child with 'exceptional needs,' including those with serious emotional disturbance. The ability of Therapeutic Foster parents to secure additional compensation by working with more than one child draws individuals to that program who might otherwise apply as Professional Parents in the FBTP, where the current regulation permits only one 'program' child per home unless the provider seeks a special waiver."[12] Since this time, OMH has changed the regulations to permit waivers allowing more than two children.
- *Difficulty getting homes certified by OMH:* OMH guidelines on the use of the home are very strict. They include requirements for space and fire safety and parents must document fire safety inspections. OMH allows a home to be an apartment or a house. However they will not allow mobile homes or modular homes. OCFS has no regulations on this topic. Additionally, OMH inspects a home as if it were an institution.
- *Severity of children*: Some providers have indicated that the severity of disability and level of services required by children in the Family Based Treatment program are so great that many families are not able to work in the program long term. Programs ask parents to make a commitment to see a child through program discharge.

[9] Data from CAIRS Report - Census by Program Type by County.
[10] RTF = Residential Treatment Facilities; FBT = Family Based Treatment; CR = Community Residence; TFH = Teaching Family Homes; DIS LOS = Discharge Length of Stay; ADC = Average Daily Census
[11] http://www.omh.state.ny.us/omhweb/policy/594amend.htm 5/31/02 Amendment to Part 594 Regulations.
[12] http://www.omh.state.ny.us/omhweb/policy/594amend.htm Amendment to Part 594 Regulations.

- *Fingerprinting law*: Some providers indicate that in some places, the state fingerprinting requirement is affecting the recruitment of parents. Parents with a criminal record get identified by OMH. However, people running the Family Based Treatment programs do not know the nature of the criminal offense. Parents can still be approved to participate in the program as long as there is a risk management plan. Without knowing the nature of the criminal offense, a risk management plan is hard to establish. One agency noted that they had an internal form to collect detailed information from parent applicants. This form is used to collect information on criminal history as well.

***Need for improved parent training*:** Approximately 10 years ago when the OMH Family Based Treatment model was first developed, OMH contracted with "People Places, Inc." in Virginia[13] to implement their Family Based Treatment model. Originally, all Family-Based Treatment providers were trained in the implementation of this model. This was a cognitive based learning model.

There is no longer a single set of training or one training approach that is taught to all of the families and staff providing Family Based Treatment. Each provider determines the training for its parents.

Increase in the number of older males needing services: According to providers interviewed, the growing population of older males in the program is a concern because they tend to have conduct disorders and get into trouble with the police. They are much harder to serve and the demands often burn out professional parents. Parents often do not want the older population for this reason. As a result there are very few housing options for the 15 to 18 year-old population.

According to providers interviewed, providers often fail in their attempts to get supported housing for older children discharged from the program. Many of these children do not have the mental health needs required for supported housing. The kids bounce between friends and family and often end up homeless. Older children tend to decompensate at around 17 years of age when they are about to be released on their own. They start acting out and regress which prolongs their length of stay.

Data from CAIRS in Table 1 on page 5 demonstrate a significant increase in the number of children aged 13 and older in Family Based Treatment. The number of children aged 13-17 increased from around 120 in 2002 to more than 170 in the second quarter of 2005. These data also show that the number of children younger than 13 years old declined from around 150 in 2002 to 116 in the second quarter of 2005.

A perceived increase in the number of aggressive adolescent girls and boys with court orders referred to Family Based Treatment. These children are hard to match with parents.

The inability to accept children referred by DSS where a match might exist because OMH will not let Family Based Treatment providers take the child without a viable discharge plan. Additionally, the child cannot be in DSS custody because OMH licensed providers do not do permanency planning.

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[13] People Places, Inc. is a licensed child placement agency providing therapeutic foster care, special education, family preservation, parenting classes and crisis intervention.

Difficulty serving children from RTFs with existing resources: Children in RTF facilities have greater service needs than children in Family Based Treatment. RTFs have much higher levels of supervision, structure, and supports than can be provided by a family. Family Based Treatment is not staffed to provide 24-hour per day supervision. There is also a statewide shortage of child psychiatrists making access to care very difficult. Additionally, many children discharged from RTFs already have a biological family and may resent the idea of being put into a new "family".

Provider Recommendations

Increase social interaction for older children*:* Family Based Treatment programs do not have the resources to support the social needs of older children. Older children desire social interaction with their peers but their behavior often gets them kicked out of community recreational programs. Some recommendations from providers include:

- Fund a recreational therapist to ensure some social interaction amongst the older kids. Older adolescents want to socialize but have limited social opportunities. Most have been kicked out of general recreational programs for disruptive behavior. A suggestion was made that in some places, caseworkers could do more recreational programming.
- Fund a staffed teen drop-in center. The New York City Jewish Board of Family and Children's Services used to have a teen lounge which was grant funded.

Provide more structured supports**:** Children discharged from RTF facilities need structure during and after school. Special therapeutic after school programs and emergency care would assist professional parents in helping these children and may help to prevent parent burnout and turnover. Other related suggestions included:

- Provide a special day school for transitioned children to maintain behavior modification. Children in RTFs come from a highly structured school on the RTF grounds and they do not have an easy or productive transition to public school. They need structure and stability. A special day school would avoid a sharp transition from a structured RTF school to a public school environment.
    - One caveat is that in some rural areas kids would need to be on a bus for 1 hour to get to a special day school or day treatment program. This does not work for children that need extensive supervision and structure.

Fund pre-placement transition visits: Pre-placement visits should be funded to facilitate transition from RTF to Family Based Treatment. Several providers supported the idea of a separate budget line to fund transition from RTFs to Family Based Treatment.

Enhanced family therapy and family psychoeducation**:** Providers noted that additional resources to work with biological families would be worthwhile. Currently the OMH model provides for 1/2 an FTE to work with the birth families in a program with 10 beds.

Enhance day respite and child care for families: Currently these services are only provided to foster parents on weekends by arrangement with other families.

Increase number of homes with two children: According to OMH, "FBTP providers who have requested and received waivers for dual placements report significant success with approved dual placements. Having a second child in a FBT home often provides a direct therapeutic benefit for both children. Younger children often benefit from having an older role model; older children

often benefit by having the opportunity to be that role model. Children who have poor socialization skills have an opportunity to practice skills with a second child in the home as those skills are being taught by the Professional Parent. There are also examples of older children, whose problems may include reclusiveness as a result of an attachment disorder, being drawn out by the opportunity to help nurture a young child."[14]

[14] http://www.omh.state.ny.us/omhweb/policy/594amend.htm Amendment to Part 594 Regulations.

Statistical Overview of Family Based Treatment Programs in New York State

Admissions, Discharges, Length of Stay and Average Daily Census - Statewide Totals

Table 4
Program Type[15] by Indicator

Data from CAIRS - Quarter 1 2000-2005

Quarter 1		Category			
Program	Year	ADC	Admissions	DIS LOS	Discharges
CR	2000	155.4	40	256	30
	2001	154.3	31	333	19
	2002	142.9	26	473	32
	2003	163.9	32	430	18
	2004	178	31	405	23
	2005	194.3	32	388	30
FBT	2000	328.4	34	647	31
	2001	308.8	33	611	26
	2002	300.2	41	734	28
	2003	308.9	29	663	24
	2004	331.6	31	713	24
	2005	326.6	38	446	33
RTF	2000	498	73	619	71
	2001	516.4	70	671	70
	2002	526.8	81	613	80
	2003	530.8	76	652	73
	2004	531	103	512	108
	2005	526.2	78	565	77
TFH	2000	21.8	3	410	2
	2001	19.7	2	375	2
	2002	22	4	134	1
	2003	20.5	5	364	6
	2004	22.4	8	525	2
	2005	23.6	4	400	3

[15] RTF = Residential Treatment Facilities;
FBT = Family Based Treatment
CR = Community Residence
TFH = Teaching Family Homes
DIS LOS = Discharge Length of Stay
ADC = Average Daily Census

Admissions, Discharges, Length of Stay and Average Daily Census - Statewide Totals

Table 5

Indicator by Program Type

Data from CAIRS - Quarter 1 2000-2005

Quarter 1		Program Type			
Category	Year	CR	FBT	RTF	TFH
ADC	2000	155.4	328.4	498	21.8
	2001	154.3	308.8	516.4	19.7
	2002	142.9	300.2	526.8	22
	2003	163.9	308.9	530.8	20.5
	2004	178	331.6	531	22.4
	2005	194.3	326.6	526.2	23.6
Admissions	2000	40	34	73	3
	2001	31	33	70	2
	2002	26	41	81	4
	2003	32	29	76	5
	2004	31	31	103	8
	2005	32	38	78	4
DIS LOS	2000	256	647	619	410
	2001	333	611	671	375
	2002	473	734	613	134
	2003	430	663	652	364
	2004	405	713	512	525
	2005	388	446	565	400
Discharges	2000	30	31	71	2
	2001	19	26	70	2
	2002	32	28	80	1
	2003	18	24	73	6
	2004	23	24	108	2
	2005	30	33	77	3

Family Based Treatment Discharge Information

Table 6

Data from CAIRS *Management Indicator Report - Discharge*

Sum of Census	**Year**	**Quarter**									
	2002				**2004**				**2005**		**2005 Total**
Discharge Information	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	
Discharge CR - OMH	2	5	1			1	2	2	1		1
Discharge Crisis - OMH	1	1	3	3	2			1	3	1	4
Discharge DFY Res – OCFS						2					
Discharge Family/Guardian	16	26	25	13	9	18	21	19	14	20	34
Discharge FBT - OMH	3	5	6	7	8	7	16	5	7	7	14
Discharge FC/Group – OCFS	2		2	2			2		2		2
Discharge Inpatient – OMH					1				1		1
Discharge Other	2	4	5	1	1	2	5	3	2	2	4
Discharge RTC - OCFS							1	1			
Discharge RTF - OMH	3	4	2	3	2	3	2	3	4	5	9
Discharge TFH - OMH		3		1	1				1		1
Discharge Total	28	47	44	30	24	33	49	32	33	35	68
Discharge Unknown											
Medication No	15.0%	28.0%	24.0%	13.0%	35.0%	17.0%	19.0%	12.0%	23.0%	24.0%	0.47
Medication Yes	84.0%	72.0%	70.0%	70.0%	66.0%	83.0%	81.0%	88.0%	77.0%	76.0%	1.53