CONSIDERATIONS IN CHILDREN’S MENTAL HEALTH

APPLICATIONS FOR CHILD WELFARE AND MENTAL HEALTH PROFESSIONALS

WACASA CONFERENCE - OCTOBER 2016

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INTRODUCTIONS

CREATING CONNECTIONS
A partnership between University of Washington, Children’s Administration and Division of Behavioral Health and Recovery

Improve the social and emotional wellbeing, safety, and permanency of children and youth in out-of-home care by helping them get their mental health needs identified and met.

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Thank you to collaborators

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OUTLINE FOR TODAY

Grant introduction
Tools you can use
Understanding mental health
Resources
Common goals
Creating Connections
Conceptual Framework

Setting Common Goals
Create a common language between child welfare, mental health, and families to enhance engagement in effective services.

Screening
Embed tools that screen for trauma into existing screening processes.

Progress Monitoring
Screen children and youth for mental health needs at regular intervals after entering out-of-home care and track their progress.

Strategies
- Training
- Screening and referral
- Evaluation
- Dissemination

Referral for Mental Health Treatment
Increase social worker confidence in identifying mental health behavior problems for child welfare involved children, youth and parents.

Service Array Reconfiguration
Increase use of data to support system level planning that aligns EBP capacity building with the mental health needs of children and youth in care.
SNAPSHOT OF THE SYSTEM

In October 2015...

10,108 Concern calls received

3,741 Required a CPS response

511 Children/youth entering out-of-home care

378 Children/youth leaving out of home care

244 Children/youth reunified

97 Children/youth adopted

8,895 Children in out-of-home placement

Source: Children's Administration Monthly Metrics Trends
HOW DOES MENTAL HEALTH FIT?

Safety

Wellbeing

Permanency
CHILDREN AND YOUTH IN WASHINGTON STATE

IN FY11, 52% OF CHILDREN (AGES 3 - 17) THAT WERE FLAGGED FOR A POTENTIAL MENTAL HEALTH CONCERN ON THE CHILD HEALTH AND EDUCATION TRACKING (CHET):

- 55% Received a Public MH Service in the Same Year
- 63% Diagnosed with a Mental Illness in their Lifetime
- 24% Perscribed Psychototropic Medication
CATCH THE SMOKE BEFORE THE FIRE
CHET TOOLS

**Ages and Stages Questionnaire – Social Emotional (ASQ-SE)**
- Age of child: 3 months – 66 months old
- Screens for social or emotional difficulty (self regulation, etc.)
- Completed by the parent, caregiver, teachers, and other important adults

**Pediatric Symptom Checklist – 17 (PSC-17)**
- Age of child: 66 months – 17 years old
- Screens for emotional and behavioral health problems including: internalizing, externalizing, attention problems
- Completed by the child, youth, parent, and caregiver

**Screen for Child Anxiety Related Emotional Disorders (SCARED) aka Trauma Tool**
- Age of child: 7-17 years old
- Screens for anxiety and post-traumatic stress
- Completed by either the child, youth, parent, or caregiver

**Global Appraisal of Individual Needs – Short Screen (GAIN-SS)**
- Ages of child: 13 – 17 years old
- Screens for internalizing, externalizing, substance abuse, and co-occurring disorders.
- Only screen that asks about suicide
- Completed by the youth
Age 3 – 17
In out-of-home care for 30+ days and received CHET screening
SFY 2011-2013
TOTAL = 5,507

POSITIVE
53% n = 2,943
Referral to MH services recommended

NEGATIVE
9% n = 476
But recommended for MH services (override)

NEGATIVE
38% n = 2,088
Referral to MH services not recommended

Mental Health services received within four months?

Yes
59%
59%
52%
33%

No
41%
48%
48%
33%

NOTE: Excludes medication-only services. Services include any Medicaid-funded mental or behavioral health services including outpatient treatment, drug/alcohol assessment, residential, crisis stabilization, hospitalization, CLIP, and tribal services. MH services directly provided by funding or contracts with Children’s Administration are not depicted here and likely account for a significant number of additional youth receiving services, preliminarily estimated at 4-6 percent.
CULTURE OF FOSTER CARE

What can you do?
Consider the self-talk they might engage in.
Things I Wish My Therapist Knew

Creating Connections
Foster Care Alumni Survey Results

95% had mental health services while in foster care (12 Alumni Surveyed)

Alumni say successful counseling provides:
- Trauma Informed Treatment Plans
- Accessibility to Services
- Medication & Diagnoses Education

Barriers/crisis(es) experienced
Lack of transportation, separation from siblings, abuse/neglect, frequent placements

"I may be in the foster care system, but I am still a person."
"Not all young people need anti-depressants or medications."
"Try to be understanding and fit into our shoes."
-Foster Care Alumni

Listen

Suggested activities for foster youth
- Sports
- Independent Living Program (ILP)
- Group Therapy (Family, other foster youth, etc.)
- Alternative therapy (music, art)

To learn more on how to support foster youth & alumni visit independence.wa.gov
ADVERSE CHILDHOOD EXPERIENCES (ACES)

Mechanisms by Which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan
WHAT IS TRAUMA?

Acute Trauma

- Exposure to a single traumatic event that is limited in time (e.g. a natural disaster, death of a loved one)

Chronic Trauma

- Repeated exposure to traumatic events (chronic physical or sexual abuse, chronic neglect, domestic violence, etc.)

Complex Trauma

- Describes both chronic trauma and the immediate and long-term impact of exposure
CHILD OR YOUTH RESPONSES TO TRAUMA
CAUSES FOR CONCERN

Birth - Toddlers
- Difficulty coping with loss
- Unable to cope, manage emotions
- Quickly dysregulated when talking about the ‘event’ (i.e. quickly shift activities – become more active, engage in nurturing play, show signs of aggression, etc.)

Pre-School - School Age
- Regressive behaviors
- Clingy, unwilling to separate from familiar adults
- Resist leaving or afraid to go to places
- Significant changes in eating/sleeping habits
- Complain of physical aches and pains
- Bedwetting
- Attention-seeking behaviors

Pre-Adolescent and Pre-Adulthood
- Place more importance on peer groups and has abrupt changes of relationships
- Rebel against authority
- Feel immune to physical danger
- Isolation and reluctant to talk about feelings
- Have flashbacks, nightmares, emotional numbing
- Express shame about feeling afraid
Increased Risk for Clinically Significant Trauma Impact

Feeling terror, helplessness, or extreme fear

Prior Trauma History

Chronic Traumatic Events

Little or no social support after the event

Prior Psychological Problems

Perceived Life Threat During the Event
Although
... Not all children and youth who experience traumatic events develop symptoms of Post Traumatic Stress Disorder (PTSD)

- Kolko, et. al (2010) found among children in the child welfare system, the prevalence of PTS symptoms only 11.7%
COMMON MENTAL HEALTH AND BEHAVIOR CHALLENGES

Trauma
Re-experiencing, Avoidance, Hyper-arousal

Externalizing “Acting Out Behaviors”
Fighting, rule breaking, not listening, anger outbursts

Internalizing “Feelings or Emotional” Behaviors
Depression, anxiety (including responses to trauma)

Attention Challenges
Trouble paying attention, acting impulsively
QUALITIES AND CHARACTERISTICS OF CBT

- Short-term treatment with clear goals – less than 6 months in most cases
- Therapist is guided by principles or a manual
  - Therapist is directive, though client has input
- Education
  - Teaching about why symptoms developed and how maintained (e.g., lying, hoarding)
- Connecting thoughts, feelings, and behavior
  - Analyzing and ‘correcting’ inaccurate or unhelpful thoughts to feel better (e.g., “It’s my fault I’m in foster care.”)
- Parenting skills/Behavior management
  - Rewards, ignoring, consequences
  - Skills are taught and practiced in session with homework assigned for practice outside of session
- Coping Strategies
  - Breathing, relaxation, coping statements (“Stay calm. Take 5 deep breaths.” “It’s not my fault.”)
EXTERNALIZING “ACTING OUT” BEHAVIOR CHALLENGES

Area of Difficulty: Rule breaking, anger outbursts, not listening, aggression, etc.

Principle: Behavior is reinforced by the environment and/or people. The solution requires changing the response in the environment.

Behavior Therapy:

• The parent or caregiver’s participation is required!
  • Change and improve their response to, and supervision of, the child or youth’s behavior

• Therapist may also work with the child
  • Teach problem solving skills and skills for dealing with angry feelings
  • However, therapist-child work is not the most important ingredient

Examples:

• Parent-Child Interaction Therapy (PCIT)
• Functional Family Therapy (FFT)
INTERNALIZING “FEELINGS OR EMOTIONAL” CHALLENGES

Area of Difficulty: Depression (sadness), anxiety (worries and fears), trauma related responses or problems
Principle: Learn how thoughts, feelings, and actions relate

Cognitive Behavior Therapy:
• Emphasizes the connection between thoughts, feelings, and behaviors
  • Increase positive activities and change inaccurate/unhelpful thoughts
  • Helps teach coping strategies and skills to help children learn and manage their own emotions
• Individual work with the child or youth
  • Some caregiver involvement necessary to increase awareness of internal stress and support child in adopting new skills

Example:
• Trauma-Focused CBT
ATTENTION CHALLENGES (ADHD)

Area of Difficulty: Trouble paying attention, impulsive behavior, trouble sitting still

Principle: Therapy with medication is often the most effective treatment

Behavior Therapy & Medication Treatment:

• Behavior therapy without medication may not be very helpful
  • If a youth has internalizing and/or externalizing problems, consider Cognitive Behavior Therapy (CBT) or Behavior Therapy (BT)
WASHINGTON ANTIPSYCHOTIC MEDICATION USAGE

Compared to the other 9-states, **WA had the lower percentage of foster children and youth using antipsychotics medication**

Foster children and youth are more likely to be on multiple meds and to receive doses that exceed recommendations

<table>
<thead>
<tr>
<th>Foster Care Status</th>
<th>Antipsychotic</th>
<th>Mental Health Drug</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>WA</td>
<td>9-State Average</td>
</tr>
<tr>
<td>Foster Care</td>
<td>6.2%</td>
<td>14.0%</td>
</tr>
<tr>
<td>Non-Foster Care</td>
<td>1.0%</td>
<td>1.8%</td>
</tr>
</tbody>
</table>

Medicaid Medical Directors Learning Network – Antipsychotic Medication Use in Medicaid Children and Adolescents (2009)
# MEDICATIONS ACROSS THE BUCKETS

<table>
<thead>
<tr>
<th>Externalizing</th>
<th>Internalizing</th>
<th>Attention</th>
</tr>
</thead>
<tbody>
<tr>
<td>FIRST CHOICE: Psychosocial interventions</td>
<td>FIRST CHOICE: Psychosocial interventions</td>
<td>FIRST CHOICE: Psychosocial interventions + medication</td>
</tr>
<tr>
<td>Medications, in limited circumstances, can be effective and as the last resort</td>
<td>Medications can be effective</td>
<td>Medications can be very effective</td>
</tr>
<tr>
<td>Medications should be paired with psychosocial interventions</td>
<td>Medications should be paired with psychosocial interventions (preferably CBT)</td>
<td>Some psychosocial treatments can be beneficial, but therapy with medication is the most beneficial.</td>
</tr>
<tr>
<td>RED FLAG: Under 6yo</td>
<td>RED FLAG: Under 6yo</td>
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Consult with Apple Health Core Connections Care Coordinators for medication consultations 1-844-354-9876
CA Informed Consent Process

- Must have **biological parent permission** for the administration of psychotropic medication.
- If parent is unavailable, unwilling or unable to consent, the SW shall **obtain a court order**.
- If over age 13, youth must consent to the administration of their own medications.
- Over age 13 youth also have the right to confidentiality of information.
CONSIDERATIONS FOR INVOLVING CAREGIVERS IN TREATMENT

What can you do?

- Emphasize to caregivers how they are pivotal to improving child/youth resilience
- Facilitate reciprocal supportive relationship between child and caregiver.
- Suggest home, school, community-based therapy sessions whenever possible
- Whenever possible, attend CW meetings- FTDM’s, shared planning, etc.
- Provide resources on other community supports
CULTURAL CONSIDERATIONS

What can you do?

- Honor cultural traditions
- Respect confidentiality and privacy
- Build ally-ship
- Inquire about cultural identity
- Address cultural differences with placement
- Review talking points to be discussed with parents/caregivers with youth
LGBTQ CONSIDERATIONS

What can you do?

- Use chosen pronouns and names
- Respect confidentiality and privacy
- Build ally-ship
- Reflect chosen pronouns and names in your intake paperwork
- Ask before you “out” them
- Review considerations to be shared with parents/caregivers with youth first

Recommendations from Outspoken Speakers Bureau, a program of The Northwest Network of Bisexual, Trans, Lesbian & Gay Survivors of Abuse
CHILD AND FAMILY WELFARE SERVICES (CFWS) SPECIFIC FACTORS

- Transitions
- Court Participation
- Permanency Plan
- Visits
- Time with Siblings
- Visits with other Important Relationships
EXPERIENCES

Things I Wish My Therapist Knew...
I AM AN ADVOCATE FOR MH TREATMENTS FOR CHILDREN AND YOUTH ... NOW WHAT?

Things to Consider:

1. Specific mental health or behavior health need/s
2. EBPs available in the area
   • Consider child or youth’s age
   • Family preferences (e.g., group v individual)
   • Who delivers this service?
3. Consideration to engagement
   • Engages and involves parents in treatment (to varying degrees)
   • Accommodates parent needs
   • Collaboration with family, child, youth, and SW
4. Provide all available collateral information at the point of referral

For children birth to age 3, Department of Early Learning’s Early Support for Infants and Toddlers (ESIT) offers great resources, visit: http://www.del.wa.gov/development/esit/

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1-844-354-9876
WHY IS BEING TRAUMA-INFORMED ESPECIALLY IMPORTANT FOR FOSTER CHILDREN?

Almost all of have multiple trauma exposure and adversities (aka complex trauma)

Communicates that the provider and the organization are aware of and interested to know about the especially difficult life experiences of children/youth

Providers can be supportive and validating, and can normalize even when foster youth do not have a trauma-specific diagnosis

Ensures that children/youth get the best possible care
DISCUSSION

How do we continue the conversation between mental health and child welfare that holds the child and family at the center?
What do you already do to collaborate?

- What are some of the individual supports available for the youth?
- What resources are available?
- What has been successful for you?
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