FFTA Conversations on Family First Prevention Services Act

Conversation #4: Diving Deep in FFPSA Part II – Serving Youth and Families in TFC Foster Care or Congregate Care

Monday August 27, 2018
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Chapter 2: Ensuring the Necessity of a Placement that is Not in a Foster Family Home

- Federal funds will be restricted to children in foster family homes, or in qualified residential treatment programs, or other special settings.

A foster family home that is licensed or approved by the state and provides care to six or fewer children in foster care (exceptions to this limit can be made to accommodate parenting youth in foster care to remain with their child, keep siblings together, keep children with meaningful relationships with the family, and care for children with severe disabilities).
Chapter 2: Ensuring the Necessity of a Placement that is Not in a Foster Family Home

• Beginning October 1, 2019, states must take steps to safely reduce the inappropriate use of congregate/group care for children. States have the option delay the effective date for up to two years; however any state that does so must also postpone seeking Title IV-E prevention investments for the same period of time.
Chapter 2: Ensuring the Necessity of a Placement that is Not in a Foster Family Home

What are qualified residential treatment programs, or other special settings.

- A Qualified Residential Treatment Program (QRTP)
- A setting specializing in providing prenatal, post-partum, or parenting supports for pregnant or parenting youth
- A supervised setting for youth ages 18 and older who are living independently A licensed residential family-based substance abuse treatment facility for up to 12 months.
- A residential setting for youth who have been found to be – or are at risk of becoming – sex trafficking victims.
A Qualified Residential Treatment Programs (QRTP), is defined as a program that:

- Has a trauma-informed treatment model designed to address the needs, and clinical needs as appropriate, of children with serious emotional or behavioral disorders or disturbances, and can implement the necessary treatment identified in the child’s assessment.

- Has registered or licensed nursing staff and other licensed clinical staff who can provide care, who are on-site consistent with the treatment model, and available 24 hours and 7 days a week. The QRTP does not need to have a direct employee/employer relationship with required nursing and behavioral staff.
Stipulations of a QRTP:

A Qualified Residential Treatment Programs (QRTP), is defined as a program that:

- Facilitates family participation in child’s treatment program (if in child’s best interest)
- Facilitates family outreach, documents how this outreach is made, and maintains contact information for any known biological family and fictive kin of the child.
- Documents how the child’s family is integrated into the child’s treatment, including post discharge, and how sibling connections are maintained.
- Provides discharge planning and family-based aftercare supports for at least 6 months post discharge.
- The program is licensed and nationally accredited by CARF, the Joint Commission (JCAHO), COA, or others approved by the Secretary.
Beginning in 3\textsuperscript{rd} week of placement in a setting other than foster family home, child must be in QRTP or aforementioned placement.

(HHS will release guidance on valid assessment tools.)

Within 30 days of placement in QRTP, child must complete assessment that is EBP, age-appropriate, functional and clinical to determine if a child’s needs can be met with family members or in a foster family home.

Assessment must be conducted in conjunction with family and permanency team and if child is 14+, up to two individuals selected by the youth.
The “qualified individual” must develop a list of child-specific short- and long-term mental and behavioral health goals.

If assessment determines QRTP is not appropriate placement, state has 30 days to move the child (and will be reimbursed).

Within 60 days of placement in a QRTP, the Court must review assessment and approve or disapprove of placement.
Protocols to maintain QRTP placement:

For children who remain in a QRTP, at every permanency hearing the state agency will need to submit evidence:

- Demonstrating the ongoing assessment that the child’s needs continue to be best met in a QRTP and it is consistent with the child’s short- and long-term goals.
- Documenting the specific treatment or service needs that will be met by the QRTP and the length of time the child is expected to need those treatment and services.
- Documenting the efforts made to prepare the child to exit care or to be placed in a foster family home.

For children in a QRTP for 12 consecutive or 18 nonconsecutive months (or for more than 6 consecutive months for children under age 13) the state will need to submit to HHS the most recent evidence and documentation supporting this placement with a signed approval by the head of the state.
“Devil” is/is not in the details.

• Restriction on Title IV-E payments does not prohibit payments for administrative expenditures incurred on behalf of the child in a child care institution.

• Accreditation is a concern for HHS. ACF acknowledges that the accreditation requirement for Qualified Residential Treatment Programs (QRTPs) is a tough issue for some states. He stated that there is no flexibility to allow for pending accreditation status nor is he aware of IV-E funds that could be used by states to pay for accreditation. He also shared that HHS is developing a strategy and a plan,

• Transition Support for Waiver Jurisdictions. HHS supports establishing a form of transitional authority to assist IV-E waiver jurisdictions with a transition to FFPSA implementation.
“Devil” is/is not in the details.

• States will need to include in their state plan a certification assuring that the state will **not enact or advance policies or practices that will result in a significant increase in number of youth in the juvenile justice system** because of the new restrictions on federal reimbursement for children not placed in a foster family home.

• States will need to establish as part of their health care services oversight and coordination plan procedures and protocols to ensure that **children in foster care are not being inappropriately diagnosed with mental illnesses, disorders or disabilities** that may result in the child not being placed with a foster family home.
Opportunity/Responsibility for Treatment Family Care

• Children must be served in family settings unless clear evidence suggests that is not in best interest of treatment plan of the child.

• TFC in biological homes, kinship homes, non-relative foster homes, post-adoptive homes: prevention, intervention and reunification or stabilization.

• Shortage of foster family homes is not acceptable reason to place a child in non-family setting.
Opportunity/Responsibility for Treatment Family Care

• The child’s assessment must be done by a “qualified individual”, who is a trained professional or licensed clinician who is not a state employee or affiliated with any placement setting in the state.

• QRTP must provide family-based after care supports for 6 months post discharge.

• Expands the current RPG application requirements to include descriptions of additional substance abuse and treatment goals and outcomes for children, parents and families and requires collaboration with public partners and range of private service providers.
Opportunity/Responsibility for Treatment Family Care

Potential expansion of “service line”

• Growth in CSEC treatment for TFC.
• State grants for Kinship Navigator Programs
• Expertise in the unique needs of kinship families and their roles in prevention, intervention services, and reunification.
Opportunity/Responsibility for Treatment Family Care

Other obligations and responsibilities

• Recruiting and sustaining homes and caregivers

• Higher expectations of TFC homes especially around SUD/OUD impact and CSEC

• Acquisition of necessary skills for working with birth families

• Educating and forming partnerships with others in public and private sectors: child welfare, Medicaid/MCOs, SOC/wraparound, mental health, state and federal Representatives and Senators, CCBHCs, QRTPs, homeless and runaway serving agencies, CSEC serving agencies, churches and community organizations.
Additional supports for older youth transitioning from care

Extends the John H. Chafee Foster Care Independence Program’s independent living services to assist former foster youth up to age 23 (currently available to youth between ages 18-21) and extends eligibility for education and training vouchers for these youth to age 26 (currently only available to youth up to age 23).
• Children must be served in family settings unless clear evidence suggests that is not in best interest of treatment plan of the child.
• Requirements of trauma-specific treatment.
• Development of Evidence-Based Practices.
• Development and competency in SUD/OUD treatment.
• Focus on prevention and reunification needs, interventions, and services.
• Educating and forming partnerships with others in public and private sectors.