”It has really shown us that when you truly invest in collaboration and partnership … it just works better, not just for the child, not even just for the family, but for the entire community.”

Partnering for Excellence

JENNY COOPER

PROJECT DIRECTOR

Child Welfare Crash Course

Child and Family Teams (CFTs) use the Family Service Agreement as their documentation

CFTs focus on the needed services for parents to be able to safely parent their children and reunify the family

CFTs occur at various intervals e.g. 30, 60, 90, 180, 360

In Home Family Services can suggest child mental health services, but cannot require them

For this presentation, DSS custody and foster care are used interchangeably and do not dictate type of placement

All children who come into DSS custody have a goal of reunification that is typically worked for 12 months prior to being able to change the goal

The Problem

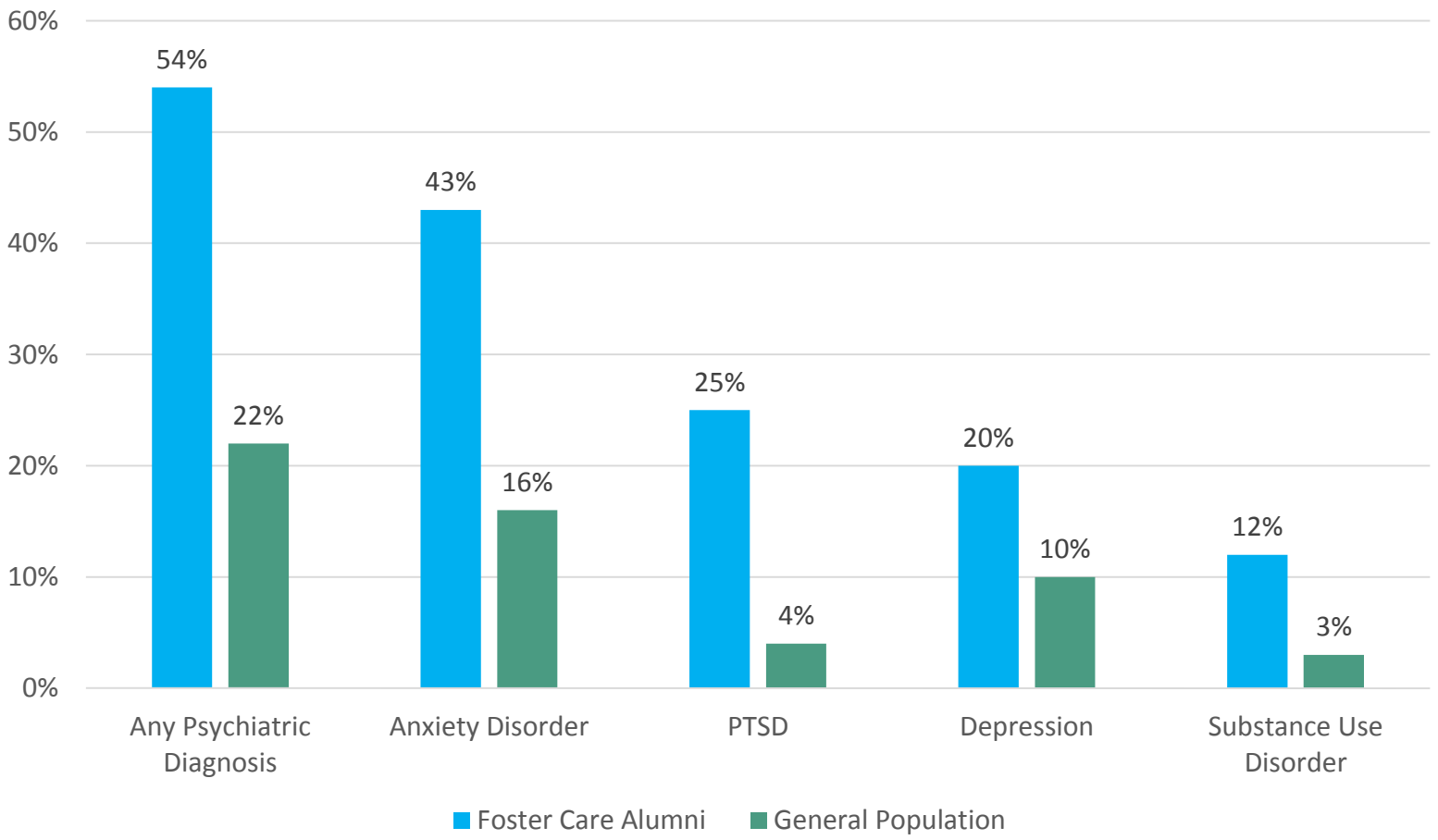
Youth in DSS custody experience higher rates of physical and mental health problems than their peers not in DSS custody

- High levels of emotional or behavioral problems
- More likely to be suspended
- More likely to have skipped school

Often have experienced trauma in their lives, which can be compounded by the system through:

- Investigation
- Removal
- Changing schools
- Multiple placements

Proportion of Foster Care Alumni with Psychiatric Problems Compared with the General Population



Costs

Children in DSS custody have greater average behavioral health expenditures than non-custody CPS involved children; about twice the cost

Children 12 years and older tend to have greater behavioral health expenditures than younger children

Placement instability is associated with increased behavioral health costs

Baseline Data Analysis

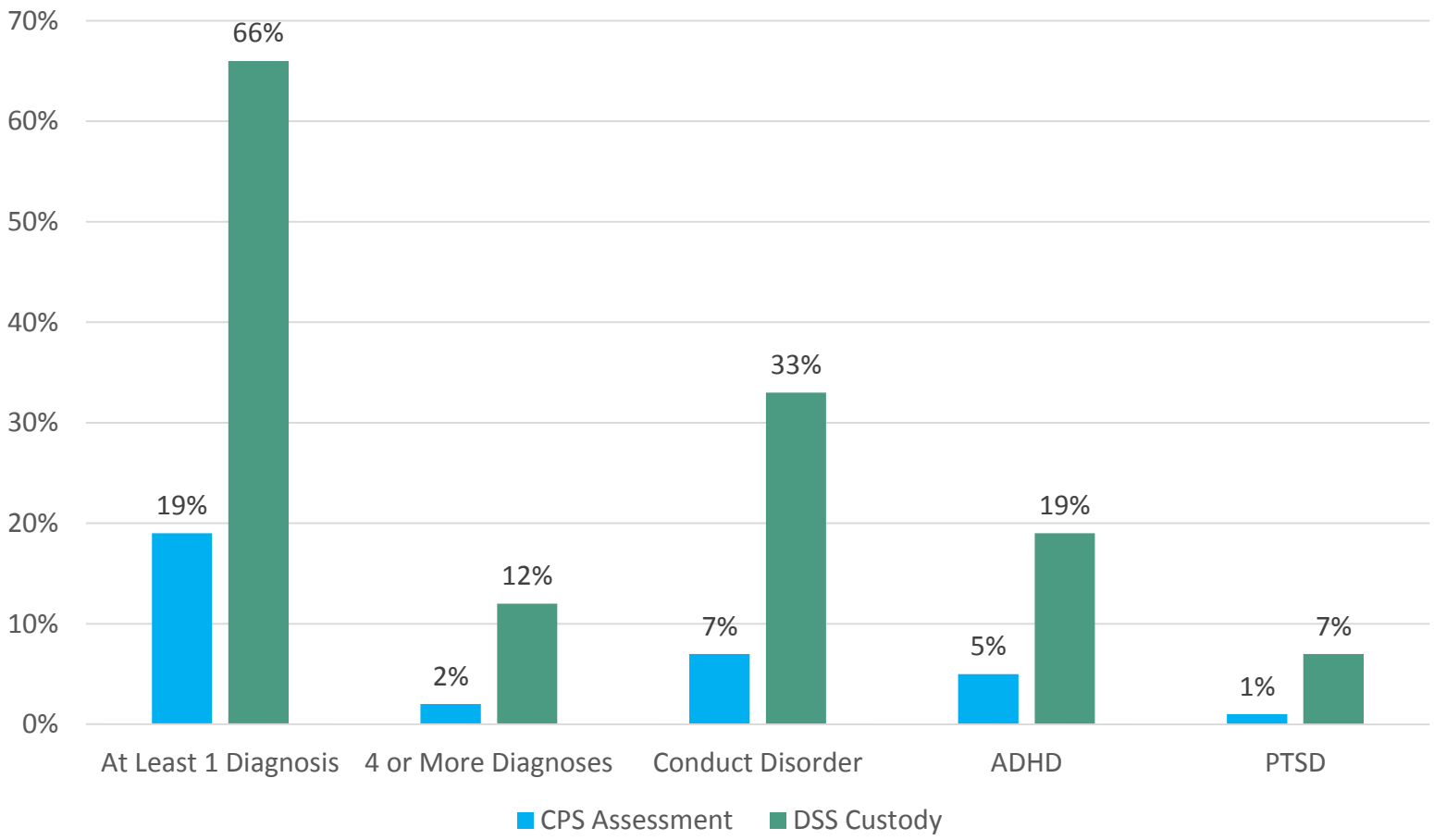
Children with at least 1 CPS investigation between July 1, 2004 and June 30, 2012

Child Welfare Data: CPS dates, findings, types and dates of services (foster care, in-home), placements (numbers, dates, types)

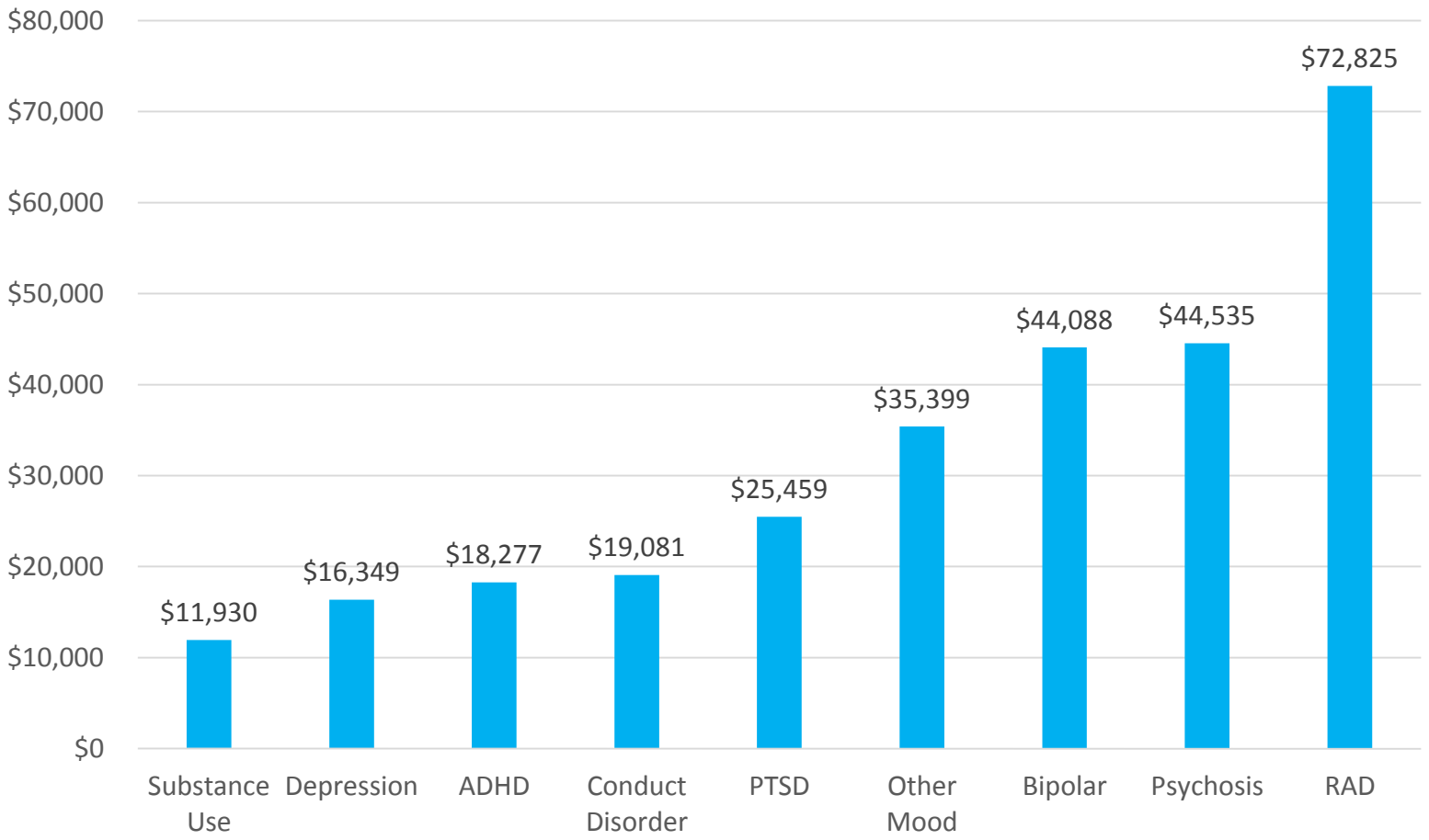
Cardinal Medicaid data: service type, diagnostic code, and the dollar amount associated with the service provided

Completed by Susan Cohen Foosness under the guidance of Dr. Katie Rosenbaum for the purpose of this pilot

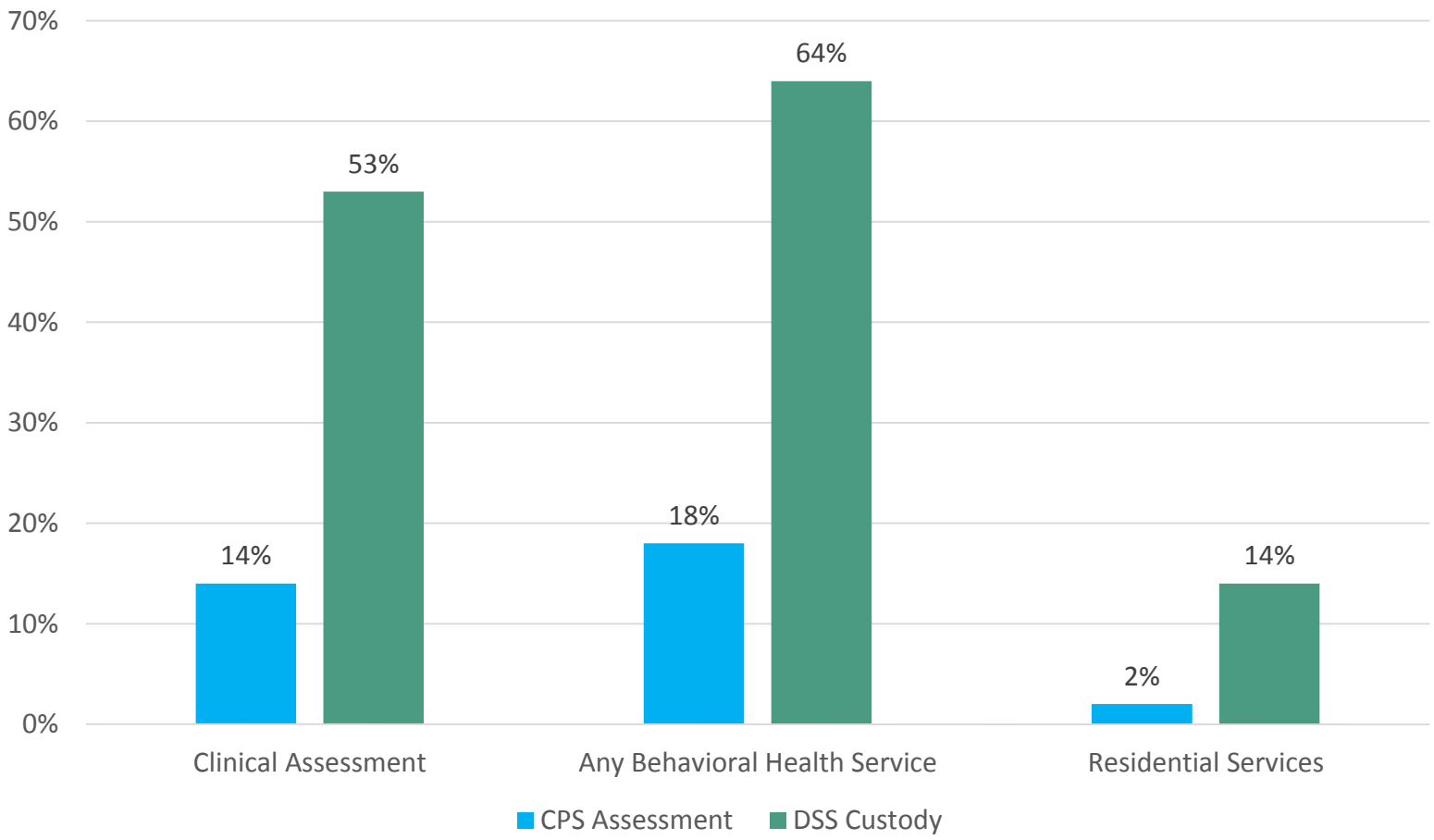
Behavioral Health Diagnosis



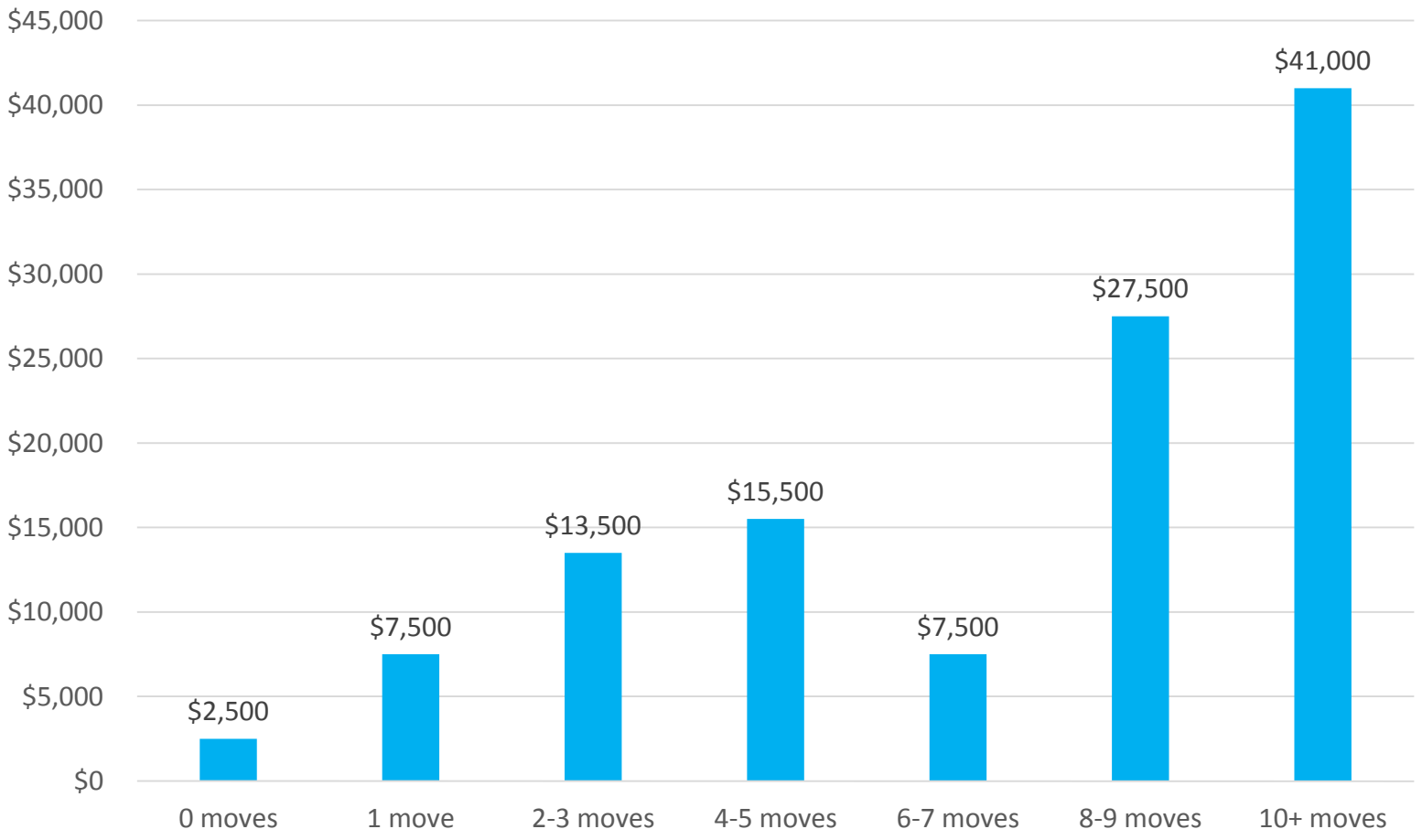
Average Behavioral Health Expenditures by Diagnosis



Behavioral Health Services



Average BH Expenditures and DSS Placement Stability

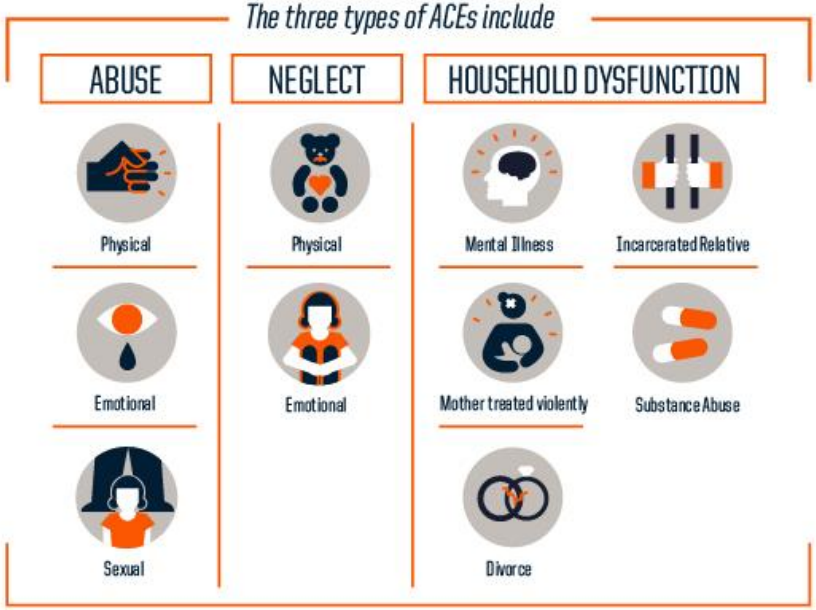


THE TRUTH ABOUT ACEs

WHAT ARE THEY?

ACEs are

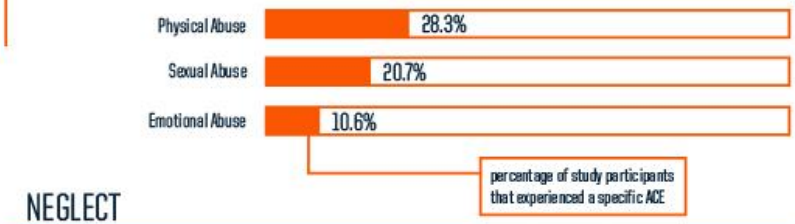
ADVERSE CHILDHOOD EXPERIENCES



HOW PREVALENT ARE ACEs?

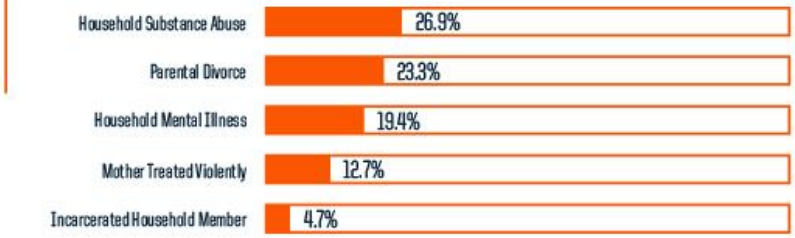
The ACE study revealed the following estimates:*

ABUSE

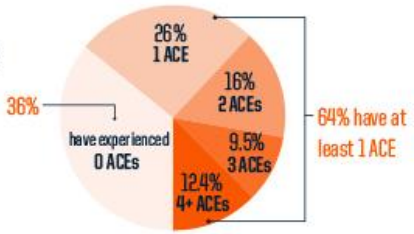


NEGLECT

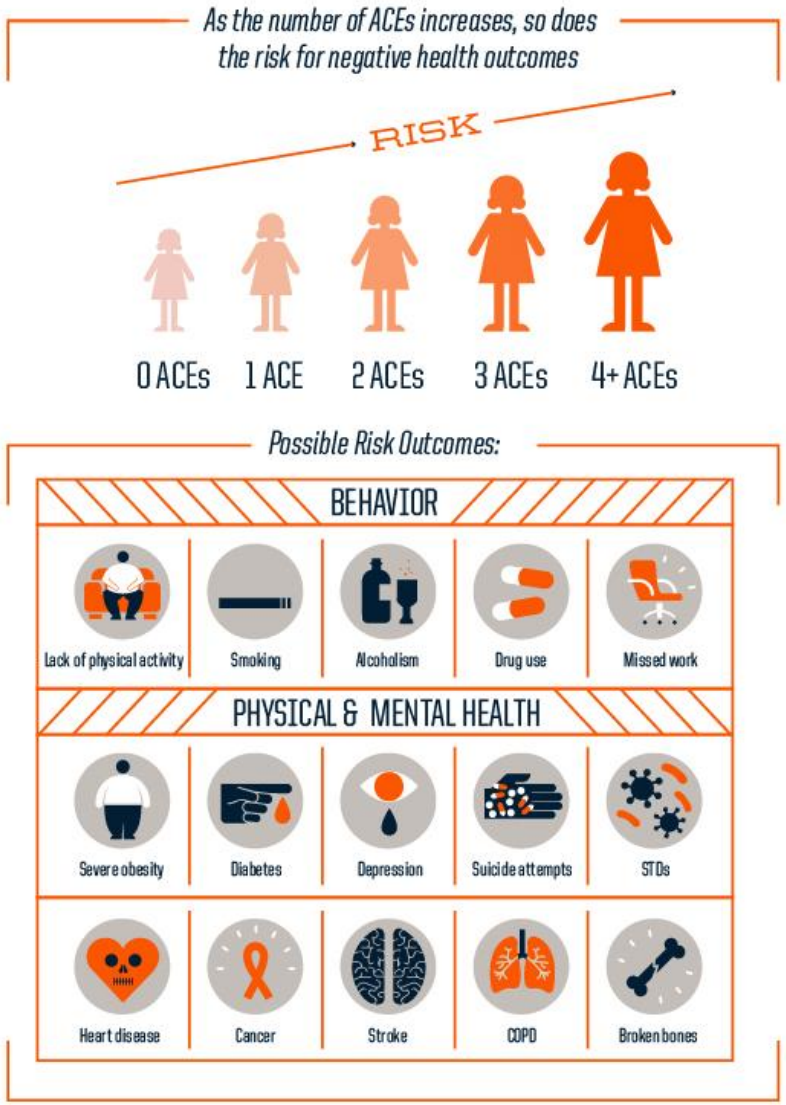
HOUSEHOLD DYSFUNCTION

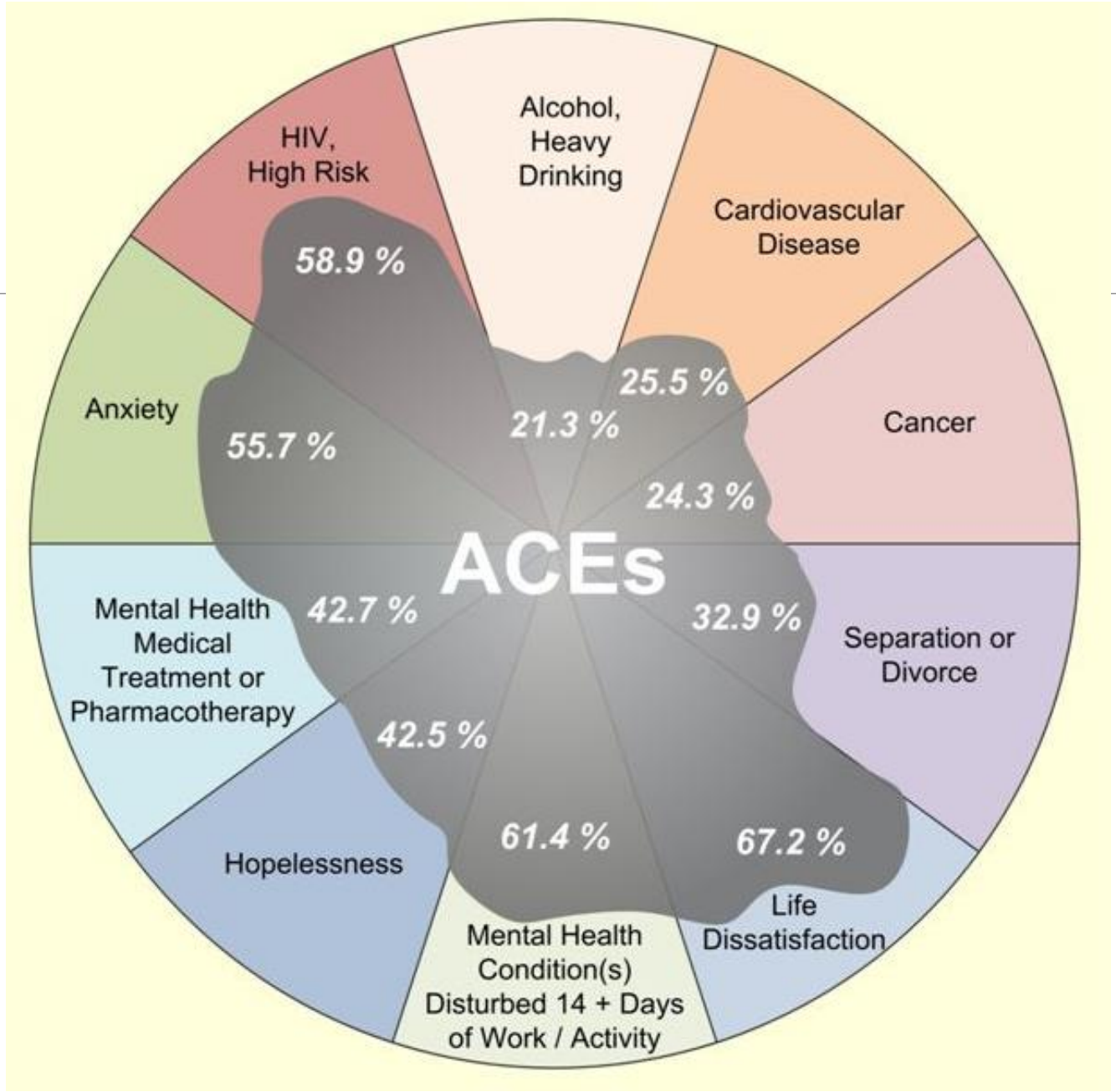


Of 17,000 ACE study participants:



WHAT IMPACT DO ACEs HAVE?




HIV, High Risk
Alcohol, Heavy Drinking
Cardiovascular Disease
Cancer
Separation or Divorce
Life Dissatisfaction
Mental Health Condition(s) Disturbed 14 + Days of Work / Activity
Hopelessness
Mental Health Medical Treatment or Pharmacotherapy
Anxiety
58.9 %
25.5 %
21.3 %
55.7 %
24.3 %
ACEs
42.7 %
32.9 %
42.5 %
61.4 %
67.2 %

Overarching Goal of PFE

To *Redesign* how the Child Welfare and Child Mental Health systems interact so they can:

Provide trauma-informed services and improve family outcomes

Reduce high-end services

Prevent children from being taken in to DSS custody

benchmarks
An Alliance of Agencies Helping Children, Adults & Families

Partnering for Excellence

- Improved social-emotional and global functioning
- Decreased use of intensive, restrictive MH services
- Decreased MH expenditures – Medicaid
- Decreased entry into foster care/DSS custody
- Increased placement stability
- Decreased CPS re-assessments

DSS Screening

DSS workers will screen for trauma for children 5-17 yrs old in In-Home Services and foster care, or have disclosed abuse at the CAC

Children who screen positive or enter DSS custody are referred to a TF-CBT rostered provider for a trauma-informed comprehensive clinical assessment (TiCCA).

Young Children 0-4: will be referred to CC4C through health department for trauma and developmental screening, and referral to Early Intervention

MH Clinical Assessment

TiCCA clinicians are TF-CBT rostered by the Child Treatment Program, will "test" a Trauma-Informed CCA protocol, and will be privileged by Cardinal to receive an enhanced reimbursement for the TiCCA

Effective Care Management

DSS, resource parents, Cardinal Innovations, and PFE provider partners will engage in activities to improve communication, coordination, and monitoring of child and family treatment.

- DSS
- Resource parents
- Cardinal Innovations
- PFE provider partners

Integrated Child Plan

Recommendations from both the child and caregiver CCAs will be integrated into CFT meetings and the DSS Family Services Agreement.

DSS will strengthen focus on child well-being goals:

- Expand youth well-being goal planning in family service plan
- Training/coaching for Child and Family Team facilitation
- Focus on ensuring children and caregivers referred to evidence-based treatment whenever possible

Quality Service Array

DSS and PFE partners will *intentionally* work together to ensure that child welfare children and families access quality, evidence-based/evidence-informed, front-end services in the community whenever possible.

- Collaborative vision of a front-end service array for child welfare children and families and work to build that array over time.
- Focus on trauma training and increased clinical support for resource parents

History of PFE

July 2012

Exploration begins in Cabarrus and Buncombe counties

July 2013

Pilot moves to Rowan county; Installation begins

February 2014

Usability testing begins for In Home Family Services and Foster Care

June 2015

Usability testing begins for CAC involved cases

2012 Common Issues

Lack of early intervention

Lengthy authorization and billing

Lack of competent and knowledgeable assessors (clinicians)

Lack of use of validated assessment tools (mental health side)

Lack of collaboration and sharing information

Child welfare versus child mental health mandates

Un-informed community regarding trauma

Reflections of 2012

"Early intervention and prevention systems have been gutted, so it is hard to get services children need to keep them out of more intensive placements"

"Sometimes, clinicians simply don't want to work with the parents- either the biological parents because they are seen as the bad guys or the foster parents because they are temporary."

"There is not much sharing of information among providers, which makes services less efficient and effective and allows families to fall through the cracks."

"Caseworkers feel that they conduct screening or assessment because of their lack of expertise."

Reflections of 2015

“From a systematic view, you can’t do child welfare without mental health partnering”

“Partnering for Excellence has really done an amazing job of bringing a lot of organizations together to work in collaboration.”

“It has really shown us that when you truly invest in collaboration and partnership….it just works better, not just for the child, but for the entire community.”

Others care….

The TiCCA- Trauma Informed Comprehensive Clinical Assessment

Rostered clinicians with additional day of training on the TiCCA

Referral packet to private agency and LME/MCO

- Cover page
- Screening tool
- CPS History
- Case Decision

Intake Form (completed by SW and family)

- Follows TiCCA
- Replaces Health and Med forms for DSS and incorporates Shared Parenting

TiCCA

Focus on traumatic event and secondary impact

Review of DSS involvement

Use of a complete battery of measures which are age dependent

Focused on collaterals

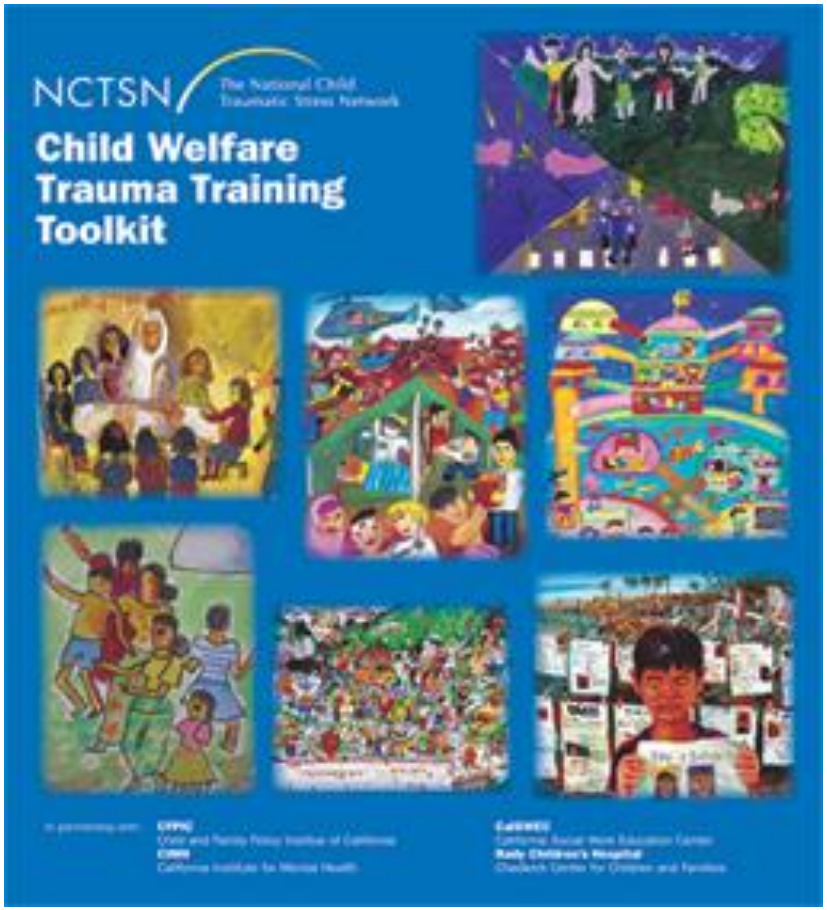
- Social worker is present
- Birth parent is present, if not feasible, is called or visited in prison
- Contact with schools, previous providers, physical health providers, previous social workers, other family members

Holistic, trauma informed recommendations

- Focus on medical, school, discipline, parenting

Building Organizational Culture through Training

- Choose trainers – ideally Child Welfare and clinical partners
- Flexible structure
- Required for all Child Welfare staff; best to include all staff
- Can include community partners and community stakeholders
- After training, determine how what is learned will impact practice



Trauma Informed Evidence Based Treatment

Focus on evidence based services- have been researched and evaluated to show results

Training for best practices post college

Mostly using Trauma Focused Cognitive Behavioral Therapy (TFCBT) but also building capacity for

- Parent Child Interaction Therapy
- Structured Psychotherapy for Adolescents Responding to Chronic Stress
- Non-clinical
  - Triple P
  - Seeking Safety
  - Celebrating Families!

Partnership between DSS and LME/MCO

Proactive face to face staffing

Co-training

- Utilization management
- Medical necessity
- PCP's

Trust

Identifying "triggers" instead of using non-clinical labels

Safety and permanency versus well-being

Steps to Creating Trauma Informed Partnerships

Find other evidence based practices to support

- Determine capacity of community
- Find out what other EBPs round out the service continuum

Invite clinicians to CFTs- may not be able to attend, but find other creative ways to share information

Challenging population to engage – work in partnership

Create communication expectations with leadership

Trauma Informed System of Care

Trauma informed System of Care

Working closely with SOC Coordinator from LME/MCO to help drive new ideas

Increase awareness at many agencies

- DJJ
- Judges
- School system
- Medical Homes
- Private agencies

Needs for Success

As much stability as possible

Management buy in- LME/MCO, DSS, and private providers

Willingness for continued, regular implementation meetings

Independent implementation specialist

Coaching for clinicians

Processing data for systematic improvement

Desire to work in true partnership for improved outcomes

A Few Success Stories

No youth in PRTF; only a couple in Level III (DJJ referred)

Using TiCCA recommendations, the CFT was able to move a child's plan to guardianship/adoption instead of waiting 12 months to change the plan to reunification

Youth with high CSBI score did not disclose at the local Child Advocacy Center (CAC), but with diligence and rapport, disclosed to clinician and was able to go back to CAC and disclose

And of course the cat! (check out Benchmarks Facebook page for more or go to #tictacnc

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