Trauma-Informed Treatment Foster Care: A Promising Alternative to Congregate Care

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Objectives

1. Review trauma and youth in foster care literature
2. Summarize call to reduce congregate
3. Define Treatment Foster Care (TFC)
4. Introduce PATH Trauma-Informed Care TFC model
5. Share PATH TFC data and outcomes
6. Statewide cross-system collaboration

Disclosure Information

31st Annual San Diego International Conference on Child & Family Maltreatment

"Trauma-informed Treatment Foster Care: A Promising Alternative to Congregate Care"

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- **We have no financial relationships to disclose**

Foster Care and Childhood Trauma

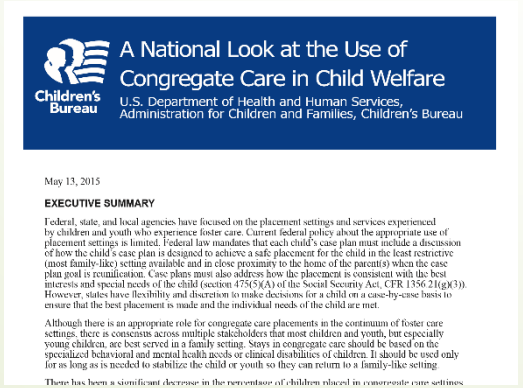
- Approximately one-half to two-thirds of all youth in the general population have experienced at least one traumatic event in their lifetime (Copeland et al., 2007; Finkelhor et al., 2009)
- Trauma exposure for youth in foster care is nearly 90% with nearly half reporting exposure to four or more (Stein et al, 2001)
- Youth in foster care are particularly likely (approx. 70%) to experience *complex trauma* or multiple interpersonal traumas such neglect, physical abuse, sexual abuse, emotional abuse, and/or domestic violence. This type of trauma is experienced early in life and perpetrated by caregivers (Oswald et al., 2010)

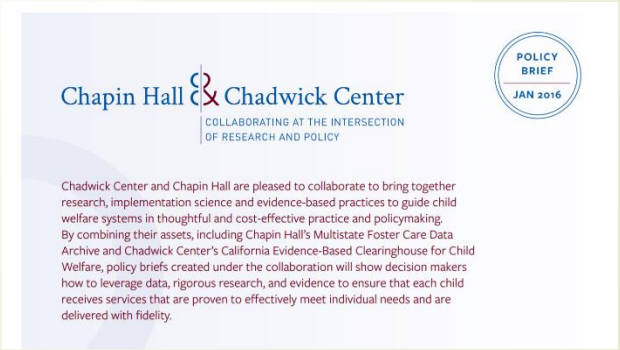
Foster Care and Childhood Trauma (Cont.)

- Research studies repeatedly demonstrate negative physical and mental health outcomes (Felitti et al., 1998; D'Andrea et al., 2012)
- Few child welfare systems routinely screen for trauma exposure or trauma-related symptoms beyond initial assessment of precipitating event (Greeson et al., 2012)
- Strong need to utilize trauma-informed child welfare practices in foster care delivery systems and several recent studies and/or reports offer key recommendations (Berliner et al., 2015; Greeson et al., 2012; Conradi et al., 2011)

The Reduction of Congregate Care

- A continued federal call for a close examination of congregate care for youth in the child welfare system
  ("A National Look at the Use of Congregate Care in Child Welfare" U.S. Dept. of Health and Human Services, Administration for Children and Families, Children's Bureau, 2015)
  - Research findings indicate congregate care is not only less effective at achieving safety, permanency, and well-being outcomes than other, less-restirictive settings but also more costly (Fisher & Chamberlain, 2000; Dozier et al., 2014; Ryan et al., 2008).





A Call for the Reduction of Congregate Care

- Report Recommendations:
  1. Identify children who may be diverted from congregate care with minimal effort
  2. ***Develop more flexible, trauma-informed treatment programs. Specifically, increase recruitment and retention efforts for and training of therapeutic foster homes***
  3. All states should evaluate congregate care programs and implement evidence-informed programming whenever possible
- Report Conclusion: Children heal best in the least restrictive, most family-like setting possible. Congregate care should be used judiciously, efficiently, and effectively.

Policy:
Families First Prevention Services Act

- Historic first steps to promote families for children and help improve child outcomes
- The act included:
  - Long overdue federal investments in prevention
  - Federal funding only for children in foster family care or in a qualified residential treatment program
  - A three year delay before the new prevention dollars and new restrictions on federal funding for group care take effect so states can make necessary accommodations
  - Also included additional provisions to promote quality care for children (e.g., extends John H. Chafee Foster Care Independence Program's independent living services)

PATH & Treatment Foster Care (TFC)

- PATH began in MN in 1972
- Moved to ND at request of state in 1994
- FFTA (Foster Family-based Treatment Association until 2016; currently Family Focused Treatment Association)
  - Founded in 1988 to develop, promote and support TFC
  - Only National, nonprofit association representing TFC programs across North America
  - 450 Member Agencies (US and Canada)
- FFTA standards
  - Initially written in 1991 – 4th Edition in 2013

Defining Treatment Foster Care (TFC)

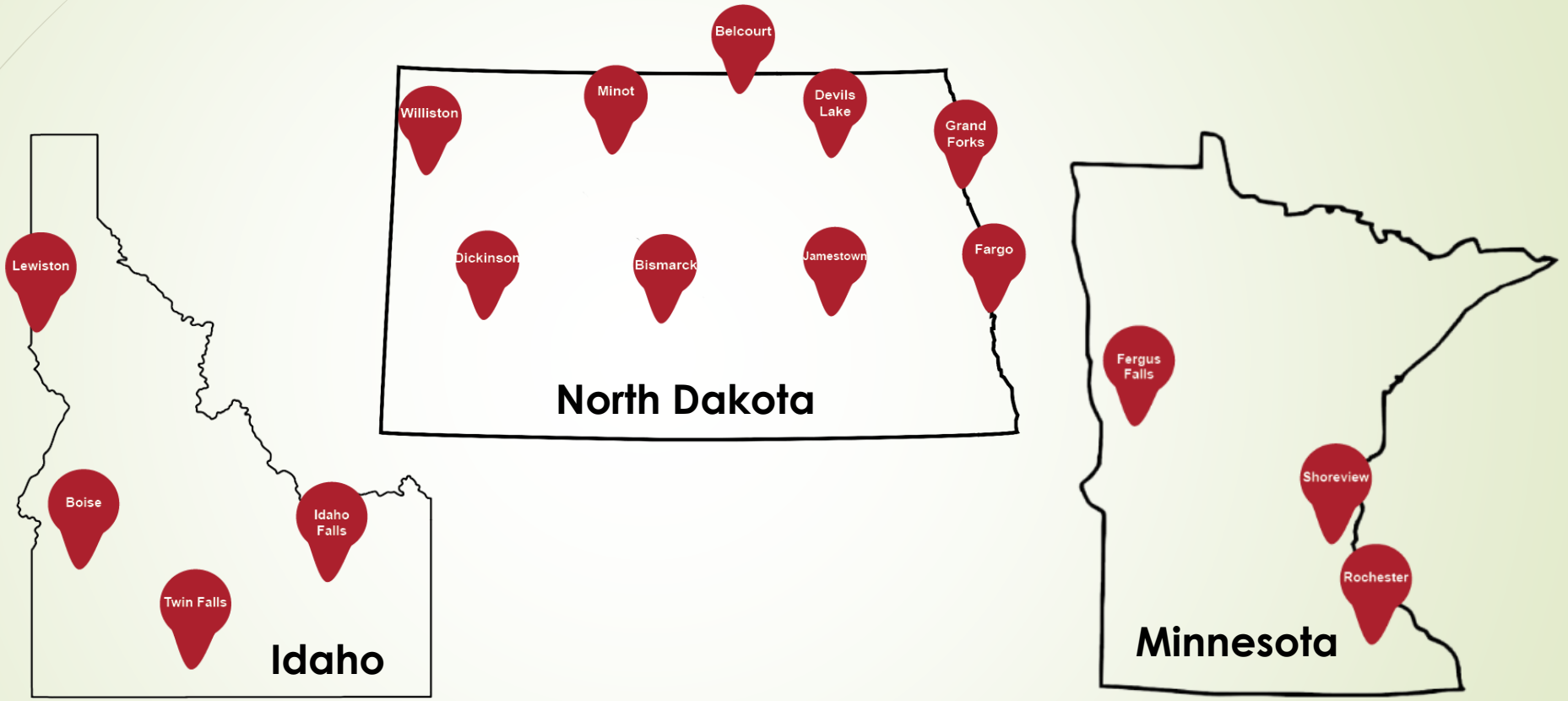
Treatment Foster Care is a distinct, powerful, and unique model of care that provides children with a combination of the best elements of traditional foster care and residential treatment centers. In Treatment Foster Care, the positive aspects of the nurturing and therapeutic family environment are combined with active and structured treatment. Treatment Foster Programs provide, in a clinically effective and cost-effective way, individualized and intensive treatment for children and adolescents who would otherwise be placed in institutional settings.

Definition approved by the Family Focused Treatment Association's Board of Directors, March 13, 2001. Definition is derived from the work of Gerald Bereika, Ph.D.

PATH Values

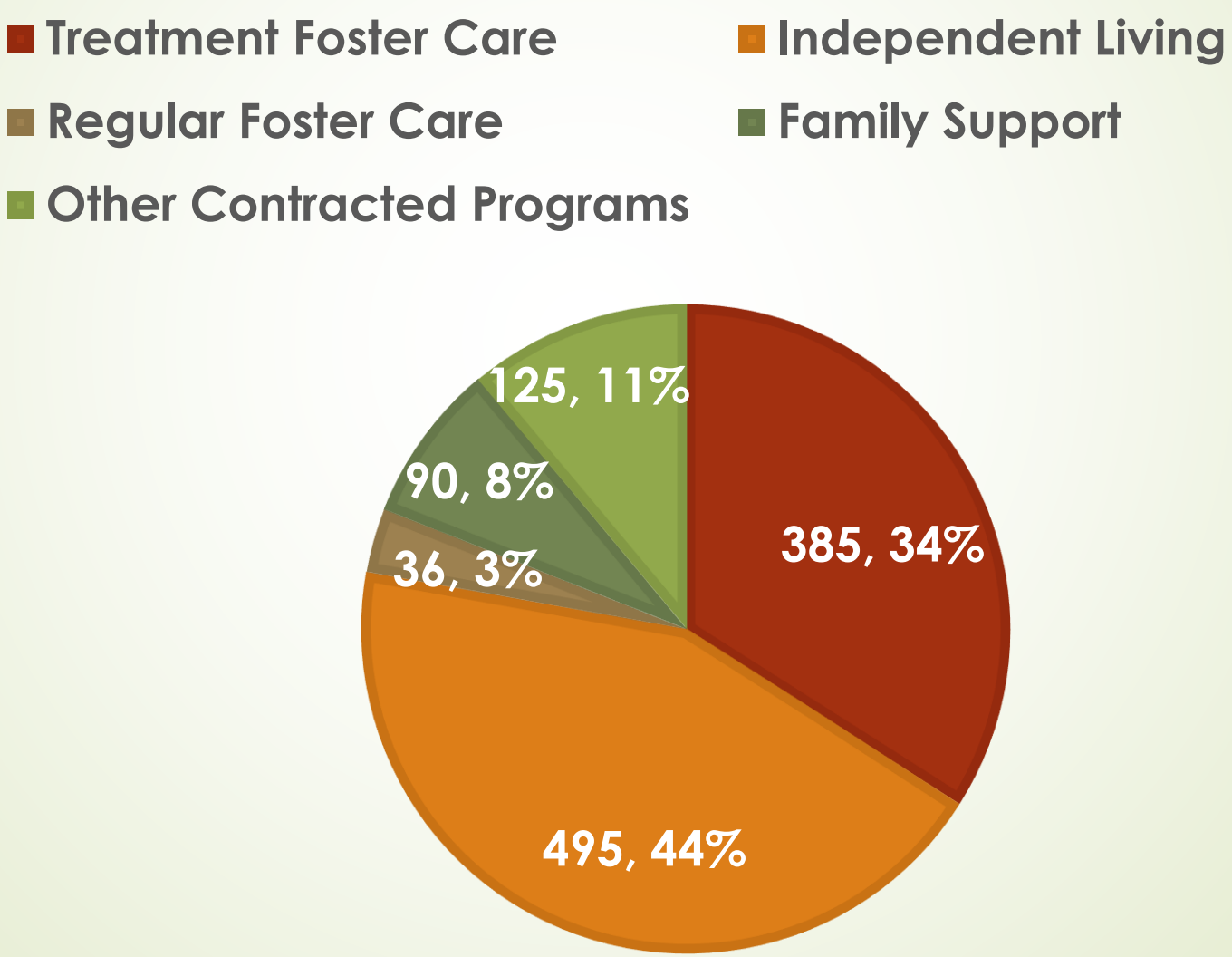
- Safety
- Family Inclusive
- Systemic
- Trauma-Informed
- Collaborative
- Culturally Sensitive
- Mission driven: We believe children are most resilient when given the opportunity to live in a family-setting in their community.

PATH Office Locations



- 129 total employees
- 400+ licensed families/755 individual foster parents

ND PATH Programs



Eligibility for TFC in North Dakota

- Must be the least restrictive, most appropriate level of care for the child
- DSM 5 mental health diagnosis and formal recommendation by licensed mental health provider
- Approval from ND Dept. of Human Services Regional Supervisor
- Age 0-21
- ND Health Tracks referral
- Prior out-of-home placement(s) or risk of out-of-home care in a higher level of care than family foster care

PATH Practice Model: Case Management

- Licensed Social Worker
- Assigned to families (8-12 families per worker)
- Caseload size = 8
- Training in trauma, mental health, family dynamics and system
- ND Child Welfare Certification Training (Wrap Around)
- Supervised by master's level social worker (1:5)
- Bill Medicaid Targeted Case Management

PATH Practice Model: PATH Families

- 1-2 TFC Youth per foster home
- Intensive licensure process and assessment (e.g., 16-PF; Quality of Life; Behavioral Tolerance Checklist; Ecomap and Genogram)
- Additional training hours
  - NCTSN's "Caring for Children Who have Experienced Trauma: A Workshop for Resource Parents"
- Unit Share and Support Meetings (face-to-face and online)
- Respite home support (14 paid days/year)
- 24 hours/7 days a week access to licensed social worker
- Annual statewide conference for networking and additional training

PATH Practice Model: PATH Familes-SFC

- Unique collaboration with the ND Division of Juvenile Services
- Weekly foster parent meetings with PATH case manager
- Biweekly foster parent training from DJS or Youth Correctional Center (YCC) staff member
- Additional youth supports from YCC as needed
  - Therapy
  - Substance abuse treatment
  - School
  - Time out
- Unique matching process

PATH Practice Model: TFC Youth

- Matching youth with a PATH family
- Comprehensive Screening and Assessment
  - Adverse Childhood Experiences Survey
  - Trauma Symptom Checklist for Children (TSCC)/Trauma Symptom Checklist for Young Children (TSCYC)
  - Child and Adolescent Service Intensity Instrument (CASII)/Early Childhood Services Intensity Instrument (ECSII)
  - Referral for specialized assessment as needed
- Comprehensive Care Planning
- Family Inclusive
- Provide or seek out EBT's for mental health concerns (e.g., Trauma-Focused Cognitive Behavioral Therapy)

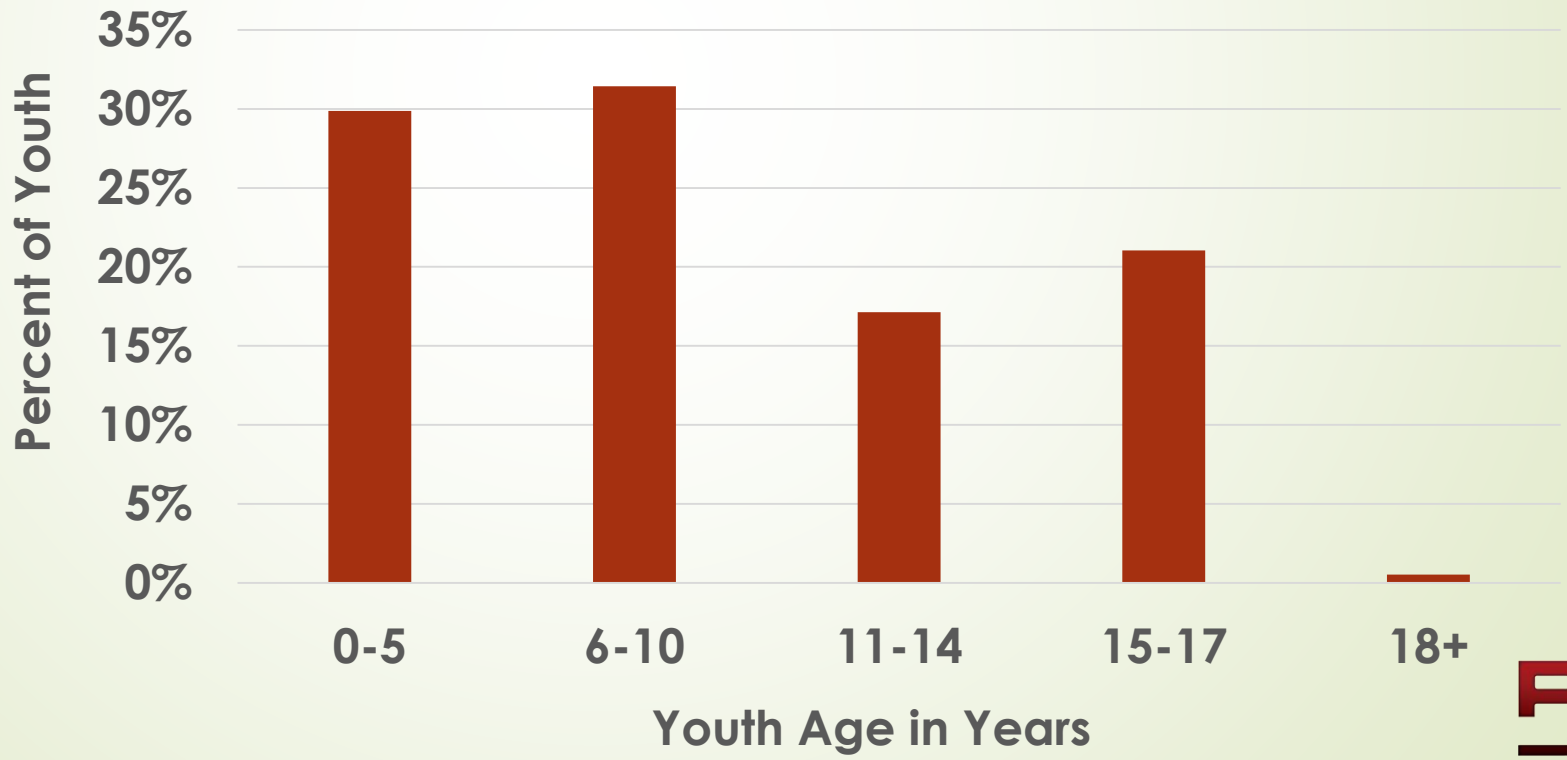
PATH Practice Model: Organizational Policy and Culture

- Trauma-Informed Key Result Area (KRA) included in PATH job descriptions and performance evaluations
- Board of Directors Trauma Training
- Emphasis on Self-Care
- Flexible Schedule
- Collaborative
- Relationship-based
- Employee Advanced Education Program
- Mission-driven

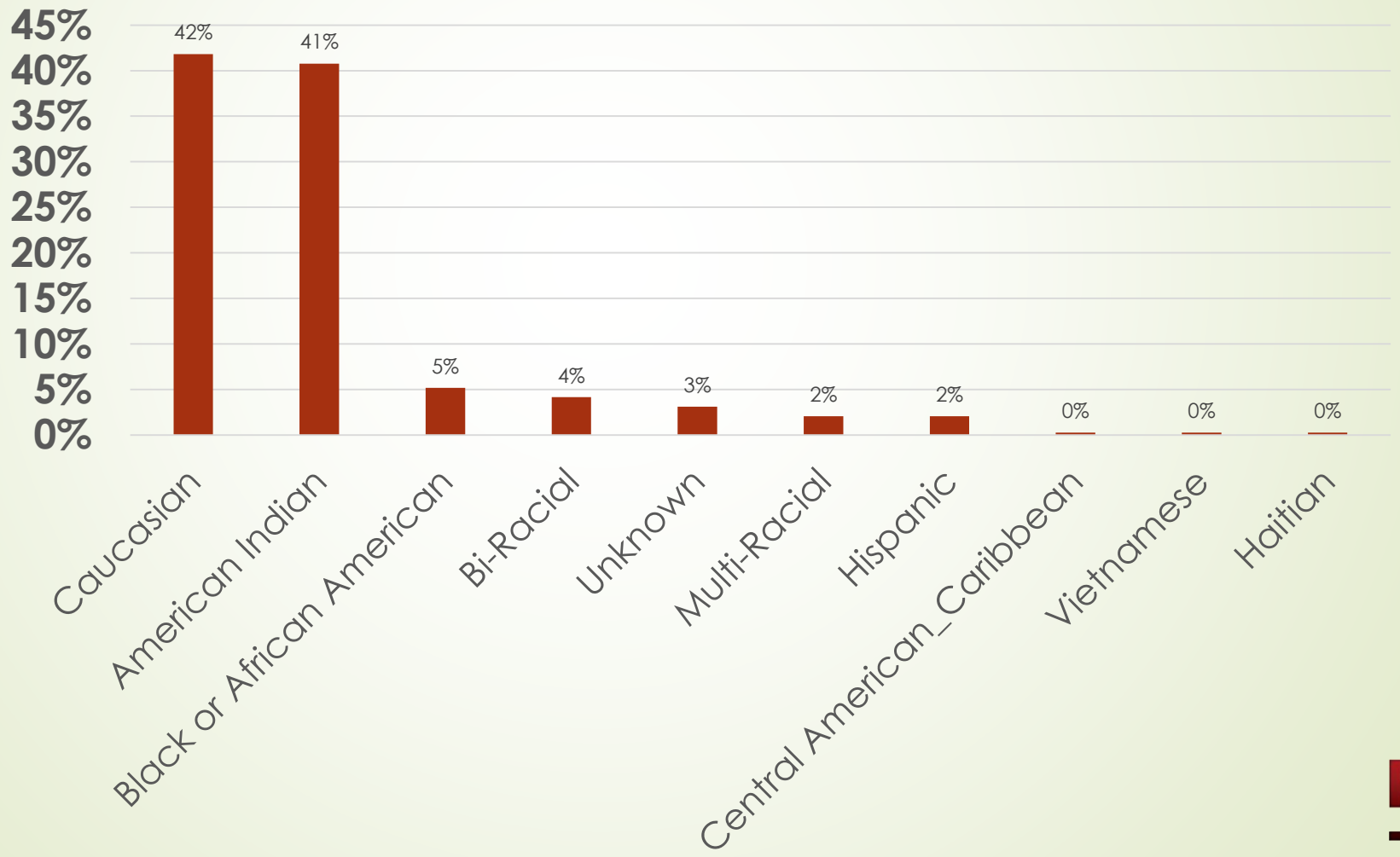
Demographic Information

TFC Youth 12/15/15 – 12/15/16

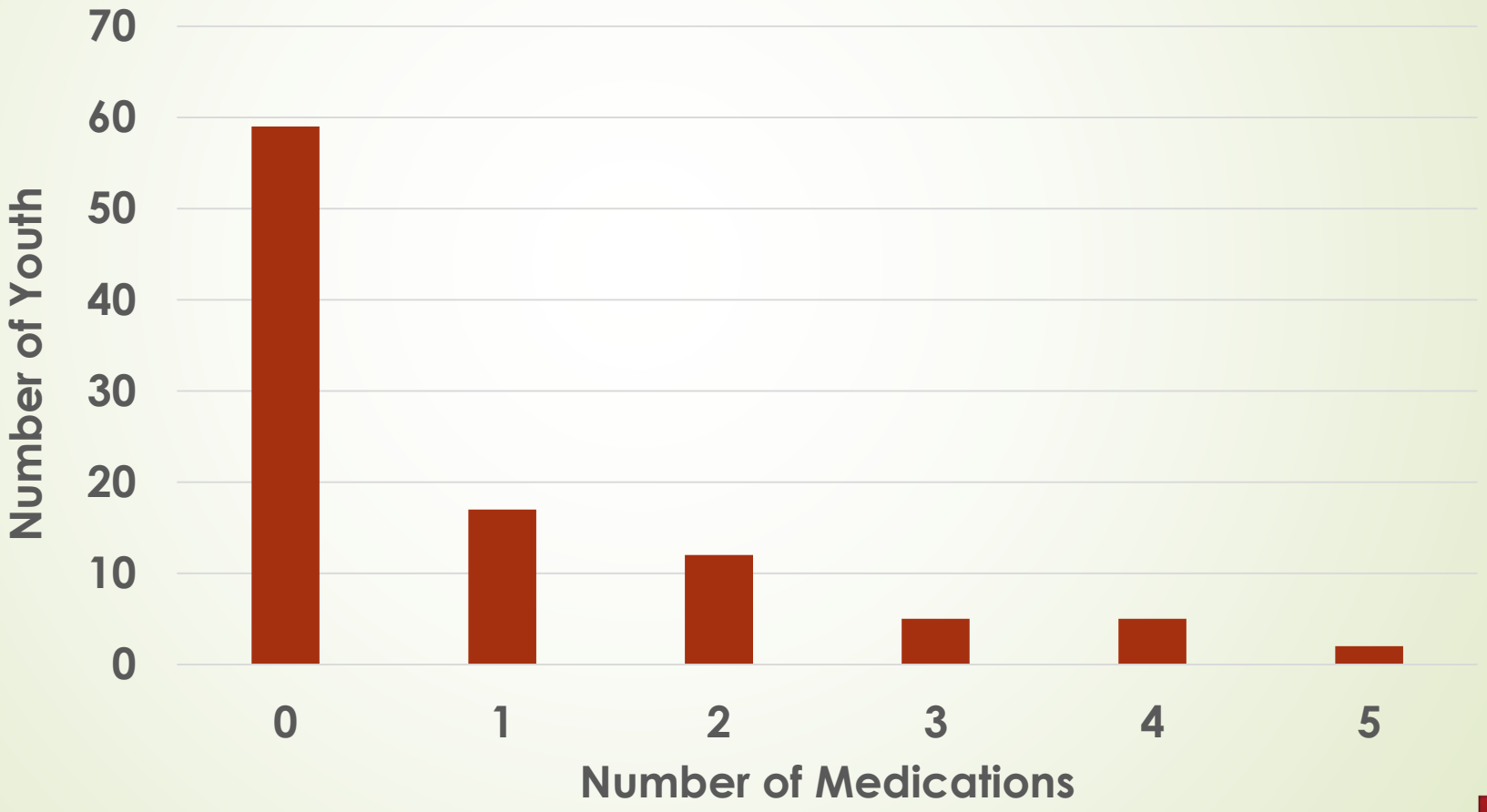
- Gender: 202 Females; 183 Males (385 total)
- AGE:



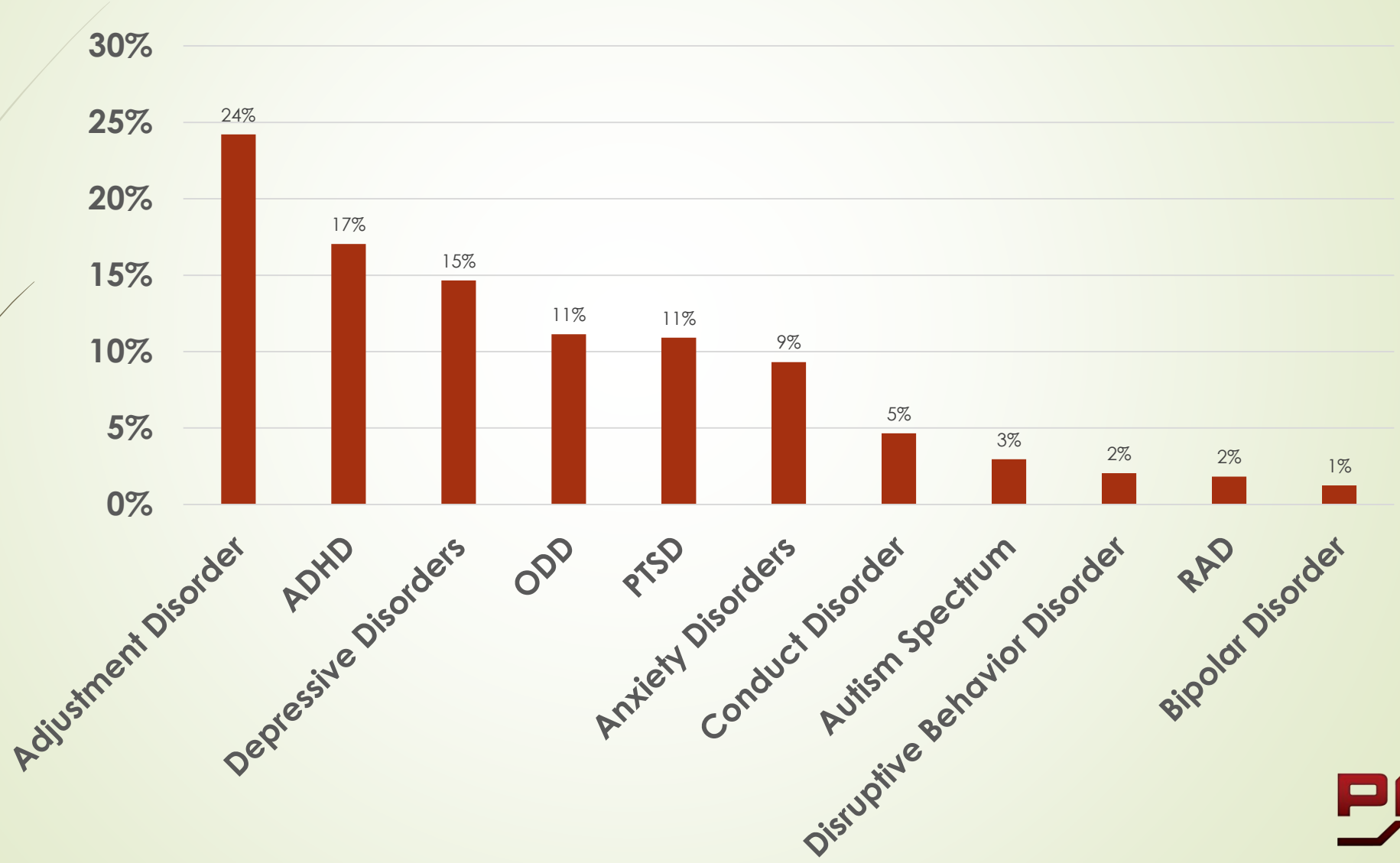
Demographic Information: Race



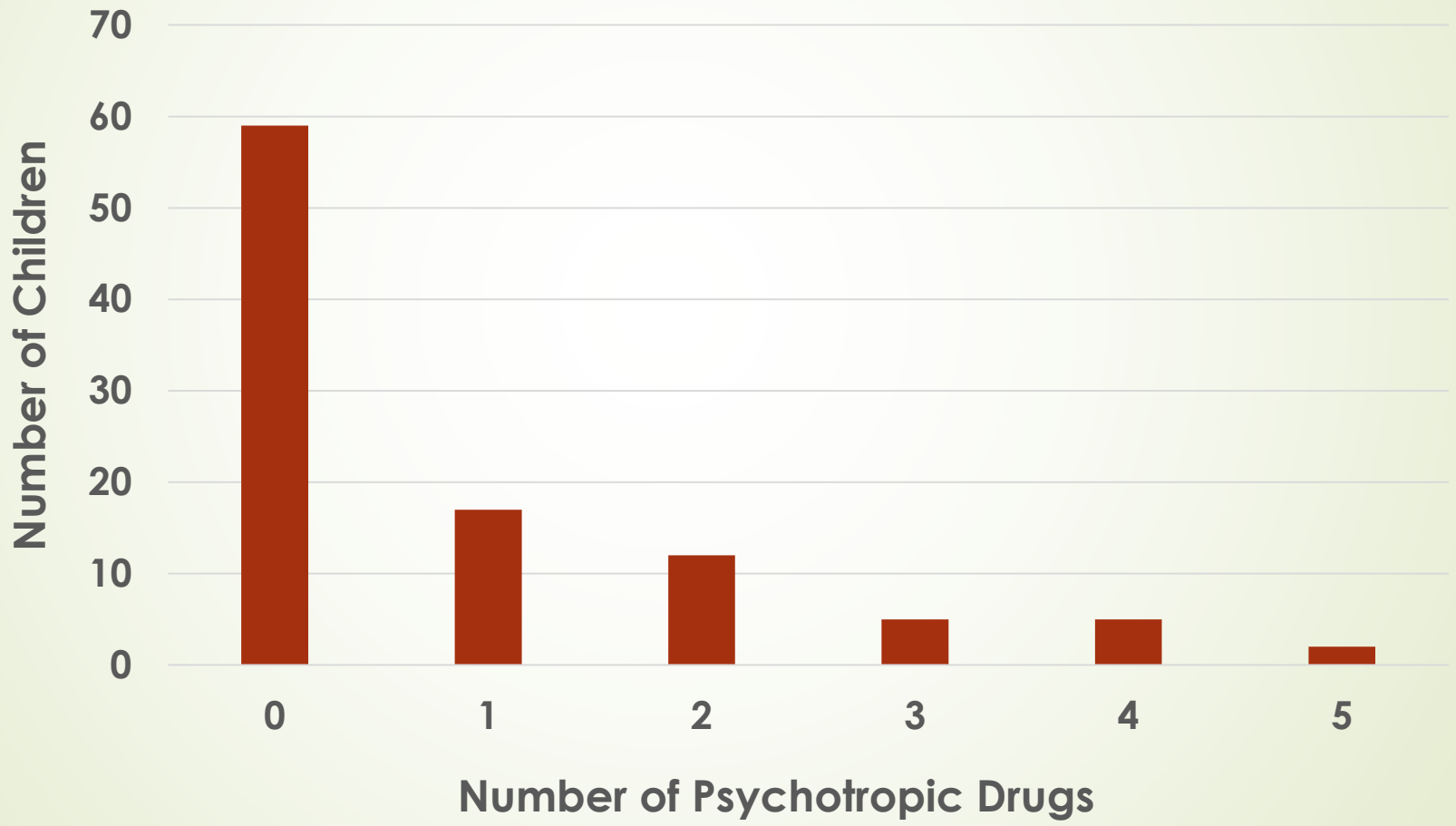
Number of Psychotropic Medications



Youth Primary Diagnosis



Psychotropic Medications at Admission

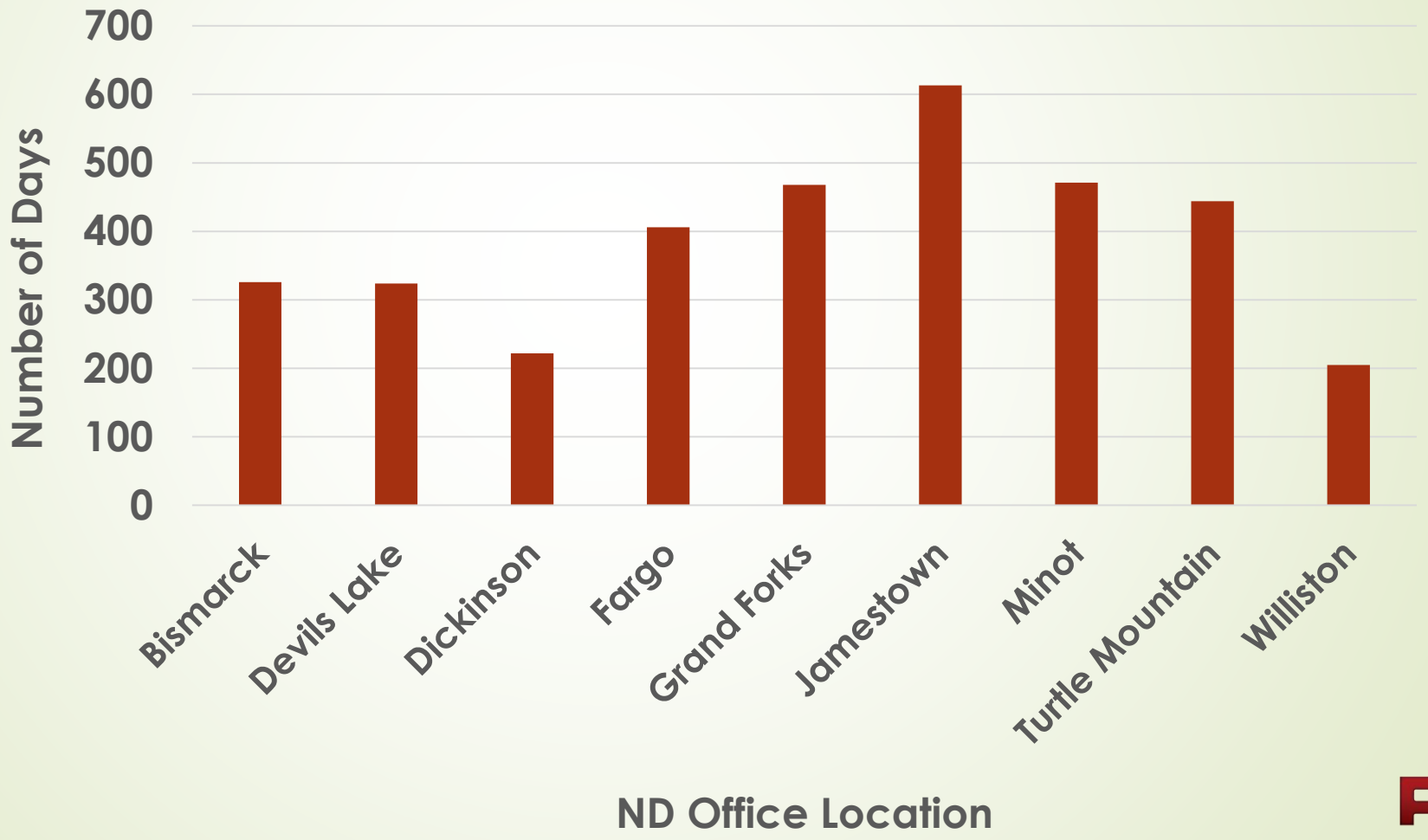


Average Length of Stay – ND Congregate Care

- Residential Child Care Facilities (11)
  - 5.9 – 7.2 months
- Psychiatric Residential Treatment Facilities (6)
  - 6.3 – 7.1 months

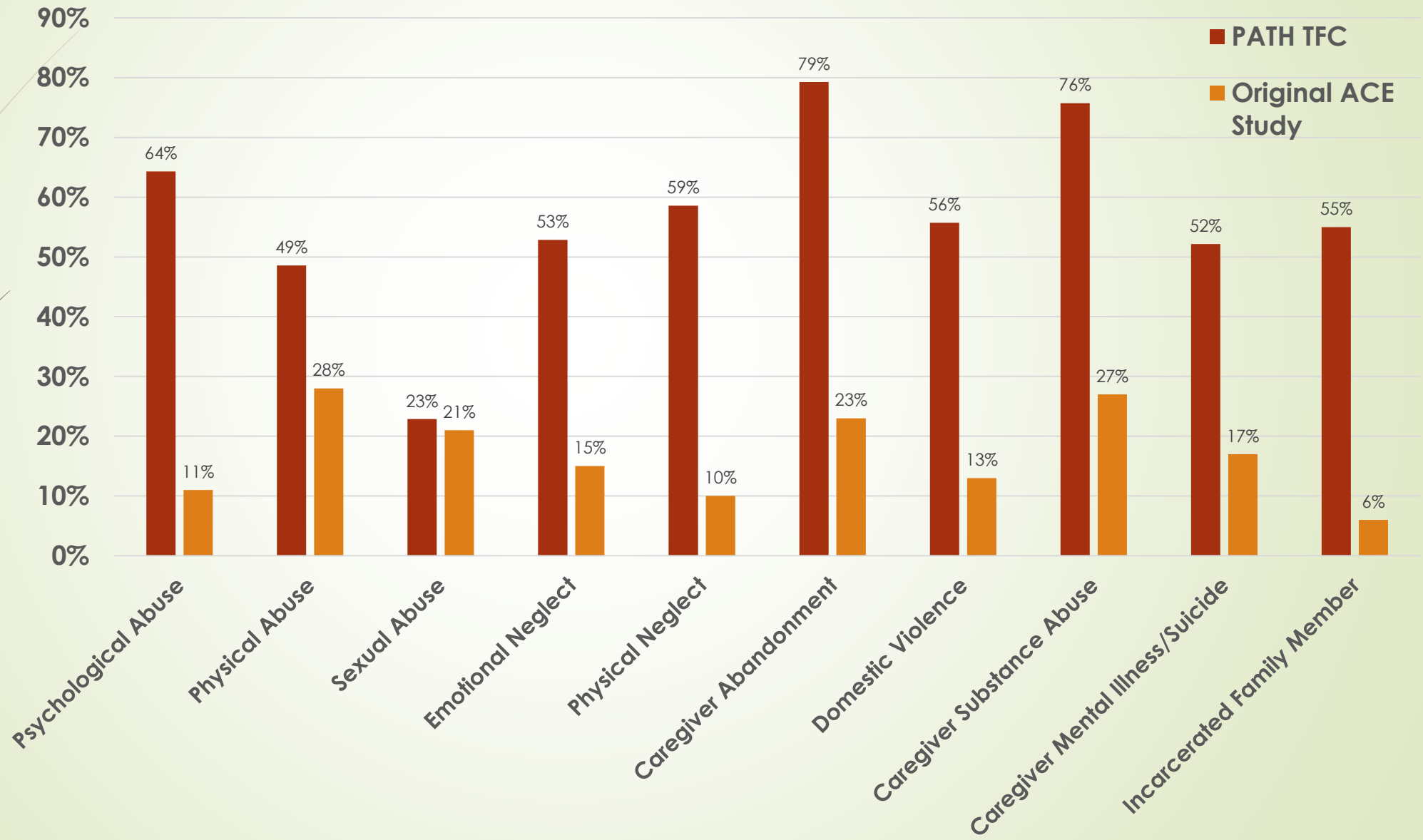
Self reported data taken from the ND RCCF and PRTF Directory compiled by the NDDHS Children and Family Services Division 2016-2017

PATH ND TFC Average Length of Stay



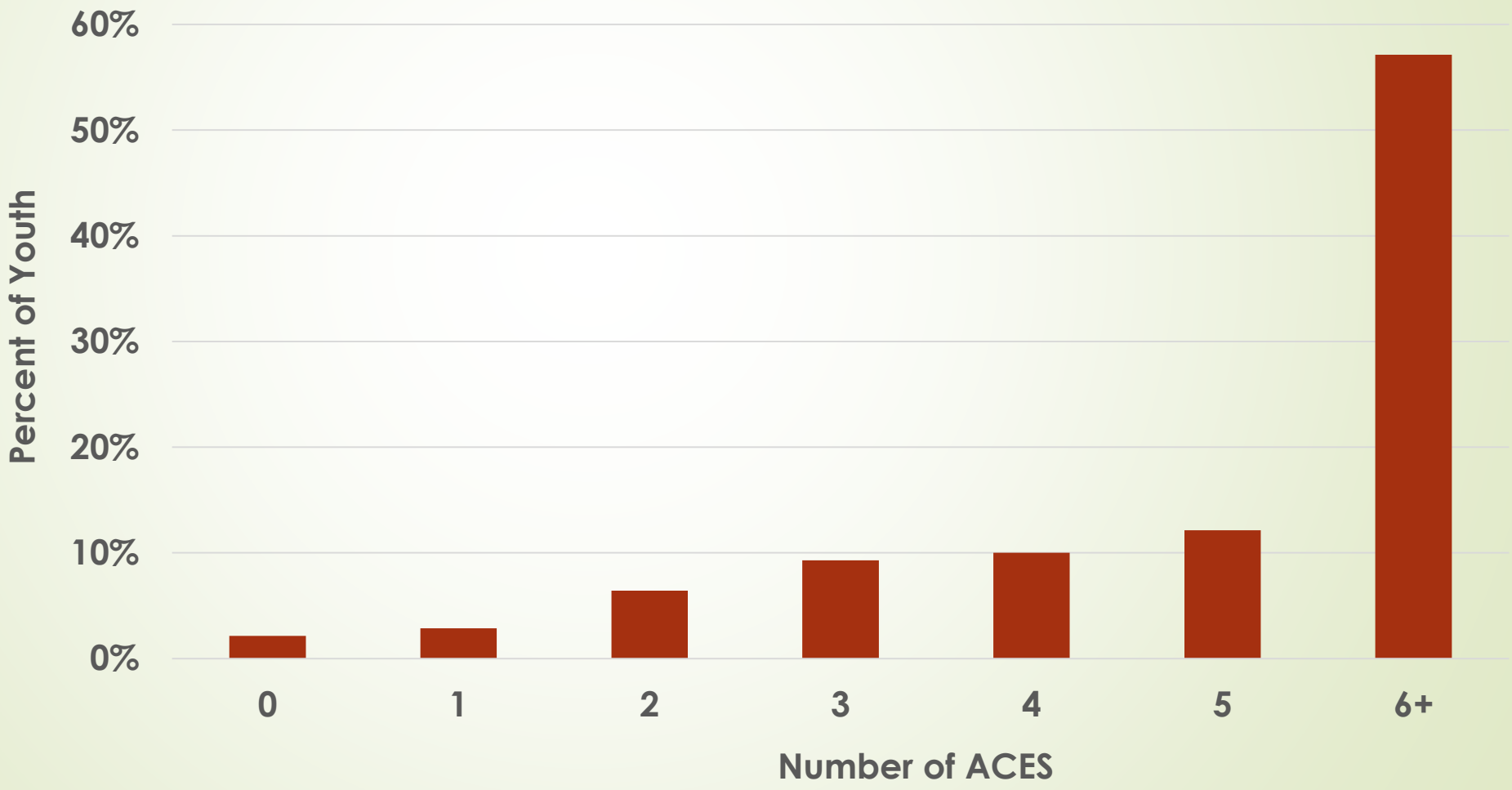
Adverse Childhood Experiences Data

ND PATH TFC vs. Original ACE Sample



Number of Adverse Childhood Experiences

ND PATH TFC (N=140)

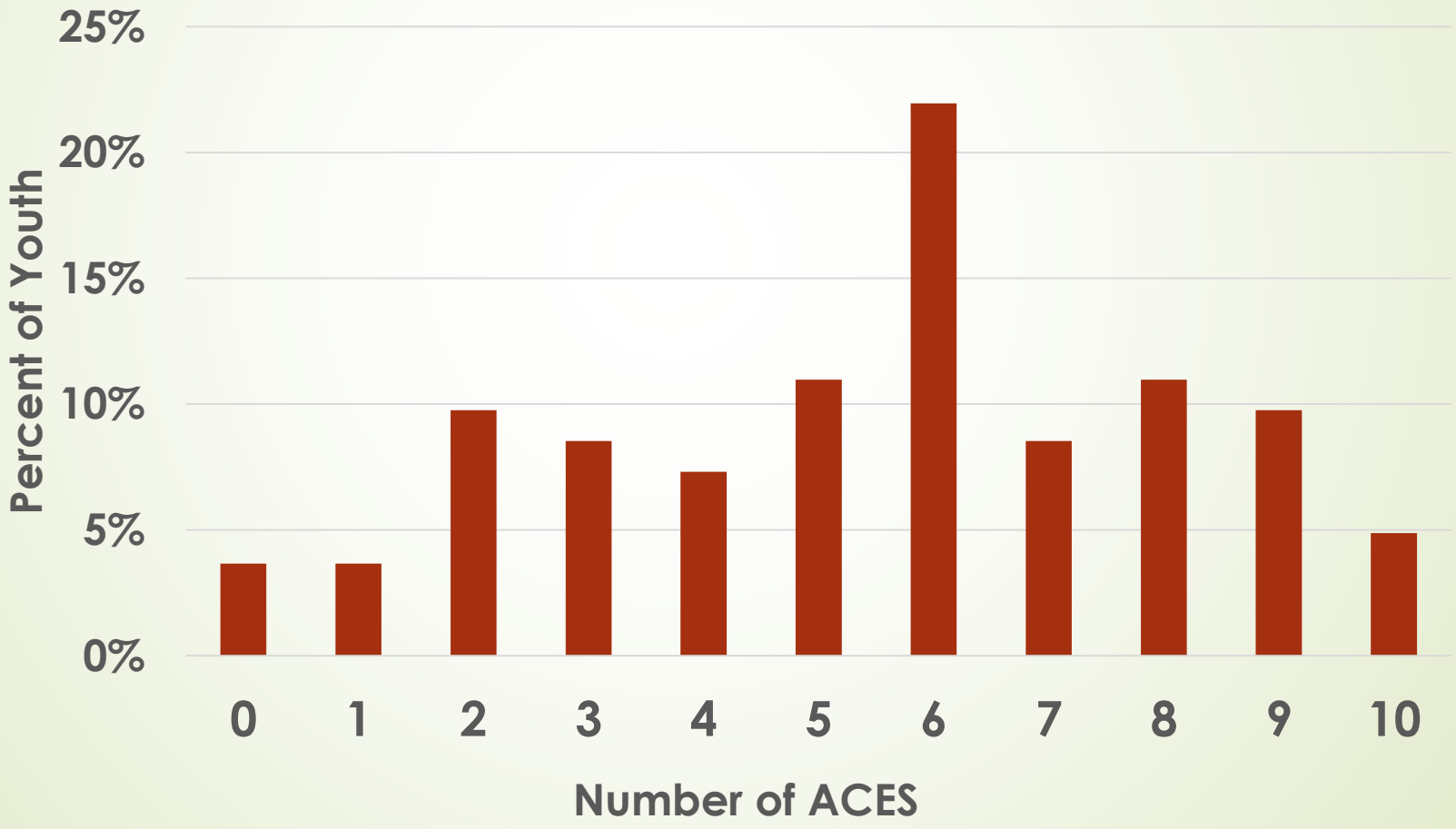


TSCC Intake Data - Average T Scores (Std. Dev.)

AGE 8-12										
	Anxiety	**Depression**	**Anger**	**PTS**	**Dissociation**	**Dis (Overt)**	**Dis (Fan.)**	**Sexual Concerns**	**SC (Preoc.)**	**SC (Dist.)**
Female (N=17)	51.2 (9.4)	49.4 (9.3)	47.1 (7.1)	50.2 (10.1)	48.1(15.4)	49.6 (16.7)	46.0 (13.8)	50.3 (12.8)	50.4 (11.5)	50.8 (12.4)
Male (N=14)	46.4 (11.1)	47.1 (12.6)	47.1 (8.4)	48.6 (12.5)	48.6 (11.1)	49.6 (11.9)	47.4 (5.8)	45.1 (4.4)	45.3 (2.5)	46.7 (6.8)
AGE 13-17										
	Anxiety	**Depression**	**Anger**	**PTS**	**Dissociation**	**Dis (Overt)**	**Dis (Fan.)**	**Sexual Concerns**	**SC (Preoc.)**	**SC (Dist.)**
Female (N=21)	49.4 (11.1)	47.8 (6.8)	44.2 (8.3)	49.7 (11.4)	49.6 (11.8)	51.0 (11.9)	46.7 (10.0)	46.9 (13.9)	43.9 (9.7)	56.4 (26.2)
Male (N=21)	49.8 (12.0)	51.2 (10.9)	45.6 (6.4)	47.9 (10.9)	49.7 (9.3)	49.4 (8.8)	50.2 (10.5)	50.6 (11.4)	49.7 (11.0)	54.3 (15.0)

Number of Adverse Childhood Experiences

TSCC Sample (N = 82)

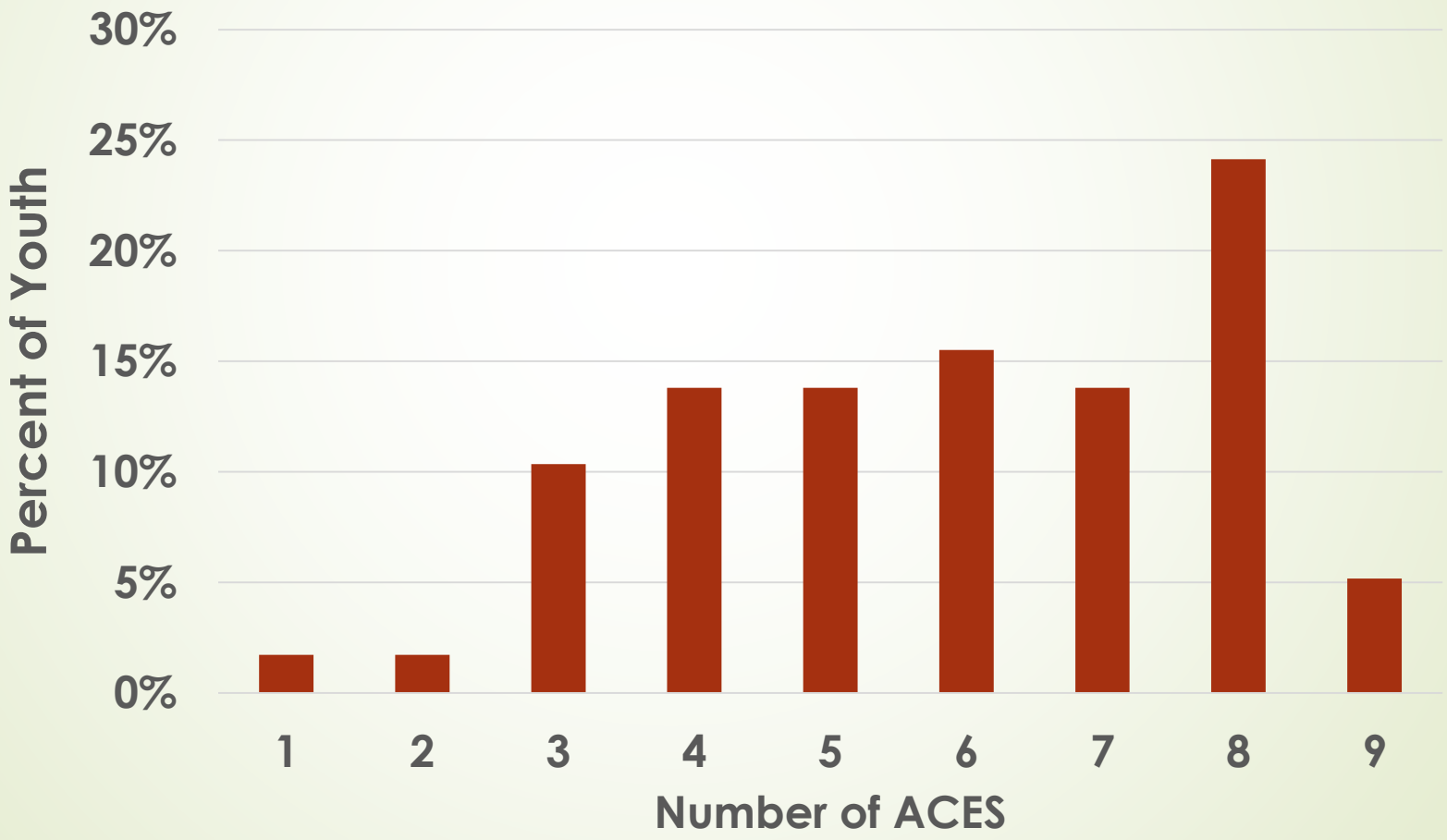


TSCYC Intake Data - Avg. T scores (Std. Dev.)

	Anxiety	Depression	Anger	PTS-Intrusion	PTS-Avoid	PTS-Arousal	PTS-Total	Dissociation	Sexual Concerns
Female (N=30)	61.6 (20.1)	61.8 (18.2)	64.6 (24.4)	63.7 (20.5)	69.9 (20.9)	68.9 (23.7)	70.0 (20.6)	63.6 (21.9)	58.1 (19.0)
Male (N=40)	61.1 (17.0)	59.0 (12.0)	61.6 (13.1)	68.4 (19.6)	69.0 (21.8)	61.6 (12.6)	68.0 (16.3)	57.4 (12.7)	59.3 (17.1)

Number of Adverse Childhood Experiences

TSCYC Sample (N = 58)



Benefits of TIC TFC

- Early intervention and more individualized care
- Enhances understanding of and relationship with youth
- Shared understanding at Child and Family Team Meetings
- Cornerstone of supervision
- Care Planning (e.g., helps determine treatment needs)
- Enhances ability to support PATH family
- Drives training needs for PATH staff and PATH families
- Outcomes driven program evaluation and development (e.g., substance abuse focused programming)

Foster Parent Feedback:

- "This class has really helped me realize and be able to see the difference of our children's actions now to how I seen it before this class. This changes everything."
- "Everything was presented to us in a very understanding and supportive way. It was wonderful hearing from other foster parents stories, we learned a tremendous amount of strategies that have helped me to prepare for what might happen in the future. Thank you!"
- "Understanding trauma must be mandatory for all of us that support children in foster care."

Moving Forward:

- Ongoing process – never done
- Video Training Modules
- Improving Youth Involvement
- Trauma Training for Youth's Family
- Specialized treatment foster homes? TF-CBT Homes?
- Increasing family-based and individual clinical services
- University relationships to enhance research capacity

Statewide Cross-System Collaboration

- Department of Public Instruction
  - Mandated Training (8 hrs/2 years)
  - Trauma Sensitive School (TSS) Curriculum
- Department of Human Services - Children and Family Services
  - NCTSN's Child Welfare Trauma Training Toolkit
- Department of Human Services – Behavioral Health Services
  - Treatment Collaborative for Traumatized Youth (TCTY)
- ND Division of Juvenile Services
- ND Juvenile Court

Questions?