



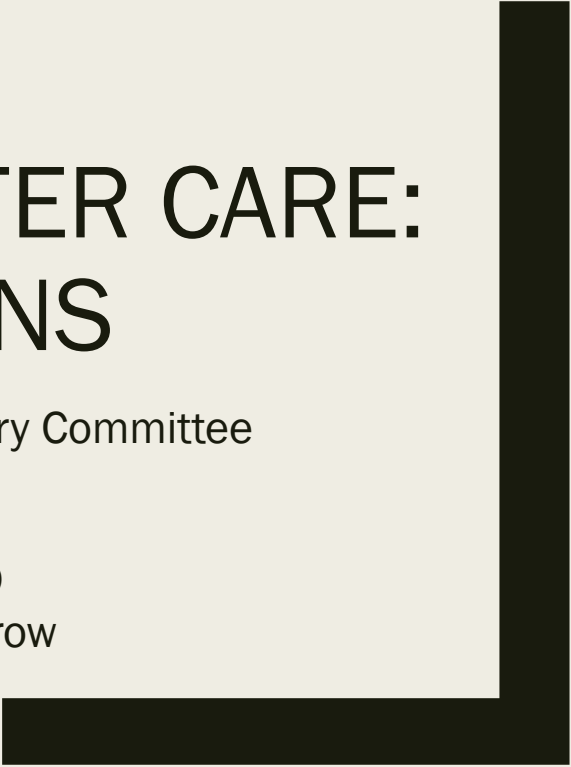
TIERED TREATMENT FOSTER CARE: RECOMMENDATIONS

Presented to The Family First Act Leadership Advisory Committee
Meeting

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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.



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.

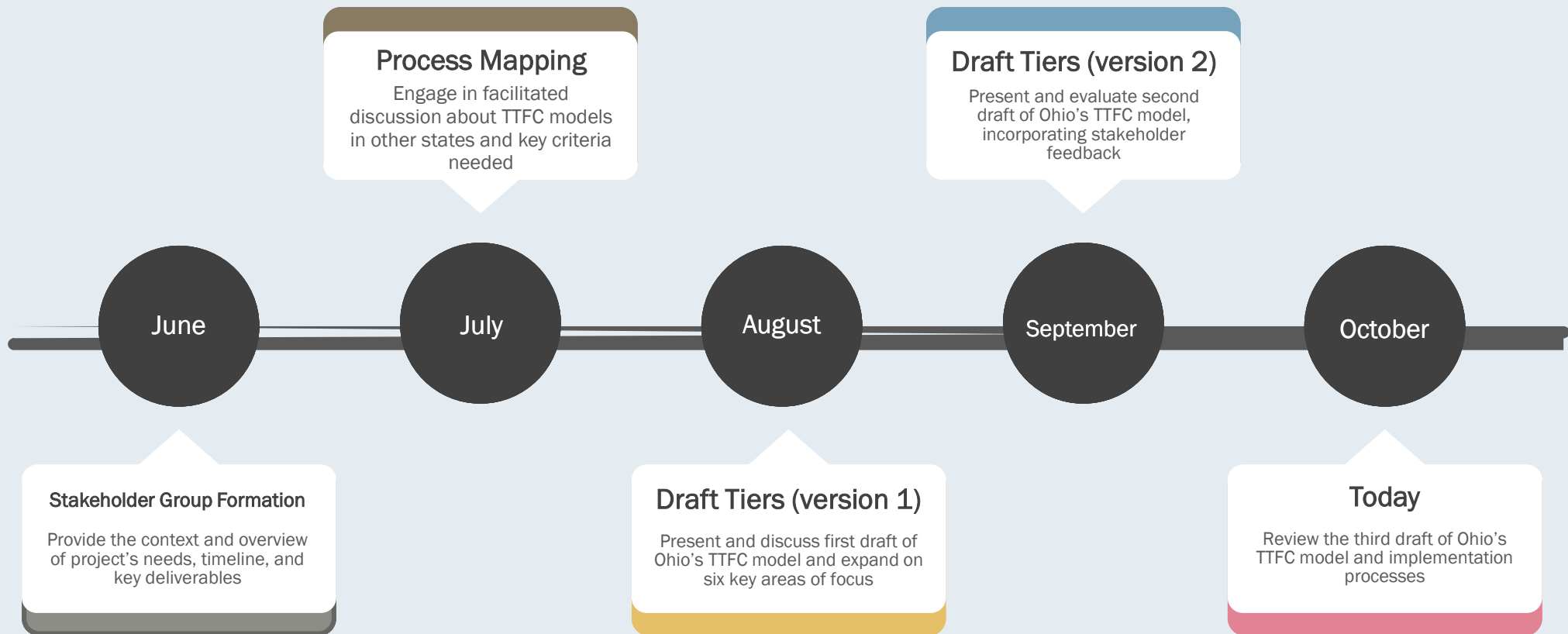
Although no single definition of TFC exists, key elements have been identified:

- *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

TTFC Stakeholder Group Timeline



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

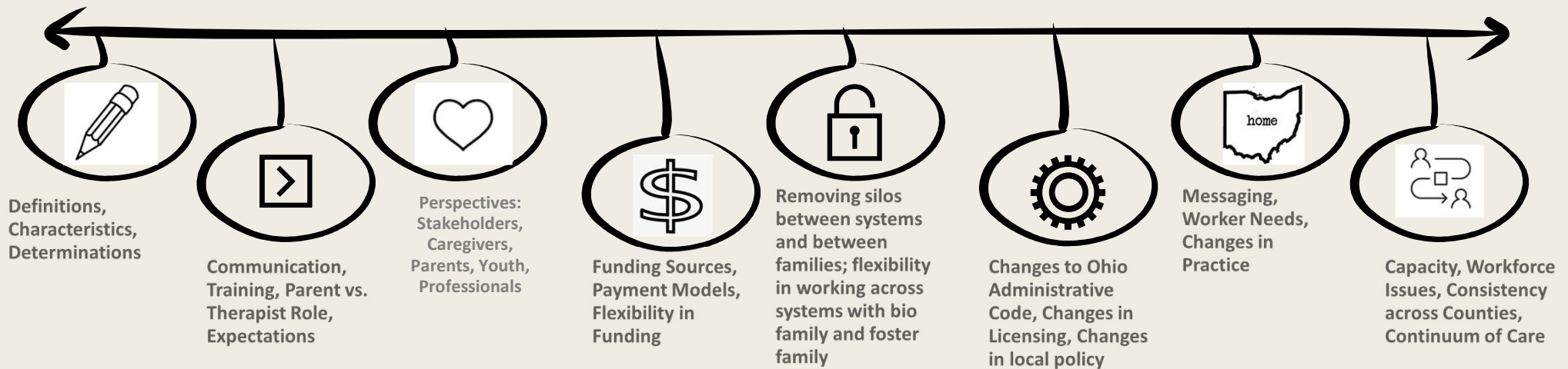
Local Impact

- Worker Needs
- Contract Changes
- Information Tech Needs

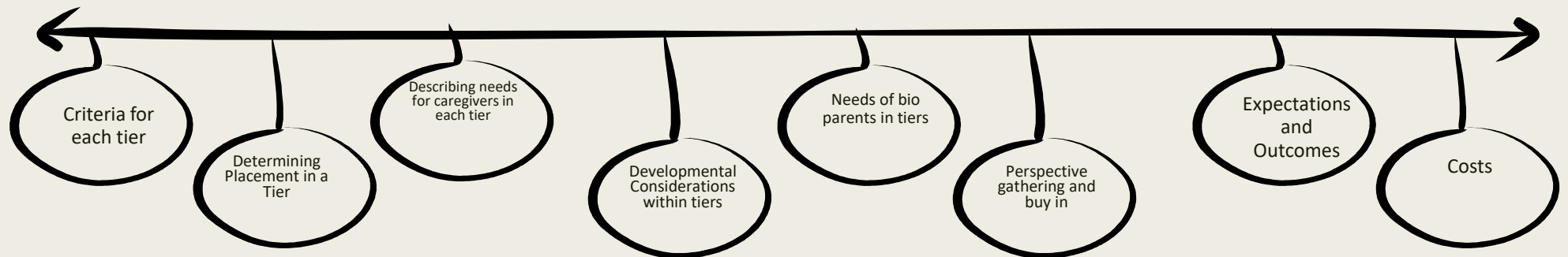
FC and BH Organizations

Caregiver Network

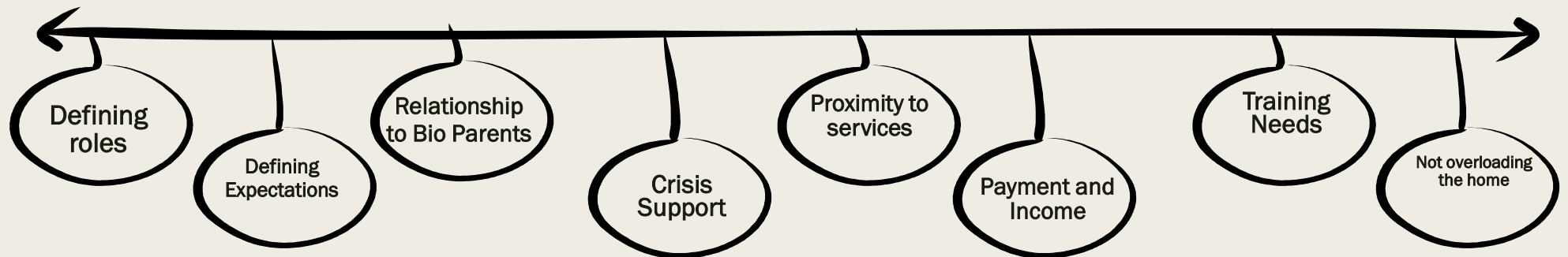
- Recruitment and Retention
- Training/Support
- Crisis and other Services



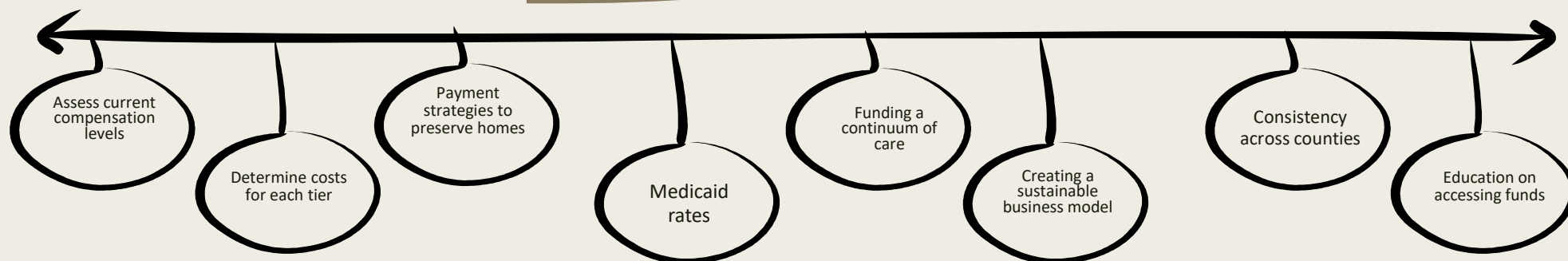
Defining Tiers



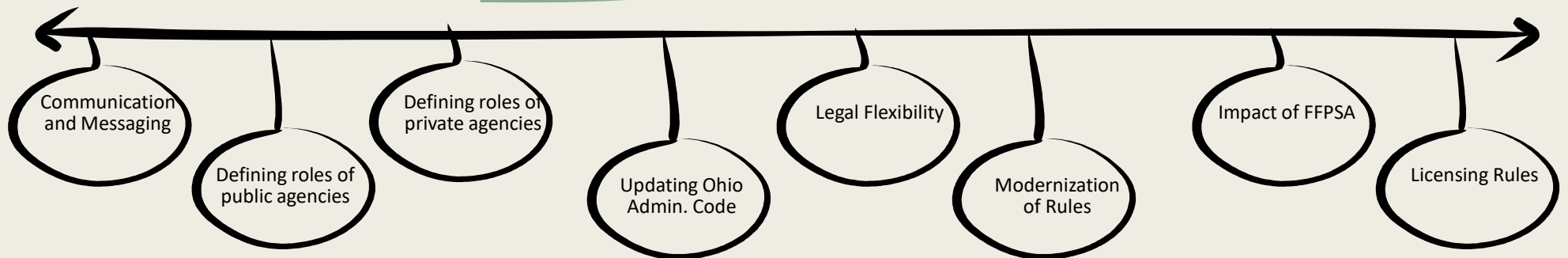
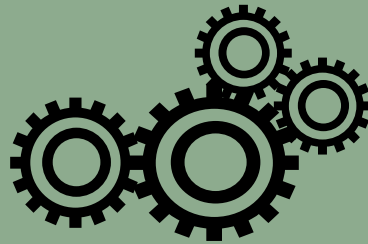
Level of Need: Caregivers



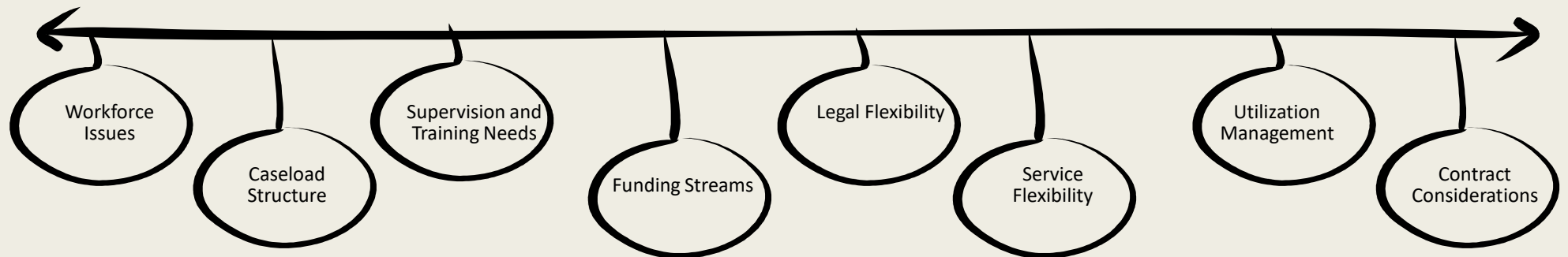
Payment Structure



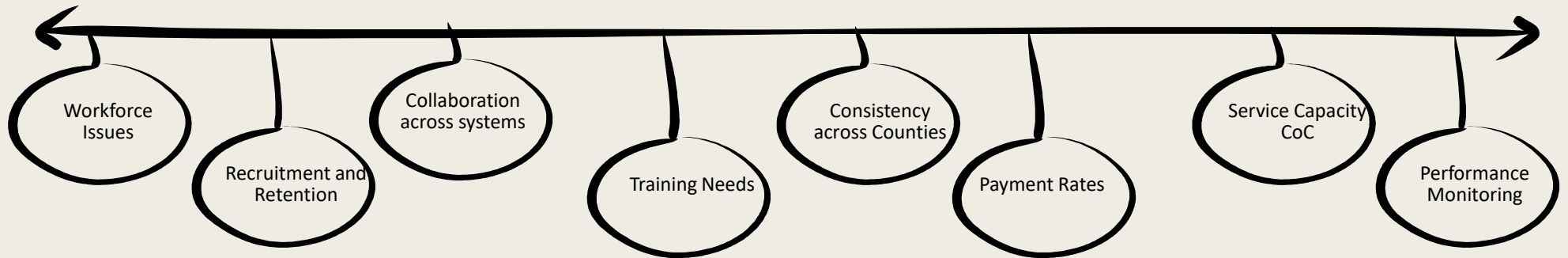
Policy Considerations



County Considerations



FC and BH Organizations



We worked closely with the Institute for Human Services and ODJFS to research other states who have implemented tiers and shared this information with the stakeholder group to use as comparison.

We also gathered available data on Ohio to try and determine which counties may have tiered treatment foster care in place, what rates were currently being paid, etc.

We examined issues related to the professionalization of foster parents, including training needs, support needs, role clarification, and the pros and cons of professionalization.

Stakeholders were provided with copies of presentations, handouts, and issue briefs.

RESEARCH

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

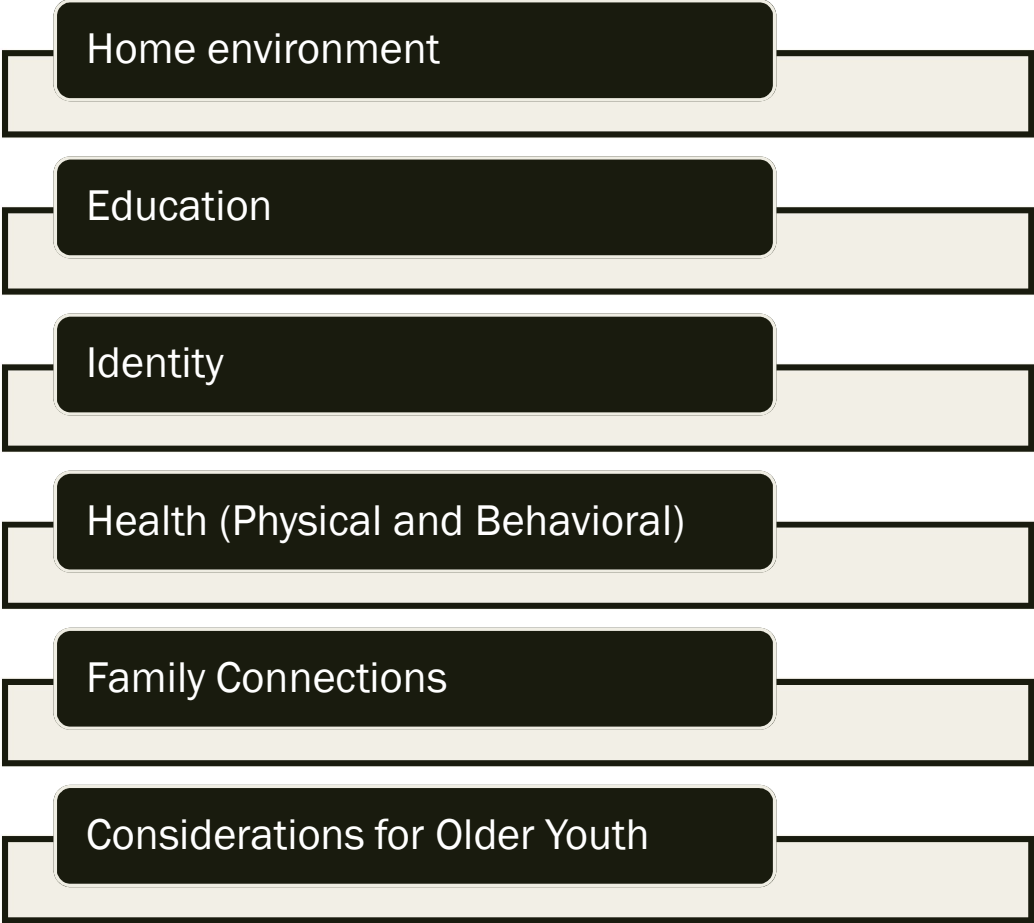
Physical Health

Substance Use

Delinquency

Guidance and Structure

Respite



Home environment

Education

Identity

Health (Physical and Behavioral)

Family Connections

Considerations for Older Youth

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	<ul style="list-style-type: none">• Inability to control physical responses to stress• Chronic illness, even into adulthood (heart disease, obesity)
Brains (thinking)	<ul style="list-style-type: none">• Difficulty thinking, learning, and concentrating• Impaired memory• Difficulty switching from one thought or activity to another
Emotions (feeling)	<ul style="list-style-type: none">• Low self-esteem• Feeling unsafe• Inability to regulate emotions• Difficulty forming attachments to caregivers• Trouble with friendships• Trust issues• Depression, anxiety
Behavior	<ul style="list-style-type: none">• 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

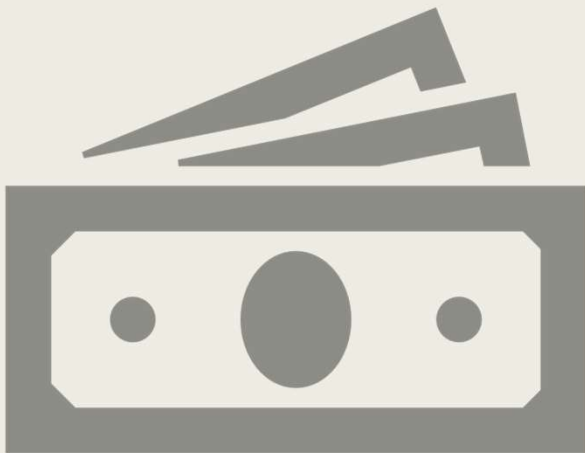
Appendix 1: ACYF Well-Being Framework

	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						

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.

Payment Ranges



- Ohio
- State-by-State Comparisons

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,

<u>Category 3: Special Needs</u>	<u>Category 4: Exceptional Needs</u>	<u>Category 5: Intensive Needs</u>
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

Professionalization Considerations

What do we mean by professional foster parenting?

In 2003, New York conducted a survey regarding [professional foster parenting](#). The authors of the survey defined professionalism and identified the core characteristics. “What professionalism means in the context of foster parenting has received scant attention in the foster care literature. ...There is a cross-discipline consensus that professionalism is not simply a matter of knowledge, or mastery of a body of knowledge; or a matter of skill or proficiency in skill sets. It is a matter of values, attitudes and behaviors.”

Core characteristics of a professional:

- Qualification requirements, admission standards, licensure
- Access to, membership in, an association
- Altruistic actions
- Caring, committed to the people they serve
- Ethical practice
- Work autonomously but also in partnership
- Responsible, committed, and accountable
- Strive to improve themselves by taking advantage of opportunities for development and betterment

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.

TRAINING

CURRENT TRAINING REQUIREMENTS PER ORC: In terms of current training requirements all the draft tiers for treatment foster care would fall into **SPECIALIZED** and would need to complete the following hour requirements:

Pre-adoptive infant foster home:

- 12 hours of pre-service training
- 24 hours of ongoing training per certification period

Family foster home:

- 36 hours of pre-service training
- 40 hours of ongoing training per certification period

Specialized foster home:

- 36 hours of pre-service training (plus additional topics on behavioral intervention, education, advocacy and CPR/First Aid certification)
- 60 hours of ongoing training per certification period

There is current legislation pending to change the training requirements in the revised code. Changes under HB 8: <https://legiscan.com/OH/bill/HB8/2019>,

The Anne E Casey Foundation (AECF), in [A Movement to Transform Foster Parenting](#), defined the professional foster parent as someone paid for skilled labor and time, plus the cost of room and board to quantify respect for their efforts and help with recruiting and retaining a reliable pool of qualified caregivers.

The AECF report notes in most instances, professional foster parent programs recruit adults that:

- Have one or both parents who stay at home full time
- Do not have other children living in the home
- Are willing to participate in 30+ hours of preservice and 15+ hours of annual in-service training
- Can effectively support youth with serious mental health diagnoses who would otherwise be in higher end residential settings
- Provide treatment plan development and implementation of interventions within the foster home
- Attend all care management, psychiatric, educational, court and other meetings as a member of the youth's treatment team
- Care for one youth in foster care at a time (typically 12-18 yr., although some programs serve children 6-18 yr.)
- Support connections between youth and their family
- Offer treatment intervention on a time-limited basis, approximately 6-18 months
- Are not permanency resources for the youth placed in their homes
- Can pass criminal background checks, child welfare checks, and extensive home studies
- Will make a multi-year commitment to be professional foster parents

Are there alternatives to paying a salary?

Alternatives include:

- [Difficulty of care supplement](#) - paying additional stipend to caregivers who have children with high needs.
- Access to liability insurance - The reasonable and prudent parenting standard has raised questions about the need to provide foster parents with liability insurance to mitigate the risks they assume when they care for children. Liability insurance that is purchased by the agency can also cover damage to a foster parents' home or property that is not otherwise covered by their homeowners' insurance.
- FMLA for foster care placement - The first few weeks of a child's transition into a foster parents' home are consumed by doctor's appointments, school visits and meetings with birth parents and caseworkers. States should incorporate provisions in their family medical leave policies to allow foster parents to take time from their jobs to help children transition into their new homes. One foster parent blog spoke to this need as well.
- [Urban Foster Care in Chicago](#) gives tax free housing subsidies and a security deposit as well as an average monthly board payment of \$350.

Professionalizing TFC Caregivers

Developed by IHS for the TTFC Stakeholders

Recruitment of Foster Parents

- Recruitment challenges were a recurrent topic for the group, especially as it related to professionalization and training.
- PCSAO has suggestions for recruitment in the CCCR and we know this issue is one that other stakeholder groups are discussing.

Summary

- Recommendations:

- *Expanding tiers*
- *Discussing payment ranges that are consistent across counties.*
- *Discussing professionalization of foster care parents, including training and support needs.*



Thank you!