



Mental Health Services for the Child Welfare System

EBP Symposium
June 6-7, 2011

Topics

- Trauma informed care
- Collaboration
- Assessment
- Formulation
- Plan of care
- Interventions



Principles of Trauma Informed Care

- Care must be collaborative, supportive, skill-based, and focused on helping children, youth and their parents reclaim control
- Providers recognize that coercive interventions can cause traumatization and retraumatization and are to be avoided.



Principles of Trauma Informed Care

- Utilize a comprehensive assessment of the child's trauma experiences and their impact on the child's development and behavior to guide services
- Support and promote stable relationships in the life of the child
- Provide support and guidance to the child's family and caregivers
- Manage professional and personal stress



Trauma informed service providers

- Appreciation for the very high prevalence of traumatic experiences in persons who receive mental health, child welfare and juvenile justice services
- A thorough understanding of the profound neurological, biological, psychological and social effects of trauma and violence on the individual, and how these effects can translate into a person's everyday behavior
- Commitment to providing care that is collaborative, supportive and skill based



Universal Precautions

- You are likely to encounter survivors of trauma who do not disclose
- Not all survivors are psychologically ready to discuss their experiences
- Assume a trauma history
- Have a standard screening procedure
- When the screen is “positive” practice discussing results with clients
- Refer to evidence-based trauma specific interventions



Useful Strength Based Assumptions

- It is critical to have strength based assumptions in order to respond constructively to a traumatized child
- Most of the time the “manipulative child” is feeling very out of control
- Behavior that may appear to be intentional usually is not – it is more likely reactive, impulsive or the result of limited social skills and emotional competence
- The child needs developmental support – and help in the acquisition of new skills
- Formation of a therapeutic relationship is critical. Elements of a therapeutic relationship: supportive, respectful, friendly, consistent, non-threatening, based on clear expectations and standards



Collaboration

- From case opening until case closing
 - Consultation prior to formal assessment
 - Assessment
 - Ensuring that everyone involved in the child's life is a member of the team
 - Intervention
 - At the very least should involve caregivers, child, teachers
- Requires that the mental health practitioner and the CWS worker have a close working relationship
- The relationship of mental health treatment to achieving the goals in the case plan should be explicit
 - Family, youth, non relative caregivers should be in agreement



Strength-Based Assessment

- Paves the way for strength based practice by focusing on capacities rather than deficits
- Strengths based assessment: the measurement of those emotional and behavioral skills, competencies and characteristics that create a sense of personal accomplishment, contribute to satisfying relationships with family, peers and other adults; enhances one's ability to deal with adversity and stress; and promotes ones personal, social and academic development

» (Epstein and Sharma, 1998)



Strength-Based Assessment

- The focus on strengths does not disregard the presence of needs
- Treatment plans reflect an awareness of both needs and strengths
 - Focus of intervention and methods in which change occurs through the building and development of strengths
 - Which is another way of saying we help children develop skills



Family-Driven Assessment

- It is a **collaborative** process
- It is holistic and seeks to bring together information from all possible aspects of the child and family's life
- It looks for ways to build on the child and family's strengths
- It determines and focuses on the goals of the child and family as they express them
- Assessment should always be presented as an ongoing process
- Evolves throughout the service delivery process



Informants

- Assessments involve interviewing multiple individuals/informants
 - Teachers
 - Physicians
 - Foster parents
- Child welfare worker for an understanding of the case plan and assumptions about how mental health services are expected to help
 - Role clarity



Assess Multiple Domains

- Gathering information about the child and family in multiple domains is an important aspect of the assessment because a child may exhibit different kinds of behavior in different circumstances.
 - Example: disruptive behavior at school but not at home
- Domains include: health, developmental history, home, school, community, culture



Formulation

- A written narrative of the child and family's story
- Describes the family's strengths, culture, challenges, symptoms and child's developmental considerations
- Shared with the child and family to ensure the service provider's understanding is accurate



Formulation

- The writing of the family's story as it relates to the presenting problem, not just the collection of information about it
- Supports the child and family's path to wellness by demonstrating understanding of them
- Includes strengths, hopes, motivations and culture and is family-driven
- Includes description of child's stage of development



Formulation

- As the basis of a therapeutic partnership
- As support for building upon protective factors
- As a demonstration of respect for the family
- As an opportunity for genuine collaboration and communication
- As the basis of a sound relationship between the family and provider



Formulation

- The formulation writing process is a determination and distillation of assessment information
- It involves isolating those details that are important to consider
- Salient details are put together in the form of a narrative
- It demonstrates understanding of the elements, including strengths and cultural awareness, that will contribute to an effective care plan



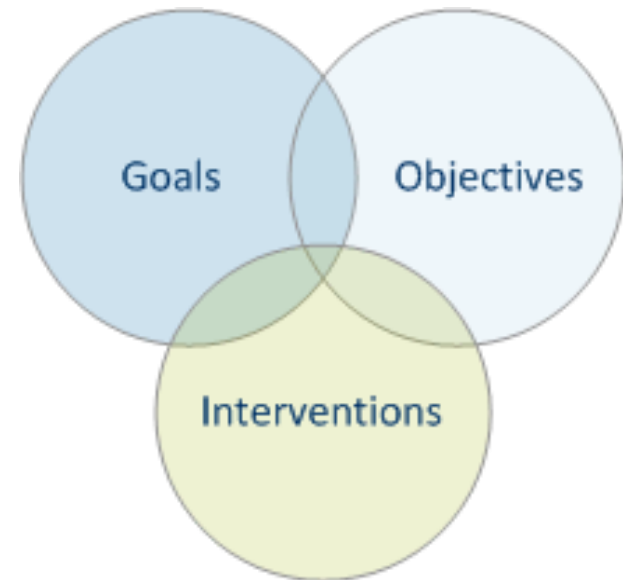
Plan of Care

- A child and family plan of care serves the following purposes:
 - A living document that guides the everyday work the provider(s) and family do together
 - A standard against which to measure progress
 - A “contract” between the family and the provider(s) to guide the work they do together



Plan of Care

- Responds to the assessment
- Spells out actions that will be taken
- Indicates small steps necessary to reach larger goals
- Defines goals, Objectives, and Interventions



Plan of Care

- Re-framing “problems” and “deficits” to needs
- The needs describe the area where mental health services are intended to help
- Example:
 - Problem is aggression
 - Translates to need -- the youth needs help developing skills which provide alternatives to physical aggression
- Prioritize needs
 - Family and youth determine what areas of need are of greatest concern



Identifying Strengths

- Qualities that assist the family or youth in facing challenges and improving overall functioning
- Describes the family's unique skills, values and abilities
- Focus is upon building on strengths to help mitigate need
- Example:
 - Youth who is aggressive also has a great sense of humor and aspires to be an actor
 - Use his aspirations and talent to motivate behavior change



Plan of Care

- Goals form the most important substance of the care plan and they reflect the big picture
- Objectives break down the big picture into smaller pieces
- Interventions are devised to realize objectives



Goals

- Goals are long-term, global, and broadly stated
- Excellent goals build on the abilities, strengths, preferences, and needs of the child and family.
- They embody hope – an alternative to current circumstances



Objectives

- Objectives are specific and must be measured
- Objectives describe changes in behavior, function, or status
- They identify the child and family's desired results
- Besides being culturally inclusive and family-driven, objectives are linked to the increasing of skills and abilities
- Objectives are geared to the child's stage of development



S.M.A.R.T. Objectives

- Simple
- Measurable
- Attainable
- Realistic
- Time-framed



Interventions

- Interventions are specific actions that are incorporated into objectives
- An intervention is an action by staff, family, peers, or others designed to assist the child and family in moving toward their goal



Interventions

- Who: which member of the team or support system will provide the service or support
- What: what specific service/support will be provided
- When: how often and how much time will be involved
- Where: the location of service delivery
- Why: the purpose of doing the action (link the intervention back to the desired outcome)



Plan of Care

- Treatment plans should be revisited and revised on a regular basis
- Use to measure progress and celebrate success
- Partnership and collaboration, the fundamental processes involved in building a treatment plan, will lead to the identification of strengths that can be incorporated into the plan to meet the family's changing needs, address their evolving challenges and achieve their unfolding goals



Plan of Care

- Strengths and needs identified in the assessment process inform intervention decisions
 - There should be no disconnect between the two processes
- Discussion with youth and family regarding possible service delivery options and interventions



Phases of Interventions

- **Engagement**
 - May be the most critical stage as drop out is likely without successful engagement
 - Decrease barriers to participation
 - Increase hope
- **Skill building and coping phase**
 - Helping youth and families develop skills needed to manage without services
- **Generalization**
 - Provide opportunities to practice and relapse prevention



Evidence Based Mental Health Programs for Children and Youth in the Child Welfare System

Why evidence-based practices?

- The ultimate goal of evidence-based services is to decrease the use of out-of-home care, decrease foster care re-entry, and improve youth permanency and well-being
- Children in the child welfare system frequently experience several specific mental health problems that require targeted treatment. The most prevalent problems include PTSD and abuse-related trauma, disruptive behavior disorders (including ADHD), depression and substance abuse



Evidence Based Programs

- Prevalence rates for mental health problems for youth in the child welfare system are 50-75% higher than for youth in the community
- A recent study using national child welfare data demonstrate that children who received usual care mental health services got slightly worse – this was particularly true for children from diverse cultures (McCrae et al., 2010)
 - The authors conclude that usual care services are not adequate for meeting the needs of youth in the child welfare system



Parenting Models

- Incredible Years for children ages 0-12
 - Parenting programs include
 - Baby
 - Early Childhood 2-8
 - School Age – 6-12
 - Child program for children 4-8
 - Child Welfare Outcomes
 - Safety
 - Family/child well-being



Parenting Models

- Parent-Child Interaction Therapy (PCIT)
 - Children 3-6
 - Adaptation for children 4-12 whose parents have been physically abusive
- Child Welfare Outcomes
 - Safety
 - Child/Family well-being



Parenting Models

- Positive Parenting Program – Triple P
 - A multilevel system of parenting and family support
 - Parents of children and adolescents from birth to 16
- Child Welfare Outcomes
 - Safety
 - Child/Family Well-being



Disruptive Behavior

- Triple P, PCIT and Incredible Years
- Functional Family Therapy – FFT
 - 11 to 18 year olds with very serious behavior problems and substance abuse
 - Family intervention
- Child Welfare Outcomes
 - Child/Family well-being



Disruptive Behavior

- Multidimensional Treatment Foster Care – Adolescent, School Age and Preschool
 - Boys and girls ages 3-18
 - Severe emotional and behavioral problems
 - Who would otherwise be in group care
 - Preschool (3-6) program is for young children with 3 prior placement disruptions
- Child Welfare Outcomes
 - Permanency
 - Placement Stability
 - Child/Family Well-Being



Trauma

- Trauma Focused Cognitive Behavioral Therapy – TF-CBT
 - Children ages 3-18 and their caregivers
 - Children who are experiencing significant emotional and behavioral difficulties related to traumatic life events
- Child Welfare Outcomes
 - Child/Family well-being



Trauma

- **Child Parent Psychotherapy**
 - Treatment for trauma exposed children 0-5
 - Child is seen with his/her caregiver and the dyad is the focus of treatment
- **Child Welfare Outcomes**
 - Safety
 - Child/Family well-being



Depression

- **Interpersonal Psychotherapy – Adolescent Skills Training**
 - Adolescents 12-16 with elevated depression symptoms
 - “Teen Talk” – 2 individual and 8 weekly group sessions which focuses on psycho-education and skill building
- **Child Welfare Outcomes**
 - Child/Family Well-Being



Additional Evidence Based Programs

- Not an exhaustive list
- Best resource is The California Evidence-Based Clearing House for Child Welfare
www.cebc4cw.org

