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Engaging foster parents in treatment: A randomized trial of supplementing Trauma-focused Cognitive Behavioral Therapy with evidence-based engagement strategies☆

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ABSTRACT

The goal of this study was to examine the impact of supplementing Trauma-focused Cognitive Behavioral Therapy (TF-CBT; Cohen et al., 2006) with evidence-based engagement strategies on foster parent and foster youth engagement in treatment, given challenges engaging foster parents in treatment. A randomized controlled trial of TF-CBT standard delivery compared to TF-CBT plus evidence-based engagement strategies was conducted with 47 children and adolescents in foster care and one of their foster parents. Attendance, engagement, and clinical outcomes were assessed 1 month into treatment, end of treatment, and 3 months post-treatment. Youth and foster parents who received TF-CBT plus evidence-based engagement strategies were more likely to be retained in treatment through four sessions and were less likely to drop out of treatment prematurely. The engagement strategies did not appear to have an effect on the number of canceled or no-show sessions or on treatment satisfaction. Clinical outcomes did not differ by study condition, but exploratory analyses suggest that youth had significant improvements with treatment. Strategies that specifically target engagement may hold promise for increasing access to evidence-based treatments and for increasing likelihood of treatment completion.

Youth in foster care have disproportionately high rates of trauma exposure and mental health problems. Over half of children entering foster care have been exposed to abuse and neglect (Leslie, Hurlburt, Landsverk, Barth, & Slymen, 2004; Pecora et al., 2003), with 85% having witnessed violence (Stein et al., 2001). Nearly 50% demonstrate clinically significant treatment needs (Garland, Landsverk, Hough, & Ellis-McLeod, 1996; Leslie et al., 2004), which is 2–3 times higher than the general population (New Freedom Commission on Mental Health, 2003). Untreated mental health problems, and particularly

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behavioral difficulties, have been linked to higher rates of placement disruption and lower rates of reunification and adoption for children in foster care (Hurlburt, Chamberlain, DeGarmo, Zhang, & Price, 2010; James, 2004; James, Landsverk, & Slymen, 2004). Studies involving foster care alumni suggest that high rates of mental health problems can continue into adulthood (Courtney, Dworsky, Lee, & Raap, 2010; Pecora et al., 2003). In the foster care subsample of a nationally representative child welfare study (Kolko et al., 2010), rates of Posttraumatic Stress Disorder (PTSD) were 24.9% (ages 8–10) and 15.7% (ages 11–14). These rates are substantially higher than those in the general population (i.e., 4.7% lifetime prevalance; McLaughlin et al., 2013) and are equivalent to those of war veterans (Kulka, Fairbank, & Schlenger, 1990).

Entering foster care can be a "gateway" to receiving mental health services, as placement is associated with higher rates of service receipt (Farmer et al., 2001; Leslie et al., 2005). Nonetheless, the percentage of unmet mental health need for this population remains high, with only between 50% (Burns et al., 2004) and 64% (Leslie et al., 2005) of those with need receiving services. For those who do receive services, it is unclear whether or not they receive evidence-based treatments (EBTs) targeting their particular mental health problem (Landsverk, Burns, Stambaugh, & Reutz, 2006). To date, a number of EBTs for a range of child and adolescent mental health problems have been developed and, in some cases, efficacy or effectiveness has been established specifically within child welfare (for reviews, see Chaffin & Friedrich, 2004). There is substantial variation, however, in the degree to which EBTs are available in public mental health settings (Bruns & Hoagwood, 2008)—the service sector in which most children, including those in foster care, receive services.

In general, EBTs that offer a good fit for mental health needs of children in foster care include interventions addressing behavioral difficulties (e.g., Parent–Child Interaction Therapy, Triple P, Incredible Years)—given the high prevalence of behavioral problems (Garland et al., 2000)—and trauma exposure and resulting sequelae. Trauma-focused Cognitive Behavioral Therapy (TF-CBT; Cohen, Mannarino, & Deblinger, 2006), a well-established EBT, provides a good fit for children in foster care as it is designed to address behavioral problems and trauma-related symptoms. TF-CBT includes individual sessions with children and non-offending caregivers and conjoint child-caregiver sessions delivered over approximately 12–24 sessions focused on psychoeducation, skill building (e.g., relaxation), exposure, and cognitive work (for adaptations/guidelines on including offending caregivers in TF-CBT, see Dorsey & Deblinger, 2012; Runyon & Deblinger, 2013).

To date, the empirical base for TF-CBT includes over 14 randomized controlled trials (RCTs). Efficacy data exists for preschool, school-aged, and adolescent male and female children (for reviews, see Dorsey, Briggs, & Woods, 2011; Silverman et al., 2008). Studies have included a substantial percentage of African American children, with no significant differences by ethnicity (e.g., Cohen, Deblinger, Mannarino, & Steer, 2004). Although initial studies focused on sexually abused children (e.g., Cohen et al., 2004; Cohen & Mannarino, 1996; Deblinger, Lippmann, & Steer, 1996), recent RCTs, quasi-experimental trials, and open trials (e.g., CATS Consortium, 2007; Cohen, Mannarino, & Iyengar, 2011; Jaycox et al., 2010) include children exposed to other diverse traumatic event types (e.g., traumatic death, domestic violence, natural disasters).

For TF-CBT to be most effective, research suggests caregivers need to be involved in treatment (Cohen et al., 2006). Deblinger, Lippmann, and Steer (1996) found that while posttraumatic stress (PTS) symptoms improved even without parental involvement, behavior problems did not. Caregivers help promote optimal treatment outcomes by reinforcing both skills (e.g., affect modulation) and psychoeducation about traumatic events, and by implementing behavior management in the home environment. However, engaging caregivers—and potentially foster parent caregivers—in treatment can be challenging. To our knowledge, empirical studies examining rates of foster parent engagement in treatment are not available. A recent open trial examining TF-CBT with children in foster care (Weiner, Schneider, & Lyons, 2009) found that treatment completion was linked to foster parent involvement. Those who received 11 or more sessions—defined as an active dose of treatment—had significant reductions in PTS symptoms (Weiner et al., 2009). However, the children who completed treatment or were still in treatment at the end of the study had high rates (76–79%) of foster parent involvement (Northwestern University, 2008). In comparison, for the nearly one third of children who dropped out of treatment, only 10% had a foster parent involved.

Engagement challenges are not unique to the foster parent population. Rates of engagement in community mental health treatment can be low for all families. Less than half of families attend the first scheduled visit (Harrison, McKay, & Bannon, 2004) and less than 10% remain in treatment after 3 months, with more than two-thirds dropping out within seven sessions (McKay, Harrison, Gonzales, Kim, & Quintana, 2002; Miller, Southam-Gerow, & Allin, 2008). Engaging foster parents is likely as important as engaging biological or adoptive families. In foster care, learning and implementing behavior management is critical, given the high rates of behavior problems and the negative association between behavior problems and placement stability, reunification, and adoption (James et al., 2004). In general, foster parents are inadequately trained and prepared for the behavioral problems of children in foster care (Dorsey et al., 2008). Interventions that build behavior management skills have stabilized placements and increased "positive exits" from foster care (e.g., reunification, adoption; Price, Chamberlain, Landsverk, & Reid, 2009), with better outcomes for children in their care when foster parents attend treatment and are active participants (DeGarmo, Chamberlain, Leve, & Price, 2009).

In response to these challenges, engagement interventions have been developed. Three relatively recent reviews (Becker et al., 2013; Ingoldsby, 2010; Lindsey et al., 2013) describe common elements of engagement interventions from over 40 RCTs. Studies have tested the combination of EBTs and specialized engagement strategies for a range of populations, including Latino families, child-welfare involved parents, and parents of children with behavioral disorders (e.g., Chaffin, Funderburk, Bard, Valle, & Gurwitch, 2011; Nock & Kazdin, 2005; Szapocznik, Dantisteban, Rio, Perez-Vidal, & Santisteban, 1989). These studies have demonstrated higher rates of engagement with the inclusion of a specific engagement-focused intervention, and in turn, better clinical outcomes, given that participants receive a higher dose of treatment and/or are more

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