Department of Children, Youth and Families

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Senate Task Force On DCYF and Family Care Networks

Honorable Louis P. DiPalma, Co-Chairperson
Honorable Catherine Cool Rumsey, Co-Chairwoman

October 14, 2014

DCYF Mission: Partner with Families and Communities to Raise Healthy Children in a Safe and Caring Environment

Diligent Foster Care Trauma-Informed Recruitment

Strategies:

- Create a coordinated, community-wide message for resource family recruitment and retention
- Partner with new and diverse community agencies and members to identify new families and resources.
- Ensure that *all* resource family settings are therapeutic, trauma-informed and are enhanced with evidenced-based programs
- Improve the overall well-being of children and families through the implementation of a trauma-informed, adoption-competent approaches to well-being and permanency outcomes

Objectives:

- Create a collaborative, statewide virtual Resource Family Center to ensure standardized training and practice, as well as maximizing financial and human resources by June 30, 2014.
- Identify and implement the community-based supports needed to ensure that families have the appropriate resources to support the children in their care by June 30, 2014.
- Increase the knowledge and practice of kinship placements with internal and external staff by June 30, 2014.

Action Steps:

- Engage in a cost/benefit analysis to identify gaps in community and financial resources that are inconsistent with child well-being
- Create a diverse Coordinating Council to serve as the leadership for diligent recruitment efforts
- Identify and address any policy/regulatory barriers that hinder resource family recruitment/retention.
- Create a logistical and financial assessment of a virtual Resource Family Center by October 31, 2013
- Train staff on policy and permanency practices, such as kinship placement, child-specific permanency strategies, concurrent planning, etc. by December 31, 2014

Why the Need for change:

- RI is challenged with an insufficient number of resource families to address the needs of children in care. Data demonstrates the following children are least likely to reside in families: 1) children with behavioral and/or mental health needs; 2) children of color; 3) older children (ages 12 and up) and 4) children who are part of sibling groups.

DCYF Mission: Partner with Families and Communities to Raise Healthy Children in a Safe and Caring Environment

Right-sizing and Improving Congregate Care

Strategies:

- Implement intensive, evidence-based practices in the agency and community to increase the accessibility and availability of services to children and their families
- Expand the use of wraparound services to ensure that all families and youth are supported through this approach
- Expand the use of youth "voice and choice" to identify more appropriate and permanent placements.
- Enhance the quality of group care settings.
- Create a "best practice" for all internal and external providers that limit the use of congregate care as a placement.
- Increase the level of knowledge around the impact of trauma on children and youth
- Incorporate universal screening and assessment for trauma and behavioral health so that youth are matched to appropriate services
- Expand the trauma-informed, adoption competent workforce through training and collaboration

Objectives:

- An evidence-based coaching visitation model will be identified to standardize practice by June 30, 2014
- Psychotropic medication monitoring will be prioritized to ensure that youth are receiving the needed and appropriate medications by December 31, 2013.
- Introduce the Building Bridges Framework in two congregate care settings (one in each network) by February 28, 2014.
- Identify brief, evidence-based interventions that can be utilized in congregate care settings by December 30, 2013.
- Introduce crisis mobilization team to support youth in community settings by June 30, 2014.
- Expand the number of evidenced-based programs in the community by June 30, 2014.
- Incorporate the NCTSN Child Welfare Trauma Training Toolkit into the CWI Training Curriculum for child welfare workers and community providers
- Identify implementation plan for universal screening and assessment by December 2014

Action Steps:

- Invite the Annie E. Casey Foundation Child Welfare Strategy Group to engage in a "Right-Sizing" assessment by October 31, 2014.
- Re-allocate funds from Title IV-E waiver to support community-based services and programs.
- Hire a kinship investigator who will work specifically with youth in congregate care settings to identify potential placements.
- Assess child and youth well-being in congregate care verses family-based settings
- Accurate outcome and satisfaction data is gathered for each child, youth and family, and it is used to improve individual services and programs
- Chadwick Center to conduct *Train the Trainer* on the Child Welfare Trauma Training Toolkit by January 30, 2015
- CWI to offer Toolkit training 3 times per year
- Get technical assistance from Chadwick Center and NYU Langone Medical Center around screening and assessment tools.

Why the Need for change:

- Children living in RI are more likely to be placed in group care than those in many other states. According to FY12 data, RI has the third highest percentage of youth in congregate care (over 30%)

- Research shows congregate care may have a negative impact on the overall development of children. Children fare better in family care settings rather than in congregate facilities

DCYF Mission: Partner with Families and Communities to Raise Healthy Children in a Safe and Caring Environment

Wellness: Workforce Development and Support

Strategies:

- Support Wellness Committee work groups to provide a multileveled response that addresses the physical, emotional, spiritual and psychological well-being of staff.
- 1-Communication Workgroup (internal and external)
- 2-Crisis /Education and Prevention Workgroup
- 3-Physical Activity Workgroup
- On-going training on staff supervision

Objectives:

- Educate staff through training on the existence of secondary trauma and how to deal with it
- Provide a team of qualified trained certified individuals to help staff deal with the trauma associated with major events such as a client or staff death
- Create a climate that is understanding and supportive for staff
- Educate supervisors on supervision techniques or specific supervision model (re: reflective supervision)

Action Steps:

Communication Workgroup

- Enhanced activities that bring staff together for social time.
- Staff recognition activities organized
- Speakers bureau established
- Contacts with media and advertising group

Crisis/Education & Prevention Workgroup

- Establish critical incident team to support department staff
- Provide training to staff on secondary trauma
- Research feasibility of having staff "floaters"
- Create safe & supporting physical space

Physical Activity Workgroup

- Respond to staff identification of repairs/enhancements related to physical sites
- Organize or encourage physical activity to reduce stress
- Pursue outside resources to link staff to areas of interest

Staff Supervision Workgroup

- Identify staff supervision model
- Train supervisors on supervision model
- Provide support in supervision model
- Increase collaboration and cross-training around trauma-informed, adoption competent practice

Why the Need for change:

- Staff who experience secondary trauma associated with their work have a lower level of well-being, experience more illness and less effectiveness on the job. This then results in poorer outcomes for the children and families
- Staff who are overwhelmed with the complexity and stress of their jobs tend to bring the job home with them and have it permeate all aspects of their life. There is a need to help support staff in achieving a healthy balance between work and home life.
- Need a climate of awareness, understanding, support, respect and compassion toward each other

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DCYF
RI Department of Children

- **Vision**
- Healthy Children and Youth, Strong Families, Diverse Caring Communities

- **Mission**
- Partner with families and communities to raise safe and healthy children and youth in a caring environment

- **Guiding Principles**
- To fulfill our mission, we believe that:
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- The family, community and government share responsibility for the safety, protection and well-being of children through a family and child-centered wraparound model of care.
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- Decisions are made based on shared input and expertise, which includes the voice of the Department, the family, service provider, caregiver and child where appropriate.

- Timely permanency is achieved when behavioral changes are made which demonstrate the ability to create and maintain safe, stable environments for children and youth.
-
- When the family is unable to care for a child/youth, it is our responsibility, in as timely a manner as possible, to ensure the child/youth is provided permanency in his/her life in a safe, stable and nurturing home.

- DCYF staff, parents, natural supports, foster caregivers, other community and State agencies, and their staff are partners in the provision of timely and appropriate high-quality care.
- An integrated continuum of care should emphasize prevention over intervention, and reflect a partnership between family, community and government that is culturally relevant and helps families through readily available individualized services which achieve behavioral changes that can be sustained through natural supports.
  - Partnership requires open, honest and respectful communication fostering an awareness of the importance of individualized evidence-based practices and
- allowing for clear and agreed upon roles, responsibilities and authorities
-
- Professionals at all levels should be held accountable to a professional code of conduct.
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- As an invaluable resource, staff are entitled to a safe, supportive work environment that fosters professional development.

- Quality improvement is an on-going process, utilizing external and internal performance standards.

FAMILY CARE NETWORKS – CORE VALUES

- Evidence based practices [i.e., Multi-systemic Therapy, Strengthening Families, Functional Family Therapy, Parents as Teachers, Cognitive Behavioral Therapy, Alternatives For Families, Parenting with Love and Limits]
- Data driven decision making
- Outcome not output focused
- Allows failures and learn from them
- Creates a culture of innovation

FAMILY CARE NETWORKS - CHARACTERISTICS

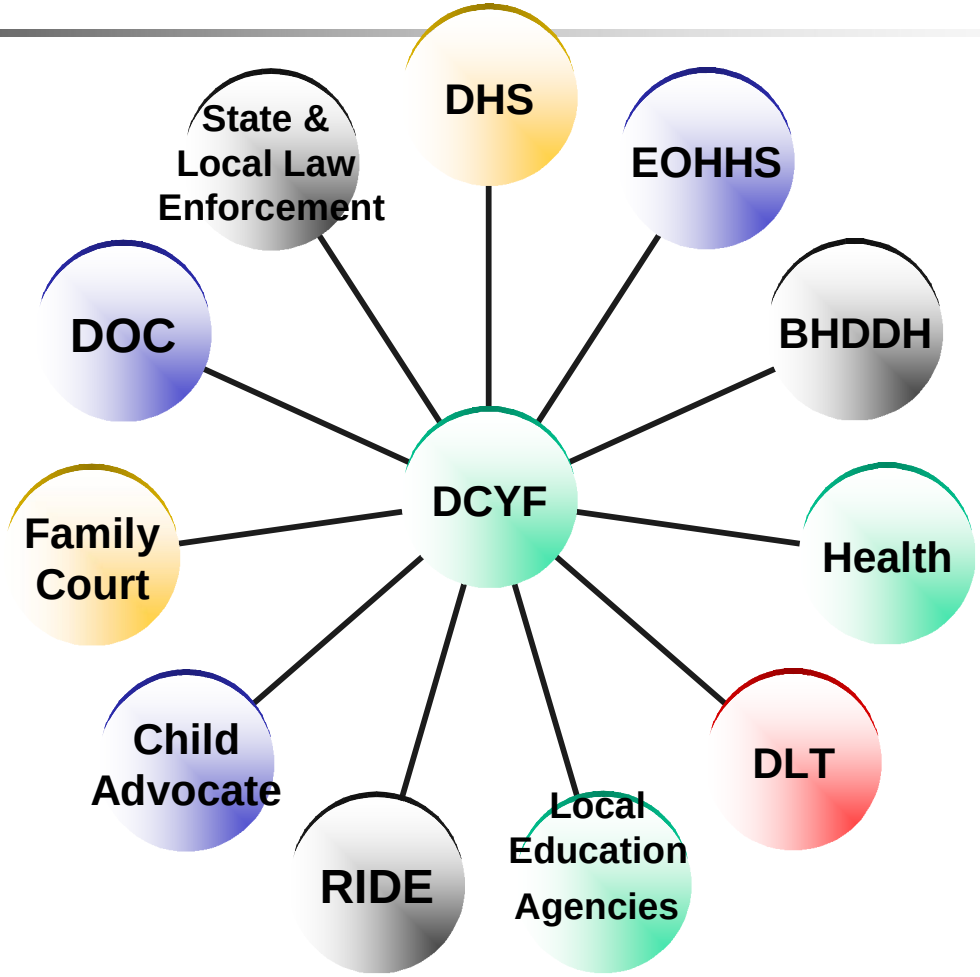
Before July 1, 2012 – 70 Service Contracts

- Fragmented services delivery
- Categorical programs/funding
- Finances including rates were secret
- Reactive, crisis-oriented approach
- Focus on "deep end," restrictive setting
- Children out-of-home
- Centralized authority
- Creation of "dependency"
- Child only focus
- Needs/deficits assessments
- Families as "problems"
- Cultural blindness
- Highly professionalized
- Child and family must "fit" services
- Input-focused
- Funding tied to programs and relationships

After July 1, 2012 – Two Networks

- Coordinated service delivery
- Shared Vision and Values
- Transparent Blended Finances
- Focus on prevention/permanency
- Community settings
- Children within families
- Community ownership
- Creation active participation
- Family as focus
- Strengths-based assessments
- Families as "partners" and change agents
- Cultural competence
- Coordination with natural supports
- Individualized/wraparound approach
- Outcome/focused
- Funding tied to populations and performance

INTERAGENCY RELATIONSHIPS



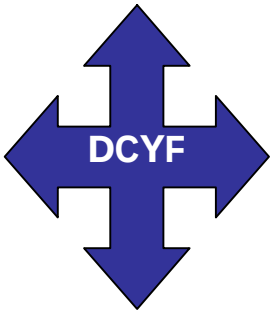
SYSTEM OF CARE FLOW

Rhode Island System of Care

A spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families that is organized into a coordinated network; builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs in order to help them to function better at home, in school, in the community, and throughout life.

Family Care Community Partnerships:

- Community Care Alliance: Northern
- Child and Family Services: East Bay
- South County Community Action Program: Kent/Washington County
- Family Service of RI: Urban Core



Networks of Care:

- Family Service of RI: Ocean State Network
- Child and Family: RI Care Management Network

Out of Network Services:

Out of Network Providers

KEY CHILD WELFARE PERMANENCY INDICATORS

The Child Welfare Permanency Indicators demonstrate improvement over time across permanency indicators and over time.

Reunification & Foster Care Re-Entry

REUNIFICATION

The percent of children reunifying with parents within 12 months of entry into foster care increased over time.

Table 1. Time to Reunification: The percent of children in RI who reunify with parents within 12 months of entry by Federal Fiscal Year

	FFY2010	FFY2011	FFY2012	FFY2013
Less than 12 months	71.2%	68.4%	72.4%	77.6%

Data Source: U.S. Children's Bureau Context Data Child Welfare Outcome Report

REENTRY INTO FOSTER CARE

The percent of children in RI reentering foster care decreased between FFY2012 and FFY2013

Table 2. Children Reentering Foster Care: The percent of children in who reenter foster care within 12 months of previous discharge by Federal Fiscal Year

	FFY2010	FFY2011	FFY2012	FFY2013
Children reentering care within 12 months of a prior episode	15.2%	16.7%	18.8%	15.2%

Data Source: U.S. Children's Bureau Context Data Child Welfare Outcome Report

Placement Stability & Young Children in Congregate Care

PLACEMENT STABILITY

The percent of children in RI foster care less than 12 months who experienced 2 or fewer placements increased over the 4 Federal Fiscal Years.

Table 3. Placement Stability: The percent of children in RI with 2 or fewer placements in care less than 12 months by Federal Fiscal Year

	FFY2010	FFY2011	FFY2012	FFY2013
Children with 2 or fewer placements	86.6%	87.2%	87.8%	88.6%

Data Source: U.S. Children's Bureau Context Data Child Welfare Outcome Report

Young Children in Group Homes or Institutions

The percent of young children age 12 or younger who entered foster care and were in group homes demonstrates an overall downward trend over the 4 Federal Fiscal Years

Table 4. Young Children in Group Homes: The percent of children in RI foster care with most recent placement setting who entered foster care and were age 12 or younger by Federal Fiscal Year

	FFY2010	FFY2011	FFY2012	FFY2013
Group homes	18.4%	11.1%	7.4%	7.9%

Data Source: U.S. Children's Bureau Context Data Child Welfare Outcome Report

Children in Foster Family Settings

Children in Foster Family Settings

The percent of children in RI foster care who are in a foster family setting has increased over State Fiscal Years. This includes both nonkinship and kinship families. In SFY2014, 29.0% of youth age 12 and older had as their first placement type a foster family setting which demonstrates an increase from SFY2013.

Table 5. Percent of Children in Foster Family Settings: The percent of children in RI foster care who are in a foster family setting by Federal Fiscal Year

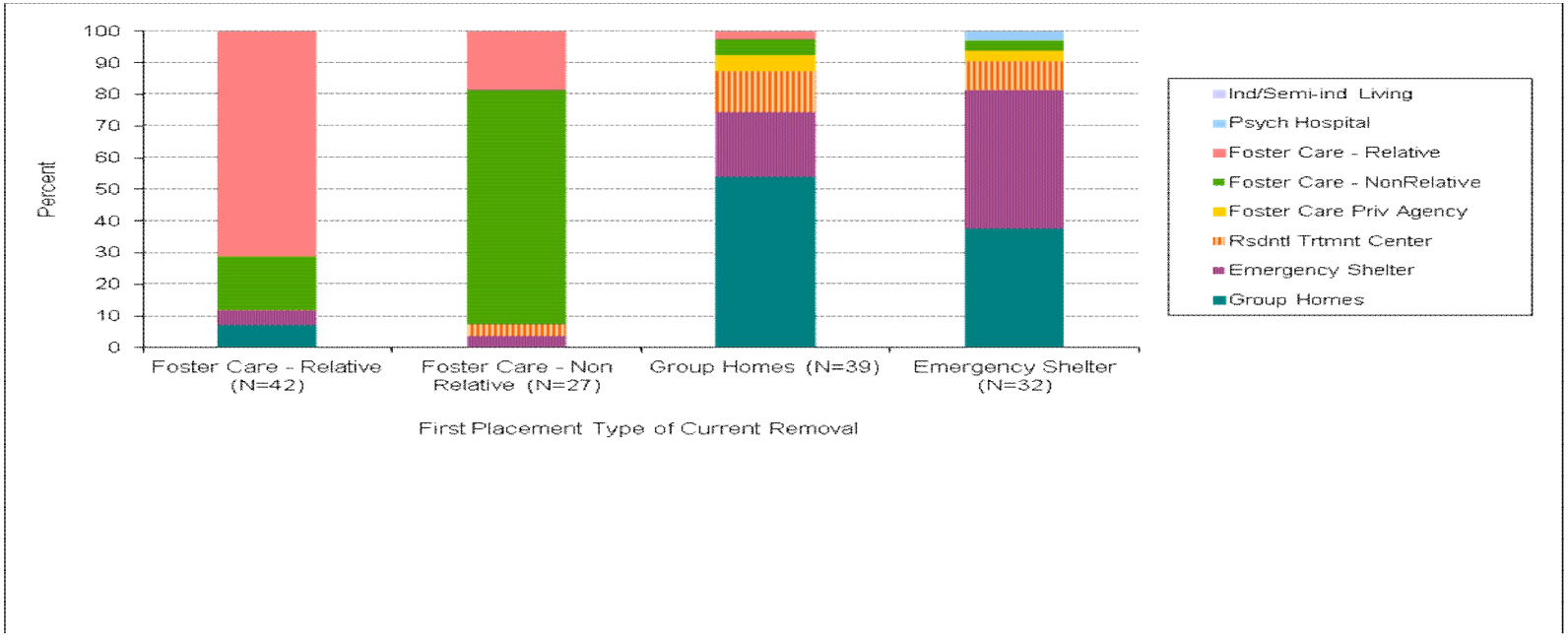
	SFY2010	SFY2011	SFY2012	SFY2013	SFY2014
Percent of children in all foster home types	61.1%	63.0%	66.9%	67.8%	68.7%
Percent of children in kinship foster homes	DNA	DNA	53.6%	54.5%	56.4%

Data Source: RI Child Information System (RICHIST) . DNA: Data not available; data not collected in that format

Congregate Care Trajectory

The figure below demonstrates the trajectory of a youth in congregate care. The data shows that a youth who is discharged from a congregate care setting who then reenters foster care is more likely to reenter into a congregate care setting for his/her first placement.

Figure 1. Percent of children re-entering into out-of-home placement, by placement service type at previous discharge for the most frequent first placement service types of current removal, FY14



WHAT IS THE SYSTEM OF CARE DOING TO ADDRESS THIS ISSUE?

The System of Care has implemented a number of initiatives to address this congregate care trajectory including:

- Implementation of evidence-based and/or evidence informed initiatives (selected highlights)
  - Triple P
  - Trauma Systems Therapy(TST), residential and community based
  - Trauma Focused Cognitive Behavioral Therapy
  - Family Centered Practice
- Grants: The Agency for Children and Families (ACF) Diligent Recruitment Grant and Adoption and Well-being after Trauma

ACTION STEPS

Care Management Protocol Revised

- Established internal processes which will reinforce and support the Department's efforts to maintain children in family like settings
- Ensure aggressive management of children/youth in congregate care settings on regional and division level
- Monitor service delivery on a bi-weekly basis through the Director's Office

Protocol on Child/Youth Service Assessments (Revised)

- Provides standardized methodology for the utilization of the Child and Adolescent Needs & Strengths (CANS) assessment and the Ohio Ages & Stages assessment for all children receiving services
- Holding providers accountable to ensure full compliance with assessment completion

PROLIFERATION OF EVIDENCE BASED PRACTICES

- After Jan. 2013
- Teen Assertive Community Teaming (Teen ACT)
- Family Centered Treatment
- Triple P (Positive Parenting Program)
- Trauma Systems Therapy
- Trauma Focused Cognitive Behavioral Therapy (TF-CBT) (funded by both DCYF and NHP)
- Common Sense Parenting

ESTABLISH BENCHMARKS FOR PERFORMANCE MANAGEMENT NETWORK

- Revising methodology to be consistent with new federal rules
- Calculating performance measures based on revised methodology

PERFORMANCE MEASURES INCLUDE:

- Maltreatment of treatment for children open to the network
- Re-entry rate for children reunified with parents
- Stability of placement for children in out of home care
- Percentage of children and youth who achieve a permanency goal within 12 months of being assigned to the network.

PROGRAM DEVELOPMENT

- CONTINUE TO PURSUE DEVELOPMENT OF AN ACUTE TRAUMA INFORMED PROGRAM FOR ADOLESCENT GIRLS IN STATE

FISCAL RESPONSIBILITY

- Formation of an efficient, effective and sustainable budget that enables the Department to provide high quality, individualized services that achieve the best possible outcomes for children and families