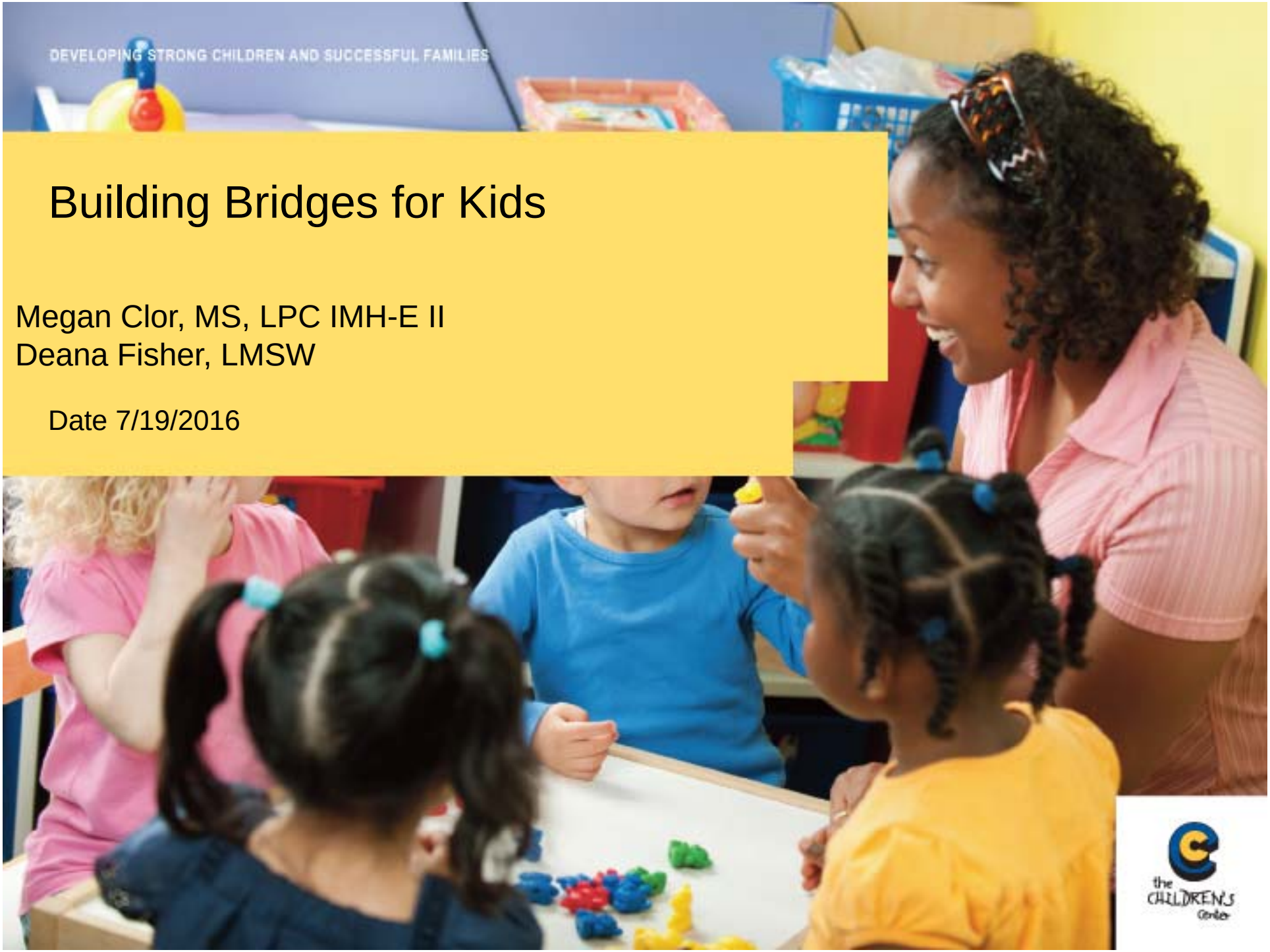

Building Bridges for Kids

Megan Clor, MS, LPC IMH-E II
Deana Fisher, LMSW

Date 7/19/2016

The Children's Center

- Founded in 1929 serving Children and Families for 87 years in the Detroit, MI.

- Mission: To Help Children and Families Shape Their Own Future

- Over 24 programs helping over 7500 youth and/or families
  - Mental Health
  - Child Welfare-servicing 200 families
  - Education and Enrichment

Why Did We Create a Partnership?

- Meet The Needs of Children and Their Families
  - 11.7% of Children ages 0-17 in Wayne County had confirmed abuse and/or neglect investigations with 4.5% placed outside the home due to abuse/neglect (kidscount.org)
  - National Child Traumatic Stress Network indicates 70.4% children in foster care experience at least two traumatic events

Why Did We Create a Partnership?

- Meet The Needs of Employees
  - National Child Traumatic Stress Network-Studies show that from 6% to 26% of therapists working with traumatized populations, and up to 50% of child welfare workers, are at high risk of secondary traumatic stress or the related conditions of PTSD and vicarious trauma

Why Did We Create a Partnership?

Meeting the needs of staff

Why should organizations be concerned about secondary trauma?

- Turnover
- Costs of recruiting, hiring and training new staff are significant
- Poor continuity of care for children and families
- Difficulty building a cohesive workforce
- Lowers overall morale

Why Did We Create A Partnership?

- Meet Contract Outcomes/Performance Based Contracting
  - Reduce number of placements of children
  - Decrease time in care
  - Increase access to mental health services
  - Meet expectations of settlement agreement in increasing mental health services for children in foster care.

Steps to Building the Bridge

- Create Buy-In For Collaboration
- Identify Curriculums or Evidence Based Practices
- Identify Trainers/Staff to Implement Models of Intervention
- Track data
- Create plan for ongoing implementation/sustainability

Create Buy-In For Collaboration

- Use of Statistics/Facts
  - Statistics on kids in care
  - Improvements seen using evidence based practices
  - Increased revenue (mental health)
  - Better outcomes
  - Reduction of Secondary Trauma

When Finding Partners to Collaborate With:

- Find partners with similar mission, vision, and values
- Find partners with similar outcomes, outcome indicators, outcome based contracts
- Partner with those who seem themselves as change agents and are empowered to make decisions

Learn Each Other's Language!!

Why Collaboration?

- Offers the best services to those we service
  - Brings systems together-less system navigation for our families

- Offers win/win to all entities involved
  - Provide quality service
  - Able to meet outcomes
  - Able to increase revenue
  - Ability to learn each other's system
  - Share and track data
  - Opens opportunities for more funding opportunities

Collaboration between Child welfare and Community Mental Health at TCC:

- Trauma informed training for child welfare staff
- Respite program for the parents whose children are involved in the mental health program, utilizing licensed foster parents.
- Infant/Toddler Foster Care Initiative
- Parenting Skills Training Curriculums

What Collaboration for Trauma Training Looked like: Identify Trainers

- Need to have flexibility within their schedule
  - Production requirements reduced

- Trained Clinicians in Trauma Informed Practice
  - Should have prior training in trauma informed care
  - Be considered a content or subject matter expert
  - Able to manage secondary Trauma as it presents during training
  - Given the prevalence of trauma-trained to manage what the training may trigger in staff

Training was mandatory for all child welfare staff, offered monthly in two half day trainings. During the training, staff were taught to recognize their ability to impact the trauma the child has experienced. Staff were empowered to:

- Recognize that trauma is the rule, rather than the exception in foster care
- Encouraged to not underestimate the impact of **witnessing** violence
- Consider that most children bring a lifetime of chronic trauma, not the event that precipitated the removal
- Gather and document information on all traumas

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- Recognize the signs and symptoms of child traumatic stress, and how they vary in age group
- Recognize that “bad” behaviors are often an adaptation to trauma
- Manage their own personal and professional stress

After the training: Integrating the Information

- Once a month, coordinators meet to discuss any unplanned replacements, request for replacements or children at risk of requests for replacement. During that discussion we assess the reasons for the problem, and determine if it is due to the child's behavior. The supervisor for the therapy unit attends the meetings, in order to help assess if the child is receiving the correct level of care.

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- During supervisions, a child's behaviors are discussed in light of their known trauma, using the language of trauma. As this is assessed, the amount, scope and duration of the therapy they are currently involved in is discussed. If an increase in therapy appears necessary, a follow up discussion occurs with the therapeutic supervisor.
- Children are given the trauma screening as part of the initial intake process, to help worker be aware of where they are.
- Family Team meetings continue this process, carrying the discussion of the child's behaviors through the trauma process.

Respite Services For Children in Mental Health Using Foster Homes

•In 2011, it was determined that Wayne County was in need of a respite program for the children receiving mental health services through the community mental health programs.

•Respite Care is defined by the Medicaid Manual as :

Services provided to beneficiaries unable to care for themselves that are furnished on a short-term basis because of the absence or need of relief of those persons normally providing care.

The purpose of The Children's Center's Respite continuum of service is to support and maintain family stability by providing short-term, planned, respite care within a family home setting in order to prevent unnecessary out of home placements.

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Service Philosophy for respite:

•Temporary, out of home placement of a child with difficult behaviors.

•Designed as a tool to reduce family stress and maintain family stability.

•Enables Foster families that are not willing to take on long term placements, but still willing to assist children, with another option to take children on a very short term basis.

Communication between units is vital:

•To ensure that all of the child(dren)s team members are “kept in the loop”, the following communications are required:

• Document specialist will email clinician when referral has been received.

•Respite Coordinator will email clinician and psychiatrist when a match has been made and meeting has been scheduled between the foster home and respite family. Clinician will be invited to attend that meeting, if that is acceptable with the respite family.

•When each respite date is scheduled, licensing specialist will email Respite Form 116—(Notice of Placement) to the clinician.

•If a placement cannot be made, licensing specialist will email Respite Form 115 (Unable to Place) to clinician.

•Following placement, licensing specialist will email Respite Form 108 (Placement confirmation/discharge form) to clinician and psychiatrist.

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During this year, planned family respite has continued to be provided via our licensed foster parents/homes. We have provided 4 additional homes with training to become respite providers. We currently have a total of 8 foster homes that accept respite placements. 45 children have been referred for respite in the past year. Of those, we have successfully matched 27 with licensed foster homes. These 27 children have used Planned Family respite for a total of 147 days, for an average of 5.4 days per child.

In 70% of the cases where the children were not matched, the parent had changed their mind when contacted by the respite coordinator, and were no longer interested in the program. The other 30% were unable to be matched due to the extreme behaviors of the child. (Sexual acting out, fire setting, aggression.)

Of the children who attended respite, only one child needed intensive residential placement.

Infant/Toddler Foster Care Initiative

- Infant Mental Health Staff trained in Foster Care/Family Court
- Increased visitation between Caretaker and infant/toddler
- Infant Mental Health and Child Welfare Staff observing parenting skills together
- Recommendations for placement jointly made by the Infant Mental Health Staff and Child Welfare Staff

Parenting Curriculums

- Resource Parent Training
  - Teaches skills to parent children that have experienced trauma
    - Taught with a clinician and a Parent Support Specialist
- Parenting Through Change
  - Using Parent Management Training Oregon Model
  - Begin group parenting skills class three months prior to reunification
  - Parenting skills assessed during visitation
  - Follow up session in the home after reunification

Tracking Data

- Survey Monkey
- Internal EMR
- Surveys after Training
- Internal Child Welfare System

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Preliminary Results:

- After one year, 80% of children have been referred and are receiving therapy appropriate to their needs
  - CAFAS scores indicated a drop in score of 10-20 CAFAS points and life domain improvement
- More children are being referred to more intensive therapy services, such as home based and wrap around services
- Number of requests for replacements due to behaviors has dropped 50%. There is a direct correlation between those teens who opt of out therapy and end up being replaced. Intervention is then focused on helping the foster parent in parenting a child that has experienced trauma

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Sustainability

- Maintaining trained staff-building infrastructure
- Ongoing supervision
- Ongoing training
- Using data for grants/funding opportunities


DEVELOPING STRONG CHILDREN AND SUCCESSFUL FAMILIES
Thank You
the CHILDREN'S Center