TRANSFORMING TREATMENT FOSTER CARE

Presented to The Public Children Services Association of Ohio
2020 Annual Conference

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Gretchen Clark Hammond, CEO, Mighty Crow


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Introductions

- Scott Britton, Assistant Director, PCSAO
- Karen McGormley, Project Manager, Office of Children Services Transformation, ODJFS
- Gretchen Clark Hammond, CEO, Mighty Crow

Acknowledgements

- The Phase I and Phase II reports were made possible in collaboration with Casey Family Programs, whose mission is to provide, improve – and ultimately prevent the need for – foster care. The findings and conclusions presented in this report are those of the author(s) alone, and do not necessarily reflect the opinions of Casey Family Programs.

- Please describe your role.
  a. *Caseworker with some responsibility for identifying/working with treatment foster care placements for youth*
  b. *Supervisor with some responsibility for identifying/working with treatment foster placements for youth;*
  c. *Manager or Director with some responsibility for working with network providers and treatment foster care*
  d. *Behavioral health provider working with treatment foster care*
  e. *Other*

Poll Question #1

Background

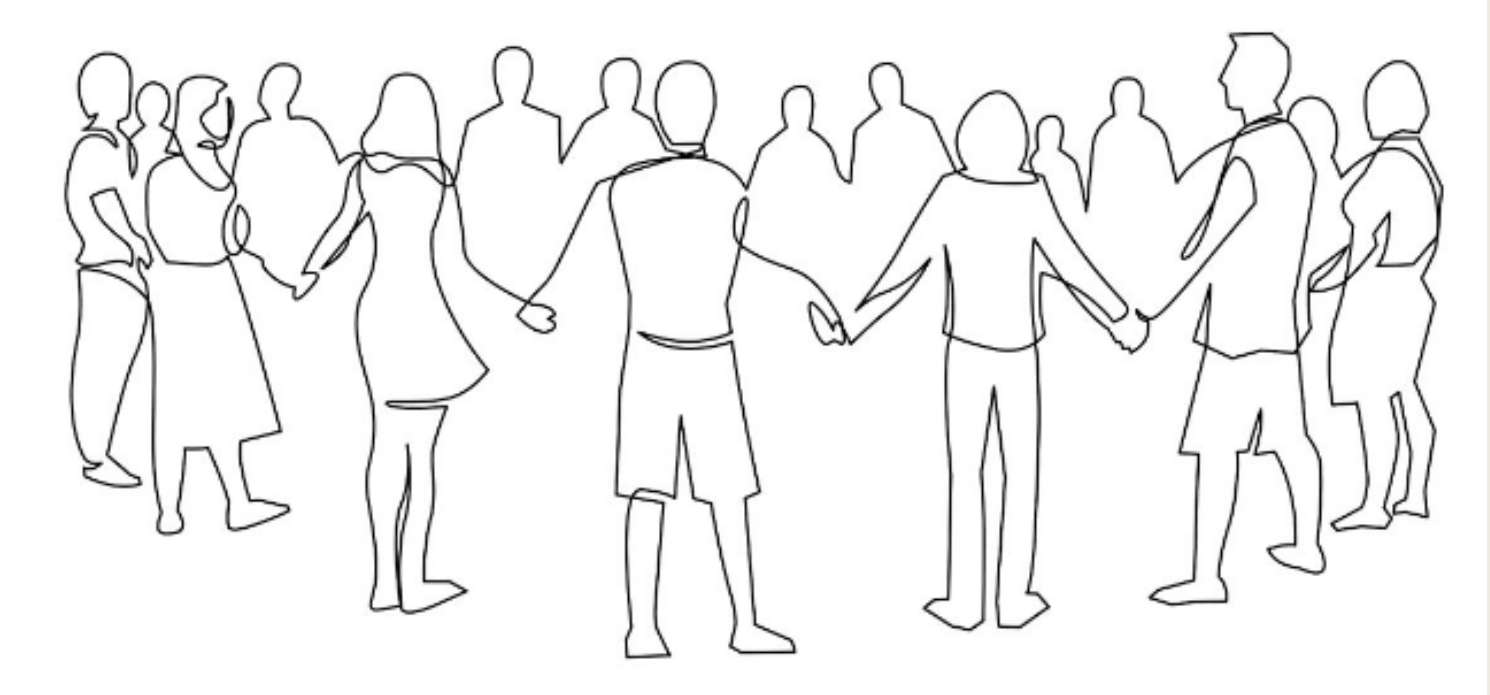
- PCSAO's Children's Continuum of Care Reform
- Family First Prevention Services Act of 2018 (effective 10.1.2021)
- Professional Project Management and Facilitation

TTFC: Goal

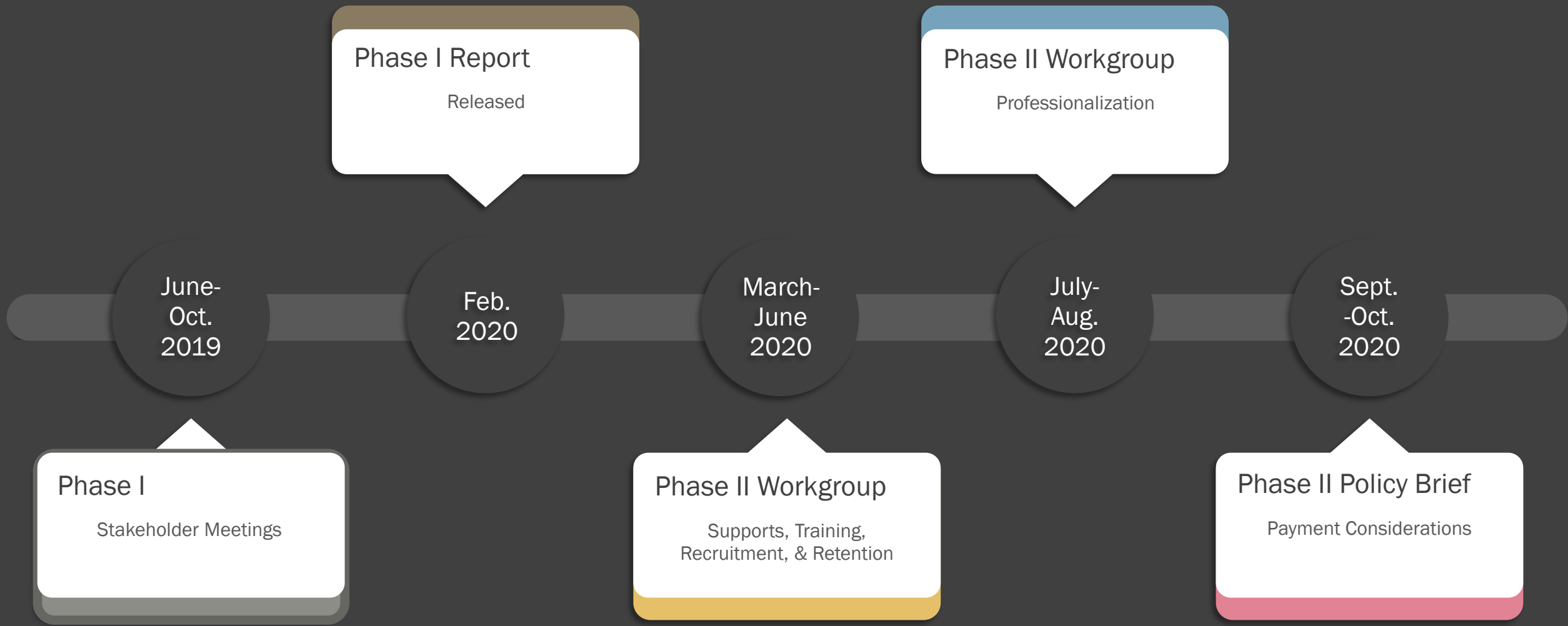
Expand treatment foster care by **creating tiers of care** that more appropriately align with the various needs and challenges of the children requiring such placement and ensure that **training**, **support**, and **payment** align with the expectations of care.

Focus of Our Work:

The best outcomes for children, their families, and the caregivers who support them.



Phased Work


June-
Oct.
2019
Phase I
Stakeholder Meetings
Feb.
2020
Phase I Report
Released
March-
June
2020
Phase II Workgroup
Supports, Training,
Recruitment, & Retention
July-
Aug.
2020
Phase II Workgroup
Professionalization
Sept.
-Oct.
2020
Phase II Policy Brief
Payment Considerations

Therapeutic Foster Care (TFC, also called Treatment Foster Care) is an intensive treatment-focused form of foster care provided in a family setting by trained caregivers.

Although no single definition of TFC exists, key elements have been identified:

- ***TFC serves children who have behavioral or emotional disorders or medical conditions that cannot be adequately addressed in a family or foster home and who would otherwise be served in a residential or institutional setting.***
- ***TFC is provided in a family-based setting by foster, kinship, or biological parents who are trained, supervised, and supported by qualified TFC program staff.***
- ***Services within TFC may address social functioning, communication, and behavioral issues, and typically include crisis support, behavior management, medication monitoring, counseling and case management.***

(U.S. Dept. of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation: (aspe.hhs.gov/treatment-foster-care-family-based-care-children-severe-needs)

DEFINITION

PHASE I

TTFC Process Map v.1

Defining Tiers

Characteristics of each Tier

- Developmental Needs
- Service Expectations
- Biological Family Needs

Level of Need: Caregivers

Expectations and Capabilities

- Training Needs
- Requirements
- Employee Status

Payment Structure

Compensation Levels

- Payment for each tier
- Options for funding
- Consistency across counties

Policy Considerations

Codes, Laws, Etc.

- Ohio Admin. Code
- JFS Policy
- Local Policy

County Considerations

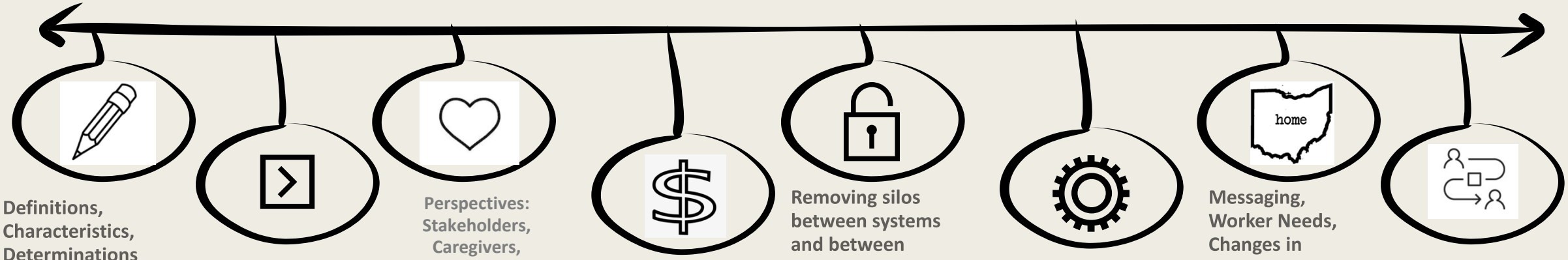
Local Impact

- Worker Needs
- Contract Changes
- Information Tech Needs

FC and BH Organizations

Caregiver Network

- Recruitment and Retention
- Training/Support
- Crisis and other Services



Definitions, Characteristics, Determinations

Communication, Training, Parent vs. Therapist Role, Expectations

Perspectives: Stakeholders, Caregivers, Parents, Youth, Professionals

Funding Sources, Payment Models, Flexibility in Funding

Removing silos between systems and between families; flexibility in working across systems with bio family and foster family

Changes to Ohio Administrative Code, Changes in Licensing, Changes in local policy

Messaging, Worker Needs, Changes in Practice

Capacity, Workforce Issues, Consistency across Counties, Continuum of Care

RECOMMENDATION 1:

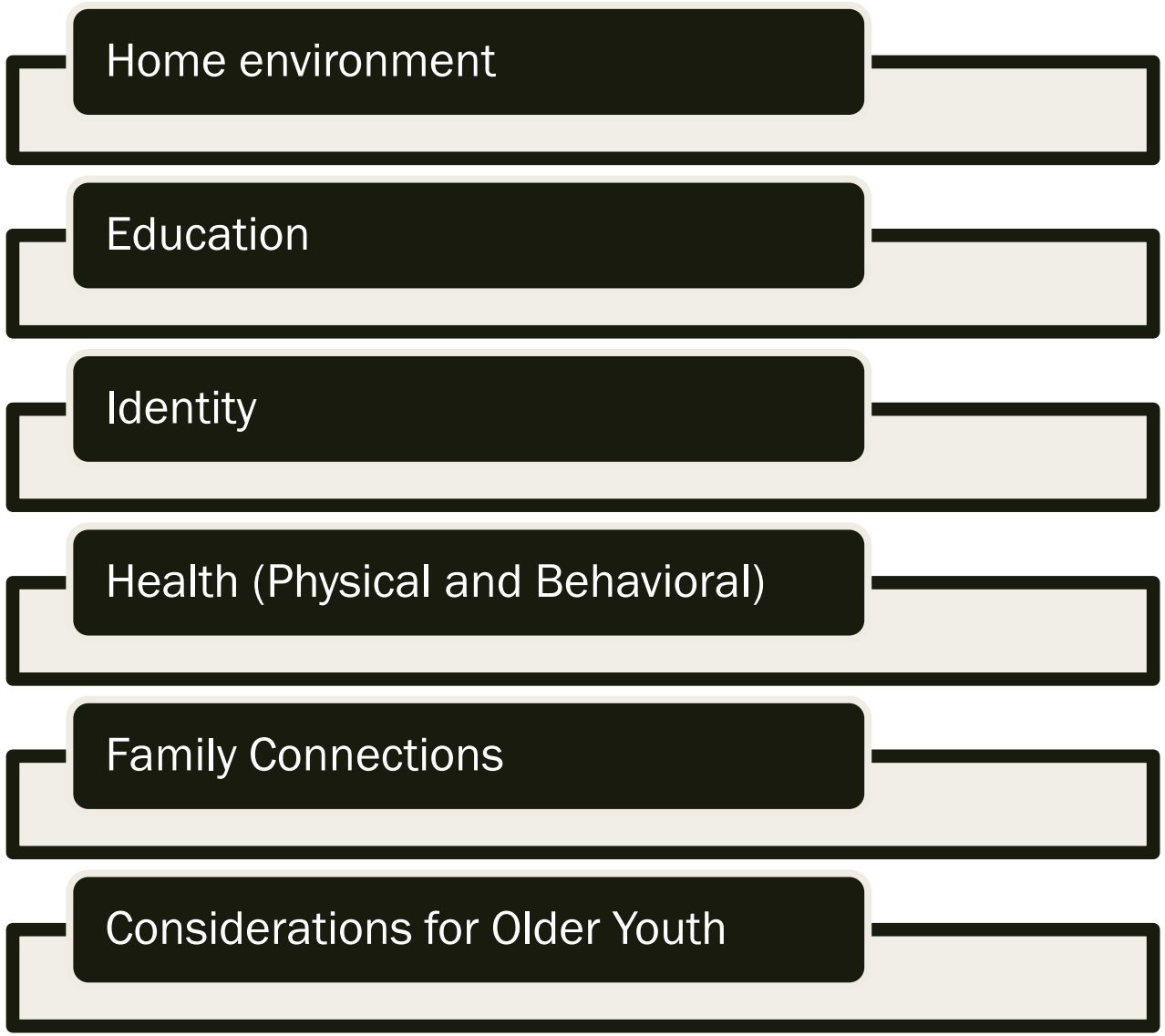
- **Expand and enhance the levels of foster care beyond traditional and treatment by creating three tiers of treatment foster care** that better meet the variety of challenging needs of children entering the system and those that may be stepping down from congregate care or entering treatment foster care in lieu of congregate placement. This expansion will establish a range of tiers, which includes the highest form of treatment foster care. This recommendation recognizes that some counties may have a tiered system in place that may correspond with these proposed tiers.

Drafting the Tiers

- We presented our first version of the tiers in August and gathered feedback from the stakeholders through large group and small group discussions.
- Version two was presented in September; we utilized large and small group discussions again and asked them to complete a survey.
- Version three was presented in October at our final meeting.
  - *Tiers were changed to reflect more narrative and qualitative descriptions*
  - *Included more descriptions for caregiver skills and expectations*
  - *Included information on working with birth family*
  - *Format is similar to the MAPCY (tool used in Minnesota) in how the domains are described*

Characteristics within Tiers for Children

- Development
- Education
- Identity
- Behavioral Health
- Physical Health
- Substance Use
- Delinquency
- Guidance and Structure
- Respite



Skills within Tiers for Caregivers

Created a List of Other Considerations

Placement History

Family Connections

Home Environment

School Transportation

Recognition of Trauma in the Lives of Children

Table 1. Effects of Trauma on Children

Trauma may affect children's ...	In the following ways
Bodies	• Inability to control physical responses to stress • Chronic illness, even into adulthood (heart disease, obesity)
Brains (thinking)	• Difficulty thinking, learning, and concentrating • Impaired memory • Difficulty switching from one thought or activity to another
Emotions (feeling)	• Low self-esteem • Feeling unsafe • Inability to regulate emotions • Difficulty forming attachments to caregivers • Trouble with friendships • Trust issues • Depression, anxiety
Behavior	• Lack of impulse control • Fighting, aggression, running away • Substance abuse • Suicide

Table 1
Symptoms that Overlap with Child Trauma and Mental Illness (AACAP, 2010)

Mental Illness	Overlapping Symptoms	Trauma
1. Bipolar disorder	Hyperarousal and other anxiety symptoms mimicking hypomania; traumatic reenactment mimicking aggressive or hypersexual behavior; and maladaptive attempts at cognitive coping mimicking pseudo-manic statements	Child trauma
2. Attention deficit/hyperactivity disorder	Restless, hyperactive, disorganized, and/or agitated activity; difficulty sleeping, poor concentration, and hypervigilant motor activity	Child trauma
3. Oppositional defiant disorder	A predominance of angry outbursts and irritability	Child trauma
4. Panic disorder	Striking anxiety and psychological and physiologic distress on exposure to trauma reminders and avoidance of talking about the trauma	Child trauma
5. Anxiety disorder, including social anxiety, obsessive-compulsive disorder, generalized anxiety disorder, or phobia	Avoidance of feared stimuli, physiologic and psychological hyperarousal on exposure to feared stimuli, sleep problems, hypervigilance, and increased startle reaction	Child trauma
6. Major depressive disorder	Self-injurious behaviors as avoidant coping with trauma reminders, social withdrawal, affective numbing, and/or sleep difficulties	Child trauma
7. Substance abuse disorder	Drugs and/or alcohol used to numb or avoid trauma reminders	Child trauma
8. Psychotic disorder	Severely agitated, hypervigilance, flashbacks, sleep disturbance, numbing, and/or social withdrawal, unusual perceptions, impairment of sensorium, and fluctuating levels of consciousness	Child trauma

Appendix 1: ACYF Well-Being Framework

	Intermediate Outcome Domains		Well-Being Outcome Domains			
	Environmental Supports	Personal Characteristics	Cognitive Functioning	Physical Health and Development	Emotional/Behavioral Functioning	Social Functioning
Infancy (0-2)	Family income, family social capital, community factors (e.g., institutional resources, collective socialization, community organization, neighborhood SES)	Temperament, cognitive ability	Language development	Normative standards for growth and development, gross motor and fine motor skills, overall health, BMI	Self-control, emotional management and expression, internalizing and externalizing behaviors, trauma symptoms	Social competencies, attachment and caregiver relationships, adaptive behavior
Early Childhood (3-5)	Family income, family social capital, community factors (e.g., institutional resources, collective socialization, community organization, neighborhood SES)	Temperament, cognitive ability	Language development, pre-academic skills (e.g., numeracy), approaches to learning, problem-solving skills	Normative standards for growth and development, gross motor and fine motor skills, overall health, BMI	Self-control, self-esteem, emotional management and expression, internalizing and externalizing behaviors, trauma symptoms	Social competencies, attachment and caregiver relationships, adaptive behavior
Middle Childhood (6-12)	Family income, family social capital, social support, community factors (e.g., institutional resources, collective socialization, community organization, neighborhood SES)	Identity development, self-concept, self-esteem, self-efficacy, cognitive ability	Academic achievement, school engagement, school attachment, problem-solving skills, decision-making	Normative standards for growth and development, overall health, BMI, risk-avoidance behavior related to health	Emotional intelligence, self-efficacy, motivation, self-control, prosocial behavior, positive outlook, coping, internalizing and externalizing behaviors, trauma symptoms	Social competencies, social connections and relationships, social skills, adaptive behavior
Adolescence (13-18)	Family income, family social capital, social support, community factors (e.g., institutional resources, collective socialization, community organization, neighborhood SES)	Identity development, self-concept, self-esteem, self-efficacy, cognitive ability	Academic achievement, school engagement, school attachment, problem solving skills, decision-making	Overall health, BMI, risk-avoidance behavior related to health	Emotional intelligence, self-efficacy, motivation, self-control, prosocial behavior, positive outlook, coping, internalizing and externalizing behaviors, trauma symptoms	Social competence, social connections and relationships, social skills, adaptive behavior
					Social and Emotional Well-Being Domains	

Poll Question #2

- How often does your agency struggle with finding the right level of treatment foster care for children?
  a) *None of the time*
  b) *Some of the time*
  c) *Most of the time*

RECOMMENDATION 2:

- Adjust foster care per diems based on the level of care provided by establishing a standard per diem range for traditional foster care that is consistent across the state. Establish a consistent per diem ranges for the three tiers of treatment foster care while further standardizing the core features of quality treatment foster care. These ranges should consider actual cost of living, including costs associated with the expected care needs of the child. We recommend a workgroup to focus on this issue, as it is quite complicated.

Rationale

- *In an examination of maintenance payment expenditures for January through July 2019, it became evident that payments varied greatly from county to county, with no similarity based on county size (rural vs. metro). Treatment foster care organizations identified the variance in rates as a challenge to contracting and for recruiting partners who know that the payments vary greatly from county to county, seemingly regardless of child need.*

Ohio Payment Data
Range, Mean, Median, Mode,

Category 3: Special Needs	**Category 4: Exceptional Needs**	**Category 5: Intensive Needs**
Range: $71.86 to $338.04 Mean: $127.32 Median: $122.67 Mode: $150.00	Range: $48.00 to $423.00 Mean: $147.54 Median: $138.14 Mode: $150.00	Range: $76.14 to $304.00 Mean: $158.62 Median: $150.00 Mode: $150.00
30 days: Mean: $3,819.60 Median: $3,680.10 Mode: $4,500.00	30 days: Mean: $4,426.20 Median: $4,144.20 Mode: $4,450.00	30 days: Mean: $4,758.60 Median: $4,500.00 Mode: $4,500.00

Next Steps

- We are developing a policy brief related to payment, as the landscape for payment continues to evolve at the state and local levels.

RECOMMENDATION 3:

- **Professionalize the role of foster parents by determining skills required, support provided, and expectations for entering foster care as one's primary area of focus**. Professionalization is not synonymous with employment; rather professionalization should be focused on role definition, skill expectation, training needs, and mentorship. Professionalism should also consider recruitment, capacity-building, and other important issues. We recommend a workgroup to focus on this issue just as we did with payment, as it is also quite complicated.

Phase II Workgroup: Supports, Training, Recruitment and Retention

- The significance of supports cannot be overstated. The discussion about the role that supports play in the lives of the Treatment Resource Families, the lives of the children and youth, and in the lives of their parents are very important and often less adequate than what is really needed and desired.

Supports

- Supports are typically understood as resources or services that are available to foster caregivers to aid them in the day-to-day care of a child. Supports play a crucial role in the retention of foster parents. Supports provided by agency staff are a significant predictor in intent of foster caregivers to refer other families and in their overall satisfaction, and the absence of supports is one of the reasons that families discontinue fostering. Health insurance, involvement in service planning, respite, and social support are recognized as impacting foster caregivers' satisfaction. Supports like involvement in service planning, social support, and stipends impact retention, while wraparound impacts stress.

Training as Treatment Foster Caregivers	• Basic and ongoing training with assessment • Training: We need a skills assessment
Day-to-Day Caregiving	• Day-to-day supports: driver, dinner-cooker, babysitter (separate from respite), tutor/mentor (e.g., Faith Bridge Foster Care). Day-to-day caregiving supports may be paid for via their own stipend or a specific stipend for such services. Other services can occur on a volunteer basis. • Seasoned/retired caregivers as "phone a friend" volunteer circle -- hot line! Peer support. • Formal mentoring with seasoned foster caregivers • Transportation to special appointments or under special circumstances
Moments of Crisis	• Crisis/emergency management that is more than "call police" or "go to hospital" • Connection in moment of crisis in addition to police/hospital (ideally professional but also fellow caregiver support) – at least by phone/Skype but ideally in person
Relationship with birth parent or caregiver	• Agency support for relationship between birth parent and caregiver • Visitation should include opportunities for frequent/daily virtual contact with birth families and parents (including siblings) and intentional weekly/semimonthly contact when the child is in foster care • Virtual contact can focus on regular updates on child's routine.

FOCUS Mentoring Program: Trumbull County

DeeDee Prezioso from Trumbull County Children Services provided an overview of their FOCUS (**F**amilies **O**ffering **C**are **U**nderstanding and **S**upport) Mentoring Program for Caregivers. Mentors have a defined purpose, which includes:

- *Being a source of information and direction*
- *Assistance with navigating the child welfare system*
- *Linkage to community resources*
- *Provide insight, understanding, and shared experience*
- *Encourage problem-solving, and provide open and honest feedback*
- *Being available to serve as a confidant in a time of crisis*

- Every newly licensed foster parent (not only treatment foster families) is matched with a FOCUS mentor, and mentors have contact with their mentee at least once per week for the first three months and then twice per month for the next nine months. Mentors also work with caregivers outside of their first year of licensing in times of need. Mentors receive training and abide by a mentor agreement, which includes confidentiality, social media use, and role definition. Mentors are compensated for their work.

Risk Management: 24/7 Support: Integrated Services for Behavioral Health

Samantha Shafer from Integrated Services for Behavioral Health (ISBH) discussed her organization's role in the Southeast and Central Ohio Systems of Care Collaborative, which is a 12-county ODJFS/CPS collaboration along with partners in healthcare and behavioral health. ISBH serves as a lead facilitator in this collaborative and provides Risk Management, Residential Services, and High-Intensity Home-based Services.

- The Risk Management Program is committed to supporting youth and families being safe and healthy together. Eligible participants include youth and families involved with children services (i.e., foster care) and/or youth and families at risk of involvement due to challenges related to mental health and substance use. Supports are delivered in the home and community setting 365 days a year. Planned and unplanned services are provided during the non-traditional hours of after 5pm, weekends, and holidays. Risk Managers have ongoing communication with all natural and professional supports identified by the family to promote meaningful coordination of care.
  - ***Planned responses*** *are activities that are scheduled ahead of time between the Risk Manager and the youth/family. Activities may include family outings, stabilization work, shared activities with foster care providers and the biological family.*
  - ***Unplanned responses*** *are initiated by the family or through the local children services agency and often warrant a face-to-face visit with the youth and/or family. Support can also be provided over the phone when appropriate.*

Supports for the Biological Family: A Parent Mentor's Perspective

Angela Cochran, Peer Mentor for Trumbull County Children Services provided the group with her perspective as a parent who experienced the child welfare system and successfully reunified with her children. She is also a Certified Peer Recovery Support Specialist.

- **Terminology:** Terminology that the field uses to describe birth parents, foster parents, etc. is a topic of interest, as the intention is to be respectful in the words we use. When asked for her perspective on the following terms: *Bio Parent/Birth Parent*, *Parent of Removal,* and *Natural Parent*, Angela indicated that most birth parents just want to be called **"Parents" or "Mom and Dad"** versus another term. She also said that hearing the children refer to the foster parents as "parents" or "mom and dad" is very painful and creates jealousy. Angela thought the term **"Resource Families"** was much better and that parents would understand what this meant. From the parents' perspective they would translate that as, "the family is a *resource* for me and my children."

Biological Parent Perspective, cont.

- **Supports:** Peer Support, Recovery Coaches, Systems Navigators are all very important roles for parents from Angela's perspective; also, these types of supports are supported in the literature.
  - *Having someone who has successfully navigated the child welfare system to support the parent is very helpful, along with a peer supporter or coach who can support them in addressing other challenges like entering treatment, entering recovery, accessing mental health services, etc.*
  - *The regular contact from persons in this role is VITAL. Peer supporters, coaches, etc. tend to see people weekly or bi-weekly, versus a caseworker who sees the parent monthly.*
  - ***Intensive Case Management** is a valued support because of the regular contact and assistance. Angela also said that there is a lack of support for fathers; they can sometimes seem to be left out of the discussions on supports and services.*

Biological Parent Perspective, cont.

Visitation: Angela said there is a lack of visitation when it comes to parents who might be in treatment. In her experience, she saw her kids less than five times in 18 months. **The lack of visits is traumatizing for the parent and the child.** She encouraged being more creative about visits: using Zoom and other platforms to engage with parents during dinner, during homework time, etc. and elevating visitation from one hour to a regular occurrence around natural/normal life events.

Keeping the parent informed of what has been going on with their child is a big issue. The children who do reunify come back as strangers to some extent. Mom/Dad need to be updated on school, medical issues, dental issues, routines, etc. They want to see report cards, go to IEP meetings, be included in doctor visits, etc. . **Plus, these experiences are learning opportunities for the parent.**

Biological Parent Perspective, cont.

- Support after reunification is essential. The transition back is hard -- and the parent is nervous about the return of their children. We discussed that for parents who have gotten sober, "sober mom" is terrifying because if you've never parented sober, you almost don't know what to do. Also, the children have changed. Before removal they may have been in a more parentified role due to a parent's active addiction or active mental illness; now that the parent is sober and doing better, those roles should change.
  - *There is a natural "rough patch" right after reunification, so the support to that parent is very helpful in preventing any further disruption or reentry into the system. Angela said if support can be provided by the foster parents after reunification, that would be great, but she also said this is where peer mentors, navigators, etc. can come into play.*
  - *The Birth and Foster Parent Partnership identifies five protective factors of relationship-building between the parents and the resource family as: parental resilience, social connections, knowledge of parenting and child development, concrete support in times of need, and social and emotional competence of children.*

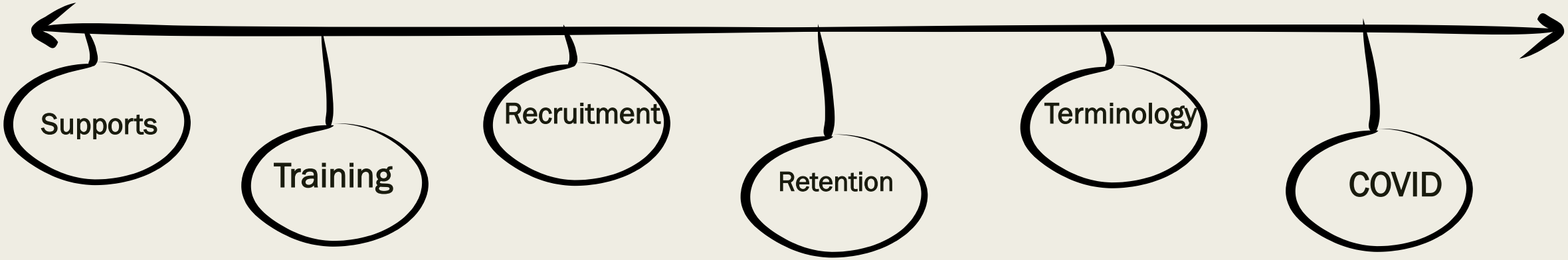
Guidance from the Supports Workgroup: How Resource Families are Treated by the System

- Resource families should feel like a respected member of the treatment team (where their voice and opinion are heard and respected) and invited to the table.
- Resource families should have clear rights and responsibilities and not experience role confusion.
- Resource families should have access to supports while a child is placed and after a child is reunified with their birth family (such as grief counseling) so that the transition after a child exits is less difficult.
- Resource families should have time to process the conclusion of a placement and be given some time in between placements to “rest and recharge” between placements while not necessarily losing the income of caregiving (e.g., family may opt to serve as a respite family for a short period of time).
- Resource families should not lose income when a child’s level of care has been reduced. Reduction of pay may be seen as a “punishment” when in reality, the decrease in level of care is often due to the hard work of the foster caregiver/family, and they should be rewarded and acknowledged for such.

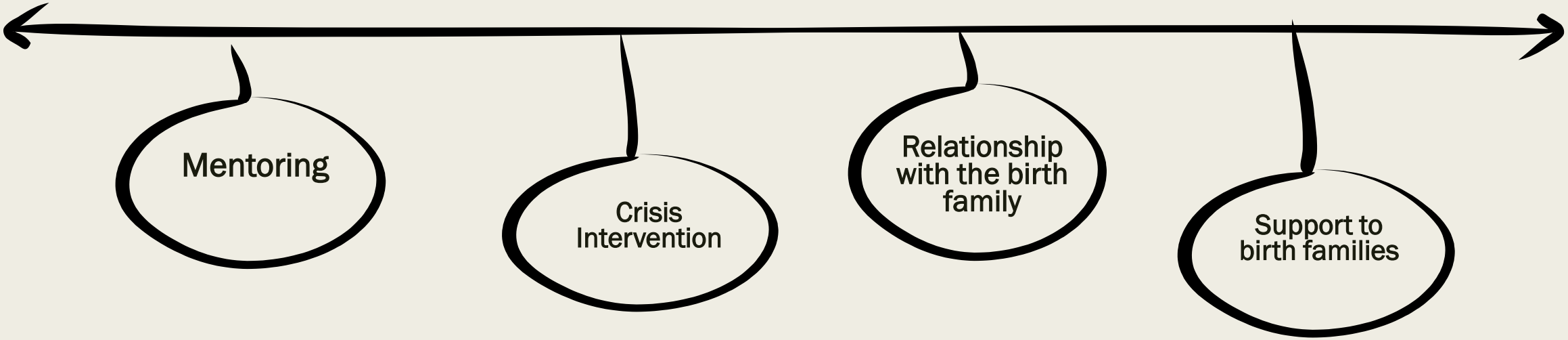
Poll Question #3

- How often are you seeing Parent Mentors being utilized in your county?
  a) *None of the time*
  b) *Some of the time*
  c) *Most of the time*

Recommendations



Supports


Mentoring
Crisis Intervention
Relationship with the birth family
Support to birth families

Workgroup on Professionalization

- Representation from county agencies, private agencies, and treatment foster parents
- Reviewed the benefits and challenges to professionalization, reviewed evidence-based pre-service training, and reviewed challenges related to liability insurance.

RECOMMENDATION 1: PROFESSIONALIZATION

Define Professionalization so that Treatment Resource Families understand what is expected of them and so that other systems recognize their important role in the safety, permanency and well-being of the child and youth they serve.

- *Understanding what it means to be a professional*
- *Expectations of the role should be clear and include both the daily expectations and the overall expectations*
- *Helping the system see resource families as professionals*
- *Ensuring ongoing support and mentoring as part of skill development and retention*
- *Considerations for recruitment of treatment resource families*

Professionalization, Defined

Treatment Resource Families represent a pool of people who have specified skill sets and experiences that reflect the levels of need for children in tiered treatment foster care. They have a desire to be engaged in caring for higher need children for multiple years.

Definition, Continued

They fulfill a dual role as families and as treatment team members. First, as caregivers they provide daily parenting and support to the child/youth, and build connections with the child's parents, siblings and other kin for purposes of permanency and overall well-being. Second, they are part of a treatment intervention which begins in their home environment and as a member of a treatment team which may include being part of a therapeutic interventions.

Definition, continued

As such, they are regarded as professionals due to these expectations and required skills. They should receive mentorship and ongoing supports to encourage their development, resilience, and retention.

RECOMMENDATION 2: PROFESSIONALIZATION

Provide enhanced training that leads to a certification process that improves the competencies and skills of Treatment Resource Parents. This training should be evidenced-informed. The certification process would ensure that Treatment Resource families build the competencies needed to care for children with complex needs.

Certification Process

Step 1: Application and pre-service training
Step 2: Providing respite care and a tier 2 placement
Step 3: Specialized training
Step 4: Pre-service mentorship and Certification
Step 5: Maintenance of Certification

RECOMMENDATION 3: PROFESSIONALIZATION

While professionalization may not mean employment in Ohio, it should include access to liability insurance that provides adequate coverage for damages related to the risks involved in treatment foster care. Treatment Resource families should be adequately compensated for their role, especially with the expectation that they not be employed outside the home.

RECOMMENDATION 4: PROFESSIONALIZATION

Provide adequate education to Treatment Foster Parents about how allegations against them may be handled. Educate them on their rights, their responsibilities, and what to expect in terms of support, guidance, and the overall process.

NEXT STEPS


Thank you!