Are there significant differences in treatment and outcomes of African American and white youth in treatment foster care?

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Introduction

Juvenile delinquency is a social and legal problem that is results from a variety of factors. Researchers have found that juvenile delinquency correlates with academic deficiency, physical discipline from a parent and/or guardian, poor self-esteem and self-identity, and peer rejection (Chamberlain, 1994). Although these characteristics describe early antisocial behavior, if left unaddressed such behavior can gradually become delinquent (Chamberlain, 1994). Antisocial children are more at risk for criminality, unemployment and welfare dependence, alcoholism and substance abuse, and poor relationships in adulthood (Chamberlain, 1994). In juvenile justice cases, up to 50 percent of cases report attention deficit hyperactivity disorder, up to 41 percent have anxiety disorders, up to 53 percent show learning disabilities and specific developmental disorders, and up to 66 percent have received some outpatient mental health treatment (Heffron et al., 2004). The majority of juvenile delinquents reside within the community, and the most effective preventative interventions of delinquency are community based (Chamberlain, 1994).

Community-based residential treatment facilities include group homes. The group home model uses teaching parents as primary staff in a family-style environment for six to eight youths (Farmer et al., 2004). The group home teaches self-reliance and utilizes peer-to-peer relationships to motivate change. Yet, in such facilities, children are easily abused or neglected, and often medication is used as their main source of therapy. Although peer relationships ideally are to create positive change for youth in-group homes, adolescents are constantly around other delinquent peers. Without effective monitoring and mentoring to decrease antisocial behavior, adolescents do not reach successful rehabilitation. They become more dependent on their peers to teach them more negative behavior. These children do not relearn healthy social behavior and as a result are at greater risk of re-entering the legal system in the future. Those who are in need of resocialization through positive reinforcement in a parent-child relationship may benefit most from family-based residential treatment such as treatment foster care. Group home residence has also been found to have negative effects on adolescent self-identity development (Kools, 1997).

Treatment foster care (TFC) is "a cost effective alternative to group or residential treatment, incarceration, and hospitalization for adolescents who have problems with chronic antisocial behavior, emotional disturbance, and delinquency" (Chamberlain, 1994). The treatment parent plays an essential role to the rehabilitation of the adolescent. Treatment parents are recruited and professionally trained to provide an intensive supervision for each adolescent. Treatment parents are also trained to provide rules and limits at home and school with consequences they will keep if the child should break these rules; a positive mentoring relationship with the child; positive reinforcement for healthy social behavior; and separation

from delinquent peers (Chamberlain, 1994). Along with the treatment parent's care, the child may also participate in other services available, such as counseling with a therapist or social worker, attending a special school, being in contact with a school psychologist, or taking medications. "The [TFC] approach combines the normalizing influence of family-based care with specialized [and individualized] treatment interventions, thereby creating a therapeutic environment in the context of a nurturant family home" (Wells et al., 2004).

With growing attention on mental health access for children and adolescents, more information has been found about the current and growing disparity between racial/ ethnic minority children and white adolescents. It must first be stated that "race" within this study does not follow a biological definition. Although racial categories in the United States may display different physical characteristics, race creates social categories that correlate with socioeconomic status, education, income, etc. Researchers have found those who are impoverished are more likely to have poor mental health status and less likely to have access to mental health services (U.S. Department of Health and Human Services, 2001). Overall, "children are more likely to have unmet need of mental health care if they were impaired because of mental illness and had had no mental health care in the six months." In addition, African American children and adolescents were more likely to have unmet need than whites (U.S. Department of Health and Human Services, 2001). African American youth account for only 15 percent of the population. However, African American children make up 45 percent of the children currently in public foster care and more than half of those awaiting adoption (U.S. Department of Health and Human Services, 2001). Abuse and neglect and the frequent moves and placement changes that often result from such experiences are associated with a high risk of mental illness. One study reported that 42 percent of youth in child welfare programs met criteria for a mental health disorder (U.S. Department of Health and Human Services, 2001). However, a significantly higher proportion of white youth received counseling and psychotherapy while in foster care than African American youth (Farmer et al. 2001). Overall, African American children and adolescents are less likely than whites to receive mental health treatment, regardless of the type of source used (U.S. Department of Health and Human Services, 2001).

While they have lower access to mental health treatment for emotional and behavioral problems, African American youth are overrepresented in all stages of the juvenile justice system; with increasing representation as court severity increases (Heffron et al., 2003). In 1996-1997, black youth accounted for 26 percent of juvenile arrests, 30 percent of court cases, and 45 percent of detention (Heffron et al., 2003).

There is, therefore, a concern about African American youth's access to appropriate mental health services and about use of restrictive and punitive services (i.e., juvenile justice) rather than treatment-oriented services for African American youth. However, little is currently known about whether African American and white youth experience different intensity, quality, or type of treatment once they access such services. Therefore, in the current study, we examined differences between African American and white youth on treatment and outcome while in Treatment Foster Care (TFC). We examined differences in the youth, their experiences while in TFC, and their outcomes. Specifically, we compared parent-child relationships in regard to activities and time spent with the treatment parent, consequences carried out for problem behaviors, and additional services received. We measured outcomes by the number of problem behaviors reported by the treatment parent and a measure of strengths known as the Behavioral and Emotional Rating Scale (BERS). For differences between the groups, we discuss what may cause these differences along with similarities between the groups.

Methods

Study Context and Design

This study is a secondary examination of data used from a larger study, the Treatment Foster Care in a System of Care (TFCSC) study. The TFCSC study is a longitudinal investigation of treatment foster care in North Carolina. The broader study examines the use, implementation, and effectiveness of TFC for youth with behavioral and emotional disorders in North Carolina (Farmer et al., 2002). The study population is youth with psychiatric disorders and aggressive behavior in TFC at the time of recruitment (June 1999 through May 2001) (Wells et al., 2004). All youths in the study group were receiving residential services through mental health referrals, and their care was supposed and provided by local mental health agencies (Breland-Noble et al., 2004).

The treatment parents of the youth were also study subjects. The treatment parents from the TFCSC sample represent the population of therapeutic foster parents providing care in North Carolina. At the time of the interview, youth have been with treatment parent for a median of 9.4 months (range= 1 month – 10.4 years).

"The data for this study came from a statewide study funded by the National Institute of Mental Health of TFC in North Carolina. Institutional review board approval was obtained from the Duke University School of Medicine, and the principles for the Declaration of Helsinki were followed. Therapeutic foster parents and the youths provided informed consent and assent before involvement in the study (Breland-Noble et al., 2004)." All data for these analyses came from the baseline interview with the treatment parent.

Components of the interview included a Parent Daily Report (PDR), the Child and Adolescent Services Assessment (CASA), the Behavioral and Emotional Rating Scale (BERS), and the Trusting Relationship Questionnaire (TRQ). Scores from the Brief Psychiatric Rating Scale for Children (BPRS) administered when each child entered TFC were also available. The PDR recorded problem behaviors and attitudes of the adolescent and interaction between the child and treatment parent within the last 24 hours prior to the interview. The CASA is a parent-report instrument developed to assess the use of mental health services by children and adolescents ages 8 to 18 years (Ascher and Farmer, 1996). For this study, only the types of services the child received were recorded. The BERS is designed to assess the strengths according to five dimensions: (1) interpersonal strength, (2) family involvement, (3) intrapersonal strength, (4) school functioning, and (5) affective strength (Epstein et al., 1999). A higher BERS score indicates more strength. The TRQ assesses the quality of the parent-child relationship from both the adult and child's perspectives (Mustillo et al., 2005). The BPRS was designed to describe child and adolescent psychiatric severity and help to categorize each patient's problems, i.e. behavioral problems, depression, thinking disturbance, psychomotor excitation, withdrawal-retardation, anxiety, and organicity (Lachar et al., 2001).

Sample

To address the question for this study- are there differences in treatment and outcomes between African American and white adolescents in therapeutic foster care? - the sample was chosen according to the race of the adolescent in TFC; African American (or black) and white.

The following table displays the demographics of the sample. There were 175 adolescents in TFC at the time of the interview; African American, 42.9 percent and white, 57.1 percent. The mean age of the sample population at the time of the interview was 14 years (SD= 2.69; range= 4-19). There were more males (73.1 percent) than females (26.9 percent) in TFC (SD= 0.44). The mean BPRS score within this sample was expected, and found, to be higher than that of an average adolescent. The mean BPRS score of the sample was 64 out of a possible 100 (range= 24-115). The mean amount of time in TFC for the sample was 492.7 days (SD= 568.26; range= 25-3743). There were no significant differences between African American and white youths on any of the demographic and pre-placement variables.

Table 1. Profile of youth in therapeutic foster care (TFC) in North Carolina.

Sample Profile			
	Black (African American)	**White**	**Total, N**
Total	75	100	175
Age (years)	14.5	13.8	14
Sex (%)	Female, 26.7; Male, 73.3	Female, 27; Male, 73	Female, 26.9; Male, 73.1
BPRS	64.9	67.2	64
Time in TFC (days)	447.2	526.9	492.7

Data Analysis

Differences in treatment and outcomes were based upon the parent-child relationship (both quality and quantity of time spent), how long the child was in TFC at the time of the interview, services received while in TFC, and the amount of discipline the child may receive for unacceptable, problem behaviors.

Data Interpretation

Figures 1 and 2 displays similarities in two types of services that adolescents in treatment foster care may receive. Case management is care coordination that mobilizes and maintains access to a variety of services and resources to meet the adolescent's needs (Farmer et al., 2004). Therapy includes sessions with a psychiatrist, school guidance counselor, therapist, or psychologist. As assessed by the CASA, African American and white adolescents receive similar case management services (89.2 percent to 90.6 percent) and therapy (78.7 percent to 81.3 percent). Other similar services included attendance to an outpatient drug or alcohol clinic, in-home counseling or crisis services, contact with a probation officer or court counselor, help from a mentor or any other natural relatives, medical visits for emotional, behavioral, or substance abuse problems, or spiritual guidance from a minister, priest, or rabbi for emotional, behavioral, or substance abuse problems. Overall, African American and white youth received similar services while in TFC.

Figure 1. Graph displaying similarities in case management service levels between African American (blue) and white adolescents (red).

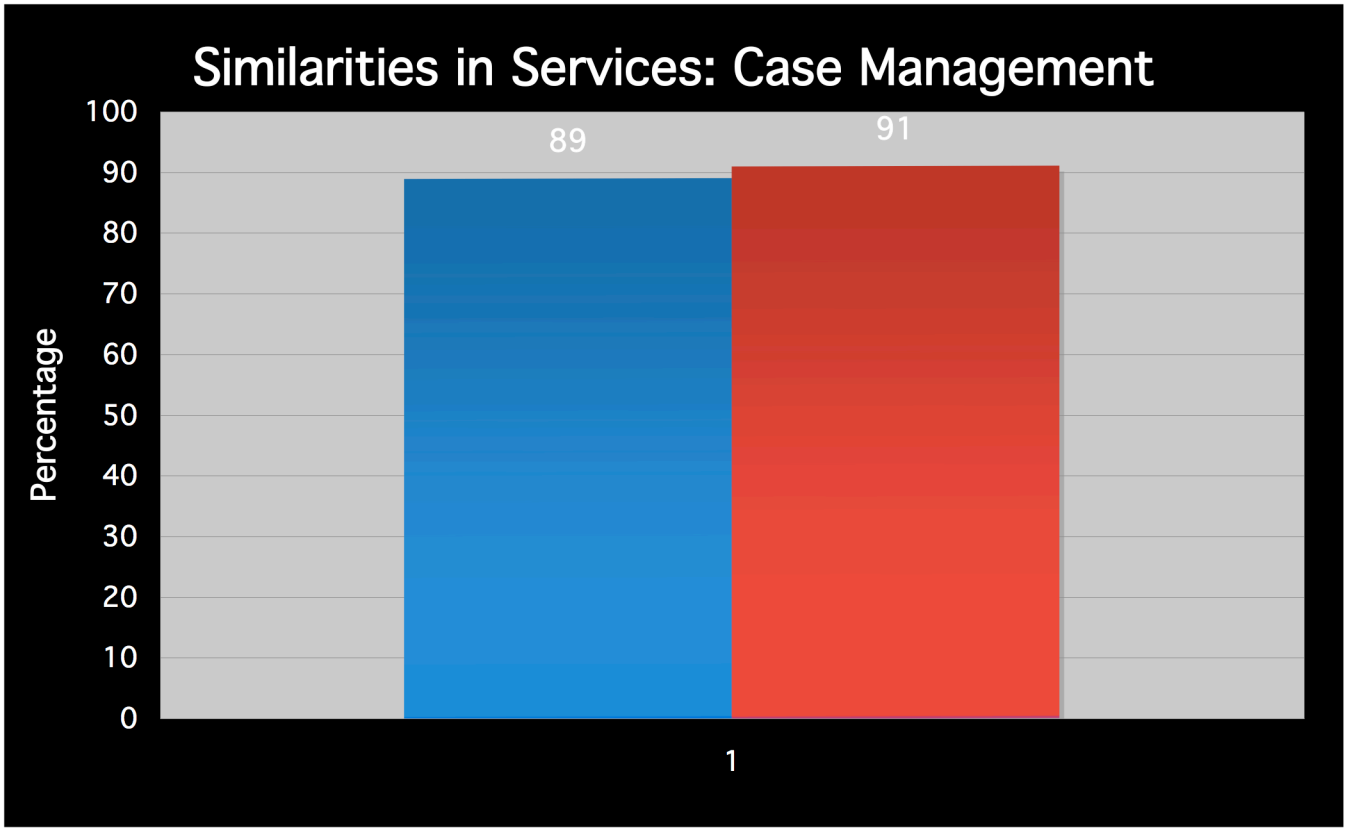

Figure 2. Graph displaying similarities in therapy service levels between African American (blue) and white adolescents (red).

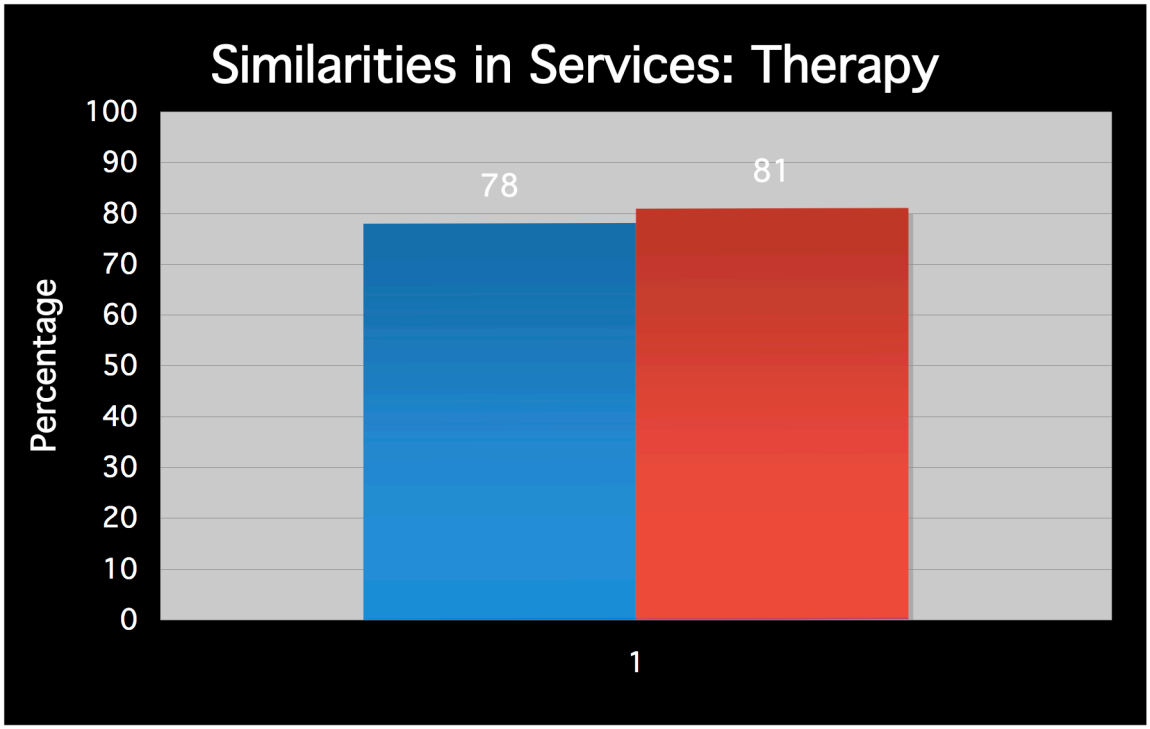

Table 2 displays the results of TFC on African American and white adolescents. These results are measured according to the level of strengths recorded by the BERS and amount of problem behaviors recorded by the PDR. African American adolescents scored a mean BERS score of 90.7 (SD= 27.52); white adolescents scored 83.5 (SD= 22.67). The BERS scores are marginally significantly different (p= 0.06), where African American adolescents show slightly more strengths at the time of the interview than white adolescents. According to the PDR, African American adolescents were reported to have an average of 4 (SD= 3.56) behavioral problems within the last 24 hours prior to the interview; white adolescents were reported to have an average of 7.5 (SD= 4.88). The PDR shows that the number of problem behaviors were significantly different ($p < 0.001$), where African American adolescents show less behavioral problems at the time of the interview than white adolescents.

Table 2. Outcomes of African American and white adolescents measured at the time of interview.

Differences in Outcomes of Black and White Adolescents			
Measure Used	**Black (African American)**	**White**	**Significantly Different?**
BERS (strengths)	90.7	83.5	YES (p = 0.06)
PDR (problems)	4	7.5	YES (p < 0.001)

Table 3 lists the problem behaviors recorded from the PDR. White adolescents were more likely to be argumentative within the last 24 hours prior to the interview (60.9 percent) than African American adolescents (18.2 percent). White adolescents were more likely to be complaining within the last 24 hours prior to the interview (71 percent) than African American adolescents (47.7 percent). White adolescents were more likely to be defiant within the last 24 hours prior to the interview (33.8 percent) than African American adolescents (13.6 percent). White adolescents were more likely to vandalize or destroy property (7.4 percent) than African American adolescents (0.0 percent); however, because of the very small number of youth for whom any such problem behavior, it cannot be said that this statistic is significant. White adolescents were more likely to be irritable within the last 24 hours prior to the interview (57.4 percent) than African American adolescents (22.7 percent). White adolescents were more likely to be negative within the last 24 hours prior to the interview (56.7 percent) than African American adolescents (29.5 percent). White adolescents were more likely to be rowdy within the last 24 hours prior to the interview (35.3 percent) than African American adolescents (15.9 percent). White adolescents were more likely to swear or use obscenities within the last 24 hours prior to the interview (23.2 percent) than African American adolescents (9.1 percent). White adolescents were more likely to show signs of depression within the last 24 hours prior to the interview (23.9 percent) than African American adolescents (4.5 percent). White adolescents were more likely to steal within the last 24 hours prior to the interview (9.0 percent) than African American adolescents (0.0 percent); however, the majority of the population did not report any such problem behavior so it cannot be said that this statistic is significant. White adolescents were more likely to be nervous within the last 24 hours prior to the interview (35.5 percent) than African American adolescents (2.3 percent). White adolescents were more likely to have a short attention span within the last 24 hours prior to the interview (52.9 percent) than African American adolescents (31.8 percent). White adolescents were more like to be manipulative within the last 24 hours prior to the interview (35.3 percent) than African American adolescents (15.9 percent). White adolescents were more likely to have a fight or disagreement with their treatment parent within the last 24 hours prior to the interview (29.4 percent) than African American adolescents (6.8 percent). It was found that African American adolescents had lower levels of problems for 12 out of the 32 problem behaviors.

Table 3. List of problem behaviors reported by treatment parent within 24 hours prior to interview.

List of Problem Behaviors Experienced Within the Last 24 Hours of Interview			
Problem Behavior	**Black (African American)**	**White**	**Significantly Different?**
Argue	18.2	60.9	YES ($p < 0.0001$)
Complain	47.7	71	YES ($p = 0.01$)
Defiant	13.6	33.8	YES ($p = 0.01$)
Destroy or vandalize	0	7.4	YES ($p = 0.08$)
Fight	2.3	7.4	NO ($p = 0.24$)
Irritable	22.7	57.4	YES ($p < 0.0001$)
Lie	25	38.8	NO ($p = 0.10$)
Negative	29.5	56.7	YES ($p = 0.004$)

Boisterous/ rowdy	15.9	35.3	YES (p = 0.02)
Not minding/ noncompliant	25	32.4	NO (p = 0.27)
Stay out late	0	1.4	NO (p = 0.61)
Skip meal(s)	4.5	5.8	NO (p = 0.57)
Run away	0	0	NA
Swear/ use obscene language	9.1	23.1	YES (p = 0.05)
Tease/ provoke	22.7	34.3	NO (p = 0.14)
Depressed/ sad	4.5	23.9	YES (p = 0.005)
Sluggish	15.9	16.2	NO (p = 0.59)
Jealous	18.4	29	NO (p = 0.17)
Skip school	0	4.0	NO (p = 0.32)
Steal	0	9	YES (p = 0.5)
Nervous/ jittery	2.3	35.3	YES (p < 0.0001)
Short attention span	31.8	52.9	YES (p = 0.02)
Irresponsible	29.5	36.8	NO (p = 0.28)
Use Marijuana/ drugs	0	0	NA
Use alcohol	0	0	NA
School problem	13.9	20.8	NO (p = 0.30)
Sexually inappropriate	4.5	4.5	NO (p = 0.66)
Manipulative	15.9	35.3	YES (p = 0.02)
Have a fight or disagreement with you	6.8	29.4	YES (p = 0.003)
Ignore you or stop talking to you	13.6	20.6	NO (p = 0.25)
Try to turn friends or family members against each other	2.3	2.9	NO (p = 0.66)
Set someone else up to get in trouble	6.8	11.8	NO (p= 0.30)
Try to keep certain people from being in his/her group of friends	2.3	5.9	NO (p = 0.35)

Despite these lower levels of problem behaviors, the interview with the treatment parents revealed that African American youth were more likely to have trouble with the law while in TFC than white youth (p= 0.023). In the month prior to the interview, 33.3 percent of African American youth in TFC had contact with the police or the courts because of something the child had done compared to 16.7 percent of white youth. Although African American youth in TFC are more likely to have contact with police because of something they have done (p= 0.01), we cannot say that the crime they committed was done while in TFC. In the last month prior to the interview, 24.3 percent of African American youth were placed in jail, detention, under house arrest, on probation, or had other legal restrictions on their behavior compared to 8.51 percent of whites. Although it can also be said that African American youth in TFC are more likely to have legal restrictions on their behavior than white youth (p= 0.005), we cannot report these restrictions are due to actions done within the last month. The only behavior found to be dangerous to others or that broke the law and statistically significant (p= 0.01) was carrying a gun or knife; 9.6 percent of African American youth versus 1.04 percent of white youth. Although significant, very few treatment parents reported such behavior in either group. In the last month prior to the interview, 14.7 percent of African American youth in TFC ran away from their treatment home compared to 5.21 percent of white youth. Although statistically significant (p= 0.04), very few treatment parents reported such behavior in either group.

In addition to problem behaviors of the youth, we also explored whether there were differences in the types of services youth received while in TFC. Figures 3, 4, and 5 display services that have statistically significant different rates of use by African American and white youth. Figure 3 shows that 38.7 percent of African American adolescents in TFC receive respite care within the last 4 months of the interview compared to 57.3 percent of whites. Because the variable is statistically significant (p= 0.012) it can be stated that African American adolescents are less likely to receive respite care than their white counterparts. Figure 4 shows that 23.3 percent of African American adolescents in TFC attend a special school compared to 13.7 percent of whites. This variable proves to be statistically significant (p= 0.08), therefore, African American adolescents are more likely to attend a special school than white adolescents. Figure 5 shows that 12.0 percent of African American adolescents have been in a detention center, training school, or jail within the last four months of the interview compared to 3.1 percent. This variable proves to be statistically significant (p= 0.025), therefore, African American adolescents are more likely to endure more restrictive settings than white adolescents while in TFC.

Figure 3. Graph displaying differences in respite care services between African American and white adolescents.

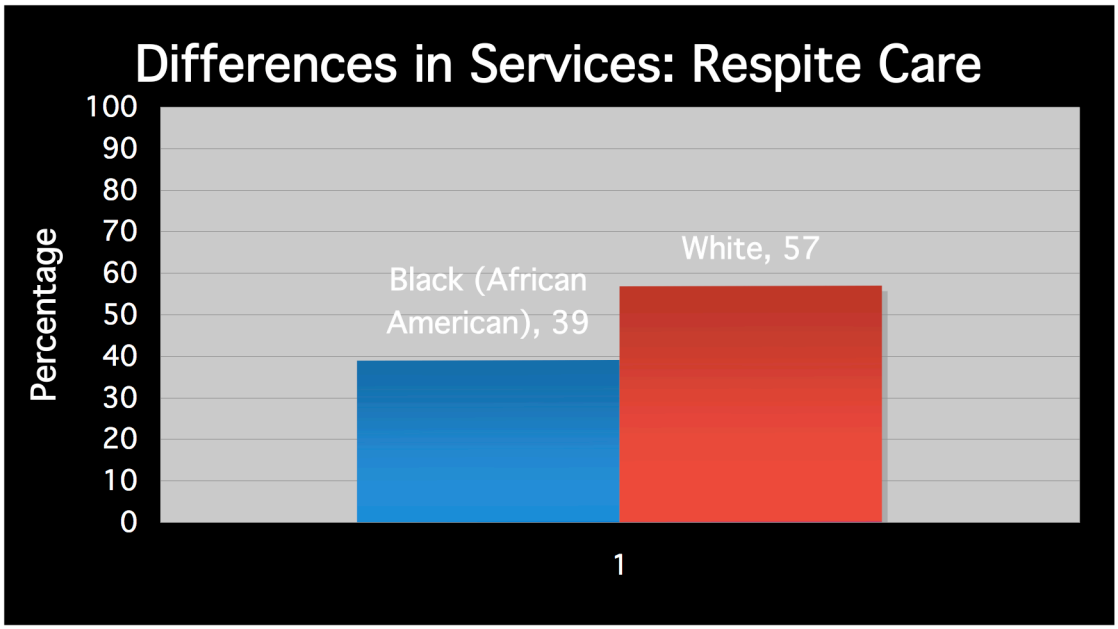

Figure 4. Graph displaying differences in special school services between African American and white adolescents.

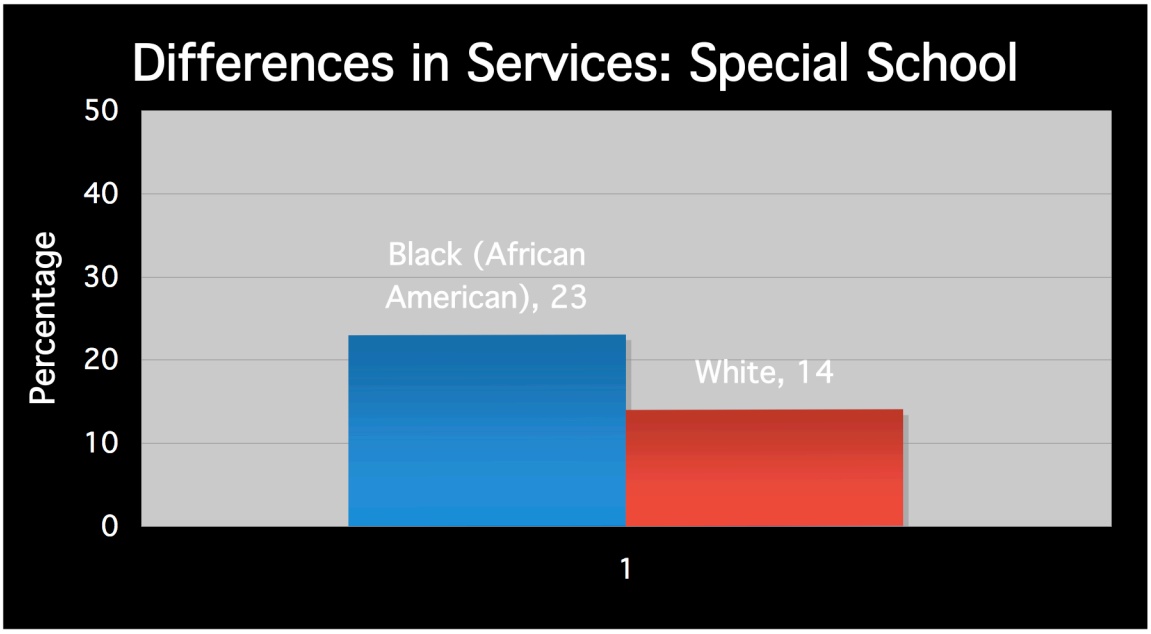

Figure 5. Graph displaying difference in detention/jail services between African American and white adolescents.

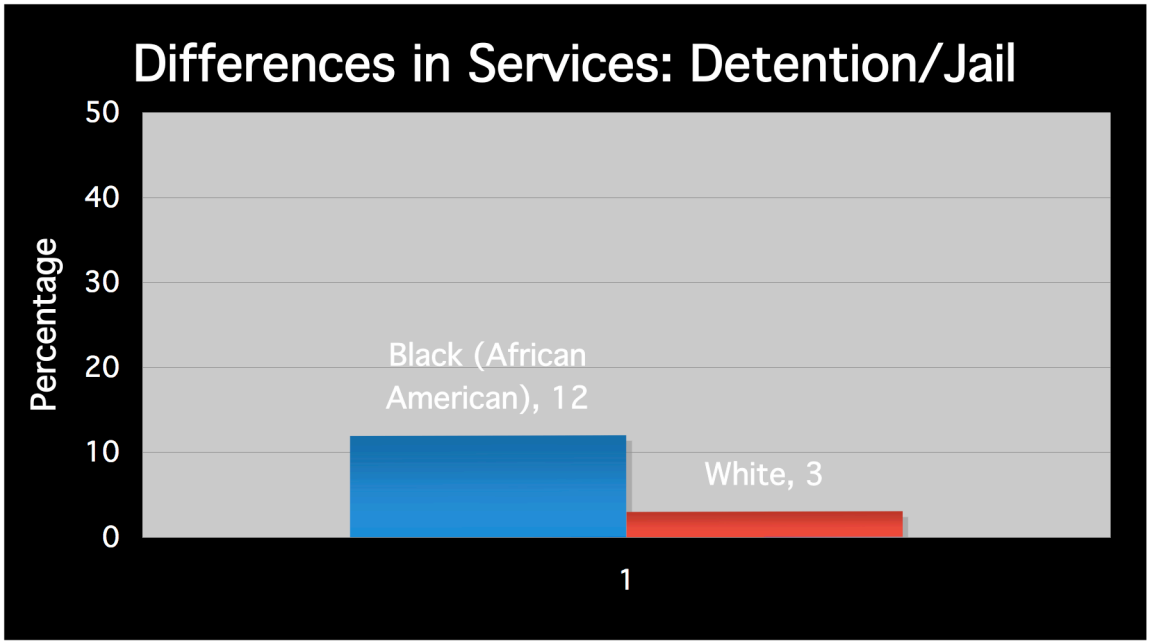

Table 4 examines several factors that may affect the outcomes of the youth. African American adolescents spent a mean time of 449.8 minutes (SD= 276.40) with their treatment parent, including meals, within the last 24 hours prior of the interview; white adolescents spent about 436.2 minutes (SD= 291.96). Total time spent with the treatment parent is not significantly different between the two groups (p= 0.81). African American adolescents on average spent 239.4 minutes (SD= 180.23) doing a one-on-one activity with their treatment parent, excluding a meal; white adolescents spent 195.7 minutes (SD= 154.4) of one-on-one time with their treatment parent. The amount of one-on-one time spent with the treatment parent was found to not be significantly different between African American and white adolescents (p= 0.44). The strength of the parent-child relationship was measured by the TRQ. The mean score from the TRQ for African American and white adolescents were 62. 9 (SD= 13.22) and 64.4 (SD= 10.06), respectively. The recordings from the TRQ are not significantly different from one another (p= 0.41). Appropriate disciplinary actions were measured by the percent of problem behaviors that received a consequence. On average, African American adolescents were disciplined in some way 47.2 percent of the time they misbehaved (SD= 0.38). On average, white adolescents were disciplined in some way 45.5 percent of the time they misbehaved (SD= 0.33). The psychiatric severity of the two groups at admission into TFC as measured by the BPRS is not significantly different (p= 0.40). Total time spent in TFC is also not significantly different (p= 0.36). Therefore, the potential explanatory variables did not differ between the two groups.

Table 4. Factors expected affect outcomes of adolescents in TFC.

Factors Expected to Affect Outcomes of Adolescents in TFC			
Variable Analyzed	**Black (African American)**	**White**	**Significantly Different?**
Time spent with treatment parent (min.)	449.8	436.2	NO (p = 0.81)
One-on-one time spent with treatment parent (min.)	239.4	195.7	NO (p = 0.44)
Strength of parent-child relationship (TRQ)	62.9	64.4	NO (p = 0.41)
Bad behaviors that received a consequence (%)	47.2	45.5	NO (p = 0.81)
Time spent in TFC (days)	447.2	526.9	NO (p = 0.36)

To finalize the analysis, we ran multiple regression models, which take, into account more than one independent variable at a time. This model examined which variable, controlling for others in the model, affected outcomes. We ran the models for each of the dependent variables: PDR and BERS. As Table 5 shows, even with other variables included in the model, race continued to be significantly related to both outcomes. Therefore, even when the model accounts for other demographic factors and experiences, African American youth continue to show fewer problems and more strength.

In addition to race, a few other variables are significant in these models. PDR was positively related to BPRS; youth who had more serious mental health symptoms at the time of placement continued to have more behavior problems by the time of the interview. For the BERS, the quality of the parent-child relationship was related to outcome. This means that youth who had a more positive relationship with their treatment parent also showed better outcomes in terms of strengths.

Table 5. Multivariate regression model run to explain differences between African American and white adolescents.

OLS Regression Model		
Individual Variables	**Problem Behaviors (PDR)**	**Strengths (BERS)**
Race (black)	*** -3.24	** 10.11
BPRS (symptoms)	** 0.08	-0.2
Sex (female)	-0.3	1.01
Age	-0.03	0.36
Time in TFC (days)	0.0008	0.0006
Parent-child relationship (TRQ)	0.03	*** 0.76
One-on-one time spent with treatment parent (mins.)	-0.71	-0.06
Bad behaviors that received a consequence (%)	1.5	-8.06
Jail	0.48	-1.94
Respite Care	0.67	0.07
Special School	-0.81	-0.79
Intercept	0.43	** 48.74
NOTE: * = p ‹ 0.1; ** = p ‹ 0.05; *** = p ‹ 0.01.		

Conclusions

African American and white youth in TFC exhibited few differences. It was found that African American youth had better reporting on 12 out of the 32 problem behaviors reported by the treatment parent. However, African American youth were more likely to have legal trouble such as contact with the police or courts, legal restrictions on their behavior, and carrying a weapon than white youth. African American youth showed some differences in specific types of care including respite care and special school. Nevertheless, African American youth showed less behavioral problems and more strength at the time of the interview than white youth.

African American and white youth in TFC shared more similarities than differences. Overall, both groups shared similar demographic and pre-placement variables including gender makeup, average age, psychiatric severity at entry, and total days spent in TFC. African American and white youth also received similar types and amounts of services outside of TFC, such as case management and therapeutic services. More importantly, the potential explanatory variables did not differ between the two groups.

Few differences between African American and white youth in TFC were not expected, and so the explanation of better outcomes for African American youth still remains an issue. The regression model reveals that race remains a significant variable when accounting for other variables related to outcome. More research is needed to understand the causes of this outcome.

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