LINN COUNTY DHS CHILD WELFARE
CHILDREN'S MENTAL HEALTH PROJECT

Children in the Child Welfare system often have a history of trauma and abuse. When the family circumstances necessitate removal of the child for their own protection, the child is often traumatized by being separated from their family and home environment. Children who have been traumatized are at high risk for behavioral problems, mental illness and later substance abuse. Once in the Child Welfare system, children who experience multiple placements and frequent changes in caregivers are at an even higher risk for future problems. This project will provide cognitive behavioral interventions and tools for the child and those caring for them that will help the child be more successful in the out-of-home placement. This project is organized around Evidence Based Practices that include Trauma-Focused Cognitive Behavioral Therapy, Cognitive Behavioral Therapy, and Brief Solution-Focused Therapy.

GOALS:

1. To ensure that every child has a mental health assessment within 30 days of being taken into State's custody.
2. To decrease the number of unplanned foster care disruptions.

OBJECTIVE 1

Provide a complete comprehensive mental health assessment to 100% of children in Linn County over 3 years of age who are taken into DHS Child Welfare custody.

This project proposes to evaluate all of the children older than three years old who are taken into the Child Welfare System within 30 days of placement. Children younger than 3 years old will be screened by DHS and referred to the Early Intervention Program, as necessary.

All children coming into care are staffed by the DHS Child Welfare caseworker at a care coordination meeting attended by a Mental Health Qualified Mental Health Professional (QMHP) therapist. The mental health therapist and a DHS Child Welfare supervisor review the weekly list of children who are in care to insure that all children receive evaluation.

Once evaluated, children who demonstrate the need for mental health treatment will receive services by a QMHP therapist who will make the clinical determination of which Evidence Based Practice (EBP) will best meet the child's needs. Those children who are not demonstrating symptoms of a mental health disorder at the time of assessment and their caregivers will receive education

about possible consequences of the child's experience and what behaviors would indicate a need to re-connect with the therapist.

OBJECTIVE 2

100% of children who are assessed as appropriate will be provided Mental Health services to help the placement be successful.

This project proposes to provide the child and their caregivers with the knowledge and skills to address any behavioral or emotional issues that occur while the child is in foster care. The Mental Health Toolkit is based upon the evidenced based practice (EBP) of Trauma Focused Cognitive Behavior Therapy as described by Esther Deblinger et. al. from the Medical University of South Carolina (www.Tfcbt.musc.edu). It will be provided as part of the treatment for children who are demonstrating problems at the time of the initial assessment.

The Mental Health Toolkit will be individualized for each child and caregiver, although it may have similar components. The specific Evidence Based Practice and tools presented to the child and their caregiver as part of the treatment will be based on the child's individual needs and circumstances and will be determined by the QMHP providing services to the child.

Some of the components of the Mental Health Toolkit are as follows:

A. **Psycho-education regarding stress, trauma and abuse**. Children are often taken out of their homes due to abuse or neglect and they often do not understand the situation. The confusion that many of these children experience causes undue stress and behavioral problems. These children express their distress in some fairly common ways (screaming, swearing, defying, hitting, spitting, throwing things, breaking things, crying, withdrawing and so forth). These behaviors are best understood as a lagging of cognitive skills (rather than, or example, as attention-seeking, manipulation, limit-testing, or a sign of poor motivation). This intervention is not to make the child talk about what happened but rather to educate the child and their caregiver about how the child's experience, whatever type of abuse it may have been, can affect children. As part of this education, the child and their caregiver will learn about how the experience affects children emotionally and behaviorally as well as why it is so difficult for children to talk about.

B. **Tools to manage stress and anxiety**. Children are often developmentally unable to put their feelings and stress into words and will more often act these things out, which causes problems in the home. This part of the Mental Health Toolkit provides the child and their caregiver's practical strategies to manage the stress and anxiety that are extremely common in children who have been traumatized and are separated from their family

and home. These skills are simple and easy to use, such as Controlled Breathing, and provide useful tools for the child and caregivers to use at home. Children should not be encouraged to talk about their distressing experiences until they have mastered the ability to manage their anxiety.

C. **Emotional Expression and Regulation:** Stressed and traumatized children often act as if their feelings are in control instead of them. They can learn to identify, rate and adjust their feelings even at a young age. The child and their caregivers are provided with coaching on identifying different feelings in themselves and others and different ways to talk about their feelings without being overwhelmed. They explore ways to express a range of feelings with varying levels of intensity appropriately.

D. **Cognitive Coping:** Children often confuse thoughts and feelings which can lead to thinking errors and other dysfunctional ways of coping with stress. The child and their caregivers learn the difference between thoughts and feelings; explore how thoughts, feelings and actions are related, and how to change thinking to change behavior. Part of this may include exploring beliefs, automatic thoughts and inaccurate messages from others.

E. **Behavior Management Training.** This module utilizes the EBP of Collaborative Problem Solving, which is based upon the work of Ross Green (http://www.explosivechild.com/). Oftentimes caregivers for children who have been abused or neglected are reluctant to provide behavioral guidance for these children; sadly they often need it the most. These children express their distress in some fairly common ways (screaming, swearing, defying, hitting, spitting, throwing things, breaking things, crying, withdrawing and so forth). Traumatized children sometimes do not respond to common behavioral management strategies as do other children. Rather, these challenges are best addressed by teaching children the cognitive skills they lack.

   The adult caregivers learn to resolve disagreements and disputes in a collaborative, mutually satisfactory manner by developing negation skills. They are taught to identify and understand the child's concern about an issue and to reassure the child that the imposition of "adult will" is not how the problem will be resolved. The second step is to identify the adult's concerns on the same issue. The final step is where the child is invited to brainstorm solutions together with the adult, with the ultimate goal of agreeing on a plan of action that is both realistic and mutually satisfactory.

F. **TRAUMA NARRATIVE.** Some of the children will be assessed to have symptoms of post-traumatic stress disorder. These children will have nightmares or react fearfully to reminders of their victimization. If these symptoms do not decrease naturally, children may try to control these

symptoms by using unhealthy patters of avoidance. This intervention will teach children healthier ways to manage and control the upsetting aspects of their traumatic experiences. This intervention will only be offered to children who have mastered the skills outlined above in the MENTAL HEALTH TOOLKIT.

During this phase of treatment, the child's caregivers are evaluated regarding their readiness to participate in joint sessions. When appropriate, the caregivers are helped to develop skills for responding appropriately when the children discuss traumatic events. The caregivers are taught to promote positive, healthy communication and they are given tools to continue the therapeutic work at home after the end of treatment.

The child will be helped to construct a narrative (a way express what happened to them) in a format that is an individualized format (book, pictures, song) for the child. The child may then share their narrative their parents.

Next, the child is helped to explore their thinking / cognitions related to their traumatic experience. The child and family are helped to correct inaccurate beliefs related to the trauma. Caregivers are helped to examine their own thoughts about the child's traumatic experience for both accuracy and helpfulness and they are taught how to effectively challenge the child's cognitive errors.

OBJECTIVE 3

95% of the "Get Back on Track" interventions (Solution Focused Therapy) will be provided within one workday of the request by the foster family.

Children in care and their foster parents possess significant positive skills and strengths. The skills taught in the Mental Health Toolkit described above support these strengths. In turn, the common consequences of child victimization include disruptive, aggressive, and non-compliant behavior. The "Get Back on Track" intervention is designed to support the caregiver system to use the skills they have learned to negotiate the distress of a crisis.

The therapist will be available to respond quickly to the foster family's call for help in order to prevent the situation from escalating. The goal will be to respond within one work day.

The therapist will be guided by the EBP of Solution Focused Therapy (http://www.brieftherapy.org.uk/). The therapist is likely to do the following:

a. Instead of going over past events and focusing on problems, the therapist helps the family envision their future without today's problems.
    - "If a miracle happened and you were acting the way you want to, how would you be acting differently?"

b. During the course of therapy (often as few as 3 – 6 sessions, the therapist helps to discover solutions.
    - "When you are doing what you want (or when the problem is solved), what will you be doing differently?"
c. The therapist encourages the family to identify and do more of what is already working.
    - "When doesn't the problem occur?"
    - "Tell me about the times when you act a little that way now."
d. The therapist works to make things better or stop them from getting worse.
    - "When doesn't the problem happen?"
e. The therapist believes that the child and caregivers are the experts about what it takes to change their lives.
    - Therapist looks for what is working and looks for positives to reinforce.
    - Therapist compliments family – giving them credit for the changes they have made.
f. There is no failure, only feedback.

NEXT STEPS

1. Using Prevention, Education and Outreach (PEO) funds from the Mid-Valley Behavioral Care Network (MVBCN) our program is going to develop a foster parent training based upon the Trauma Focused CBT toolkit. The class will be offered to new foster families as a supplement to the regular foster parent training that is provided by DHS.

2. Implement the EBP of Parent Child Interactive (http://www.nctsn.org/nctsn_assets/pdfs/promising_practices/PCIT_fact_sheet_2-11-05.pdf)

    PCIT targets children ages 2-7. Its goal is to improve the quality of the parent-child relationship by fostering positive interaction patterns. It involves live-coaching in specific skills as the caregiver interacts in specific play with the child.