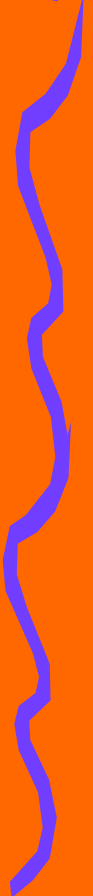


A Guide to Evidence- Based Mental Health Practices for Children, Adolescents & their Families



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Read the electronic
version of the report



<http://sccmha.org/quality.html>



Why?



- Federal, state and local EBP priorities
 - Federal (1999)
 - Surg. Gen Rpt.
 - SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP)
 - Saginaw (2004)
 - EBP Research Reports
 - A starting point to know what options are available
 - System transformation efforts / culture shift
 - State (2005)
 - Mich. Mental Health Comm. Final Report
 - MDCH EBP Initiatives



Core Values

- **Child-Centered** (target multiple domains)
- **Family-Focused** (full partners in planning & service delivery)
- **Community-Based** (natural supports in home community)
- **Collaborative & Integrated** (SOC)
- **Culturally Competent** (recognition & respect for behavior, ideas, attitudes, values, beliefs, customs, language, rituals, ceremonies, practices)
- **Holistic** (context of family, community, culture)
- **Individualized Services & Supports** (rather fitting into existing ones)
- **Strengths-Based** (capabilities, resources, strengths harnessed to facilitate families' abilities to help themselves)



Evidence-Based Practices

- The research base on risks, effective prevention strategies, and interventions for children, adolescents and their families is rapidly developing but lags behind the base of empirical evidence of interventions for adults with mental illnesses
- There is a significant gap between the knowledge base of effective interventions and what is actually practiced in everyday settings



- There is a lack of consensus on criteria for EBPs
- The same practices are rated differently by various consensus panels, organizations, and experts
- Current challenges:
 - Transporting evidence-based practices to everyday clinical practice (moving science to services)
 - Adapting interventions for individual families and children
 - Training clinicians
 - Maintaining fidelity to intervention protocols



- Evidence-based practices are not available for all needs and problems
- Even when evidence-based practices are available, they do not always produce beneficial outcomes for all children and families
- Common to all proposed criteria for determining evidence:
 - A focus on data-based empirical support (scientific validation) to ensure that scientific investigations include adequate research methodologies, sufficient power to detect meaningful differences, and statistically significant findings



EBP Criteria (APA)

Well-Established Treatments

I. At least two good group design studies, conducted by different investigators, demonstrating efficacy in one or more of the following ways:

- A. Superior to pill or placebo or to another treatment.
- B. Equivalent to an already established treatment in studies with adequate statistical power.

OR

II. A large series of single case design studies demonstrating efficacy. These studies must have:

- A. Used good experimental design and
- B. Compared the intervention to another treatment as in I. A.

Further Criteria for Both I and II:

III. Studies must be conducted with treatment manuals.

IV. Characteristics of the consumer samples must be clearly specified.

Probably Efficacious Treatments

I. Two studies showing the treatment is more effective than a waiting-list control group.

OR

II. Two studies otherwise meeting the well-established treatment criteria I, III, and IV, but both are conducted by the same investigator.

OR

One good study demonstrating effectiveness by these same well-established treatment criteria.

OR

III. At least two good studies demonstrating effectiveness but flawed by heterogeneity of the consumer samples.

OR

IV. A small series of single case design studies otherwise meeting the well-established treatment criteria II, III, and IV.



Weighing the Evidence

- At least 2 RCTs with $N \geq 30$ - independent replication
- Published in peer-reviewed journals
- High quality meta-analyses, systematic reviews of RCTs
- Demonstrated sustained effectiveness in everyday practice settings
- Theory - explains why the practice works
- Manualization
- Fidelity measurement tool



Promising Practices

- The intervention has a basis in established theory
- The model of treatment is well articulated
- The practice has the capacity to address multidimensional problems
- The intervention is based on quality evaluative research
- The practice has the potential to be replicated and/or implemented in everyday practice settings



Impact of Culture

- Children of color are underserved by the mental health system
- Children and families from minority cultures bear a disproportionate burden from mental health problems
- Children and families from minority groups experience poorer treatment outcomes



Family Effectiveness Training (FET)

- Hispanic/Latino children 6 - 12 in transition to adolescence
- Addresses family functioning, parent-child conflicts, or cultural conflicts between children and parents
- Includes both didactic lessons and participatory activities designed to assist parents in mastering effective family management skills



Interventions include:

- Using bicultural skills to promote bicultural effectiveness
- Brief Strategic Family Therapy (BSFT)
- Educating parents about normal adolescent development
- Promoting effective parenting skills
- Promoting family communication, conflict resolution, and problem-solving skills
- Providing information on substance abuse to parents



Outcomes

Reductions in:

- Conduct problems
- Associations with peers who engage in antisocial behaviors

Improvements in:

- Family cohesion
- Cultural understanding
- Self-concept



The Family



"Mental healthcare is dispersed across multiple systems: schools, primary care, the juvenile justice system, child welfare and substance abuse treatment. But the first system is the family..." (Satcher 2000)



Working with Families

Families are full participants and collaborators at all levels, including program design, evaluation, implementation and service delivery, within a paradigm of mutual respect and power-sharing that serve as a guide to the design of services and supports



Family-Provider Collaboration

- Recognition of the family as a primary resource
- A caring, non-blaming position in relation to the family; recognition of the family's limitations and other responsibilities
- Shared responsibility and power in provider-family relationships (joint problem-solving and decision-making)



- Clear and open information sharing (complete, unbiased information with consumers and family members in a manner that is affirming and helpful)
- Practical assistance to enhance the family's access to services and supports
- A readiness to change services and supports pursuant to feedback from family members



Family Therapy

- **Structural:** designed to restore family boundaries and equilibrium
- **Strategic:** reframes perceived problems to provide new perspectives
- **Milan Systemic:** positively connotes family relationships to alter interactions
- **Narrative:** families are taught to construct new stories and ways of interpreting events
- **Psychoeducational:** a combination of behavioral and structural techniques to teach relatives about the causes and courses of a family member's mental illness and helpful ways to respond and decrease expressed emotion (EE). Relatives' groups and family sessions used.
- **Behavioral:** uses operant conditioning, contingency contracting, communication training, problem-solving skill development techniques
- **Brief Solution-Focused:** promotes increases in a family's focus on solution patterns and decreases their focus on problems



Brief Strategic Family Therapy (BSFT)

- Short-term
- Problem-focused
- Modifies maladaptive patterns of interaction
- Uses a structural family systems framework to improve family interactions
- Ages 6-17, multicultural
- Displaying or at risk for behavior problems, antisocial peer affiliations, early substance use, conduct problems, problematic family relations



Components of BSFT

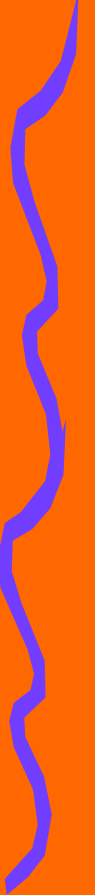
- ***Joining***: engaging and entering the family system, understanding resistance and engaging the family in therapy
- ***Diagnosis***: identifying ineffective / maladaptive interactions, family strengths, interactional patterns that promote problematic behavior
- ***Restructuring***: transforming ineffective / maladaptive interactions, developing a specific plan to help change maladaptive family interaction patterns by working in the present, reframing, dealing with alliances and boundaries



Outcomes

Significant reductions in:

- Symptoms of conduct disorder
- Aggressive behaviors
- Offender recidivism
- Improved family relationships



The Maudsley Method

- Phase I (sessions 1-10)
 - Focuses on empowerment and eating
 - Places parents in charge of adolescent's eating behavior
 - Makes food the medicine to be administered
 - Parents function as doctors who administer the remedy
 - Parents form alliance around re-feeding and agree to consistently enforce unvarying rules related to food
 - Clinician externalizes the illness by presenting the eating disorder as controlling the consumer to free parents and consumer from blame
 - Control of eating behaviors through functional rewards (e.g., not allowing the adolescent to obtain a driver's license until they regain their strength) rather than force or punishment



- **Phase II (sessions 11-16)**

- Shift locus of control of feeding process back to the adolescent
- Address related family problems

- **Phase III**

- Encouraging adolescent development; unfolds as the anorexia nervosa abates
- Establishing new family relationships extricated from the eating disorder.
- Once consumer maintains a stable weight of about 95% of ideal weight without substantial parental supervision, individual therapy is started to focus on issues (identity, independence, and development of appropriate family boundaries and anxieties surrounding adolescence) that have been avoided by having an eating disorder

Outcome studies: beneficial for 2/3 of participants x 5yrs



Functional Family Therapy (FFT)

- Manualized
- Multisystemic prevention and intervention
- 11 – 18 Y/Os and younger siblings at risk for or displaying delinquent behaviors, violent behaviors, substance use/abuse, conduct disorder, oppositional defiant disorder, disruptive behavior disorder



- Short-term (8 - 12 one-hour sessions for mild situations, 26 - 30 hours for more difficult situations x 3 months)
- Can be conducted in clinical settings, juvenile courts, and during transitions from institutional settings, or as a home-based intervention by 1 clinician or a 2-person team
- Outcomes:

Significant reductions in symptoms of conduct disorder, aggressive behaviors, offender recidivism, improved family relationships



Home-Based Behavioral Systems Family Therapy

- Families with children who have committed or at risk for juvenile offenses and engaging in substance abuse
- Ages 6 - 18
- Based on Functional Family Therapy
- Psychoeducational



- Conducted in five phases:

1. Introduction/Credibility
2. Assessment
3. Therapy
4. Education
5. Generalization/Termination



- Outcomes:

- Reductions in involvement in the juvenile justice system, self-reported delinquent behaviors, teen pregnancy, special class placement, family conflict, recidivism, out-of-home placements
- Increases in family cohesion, graduation rates, employment
- Improvements in communication, parental monitoring, discipline, and support of appropriate child behavior, problem-solving abilities, parent-school communication, school attendance, grades, child adjustment



Multisystemic Therapy (MST)

- Intensive, home and community-based family intervention
- Children/adolescents with hx of chronic offenses, violent behavior, substance abuse
- Addresses individual child, family, peer group, school, neighborhood, community supports
- Provided by teams of master's prepared therapists who receive supervision from an on-site doctoral level clinician



Principles of MST

- The primary purpose of the assessment is to understand the "fit" between the identified problems and their broader systemic context
- Therapeutic contacts emphasize the + and use systemic strengths as levers for Δ



- Interventions:

- Designed to promote responsible behavior, decrease irresponsible behavior among family members
- Present-focused and action-oriented, targeting specific, well-defined problems
- Target sequences of behavior within and between multiple systems that maintain the identified problem
- Developmentally appropriate / fit the developmental needs of the youth



- Designed to require daily or weekly effort by family members
- Efficacy evaluated continuously from multiple perspectives
- Providers assume accountability for overcoming barriers to successful outcomes
- Designed to promote treatment generalization and long-term maintenance of therapeutic change by empowering caregivers to address family members' needs across multiple system contexts



Outcomes

- Reductions in re-arrests, out-of-home placements, mental health problems, long-term criminal offender behavior, significant improvements in family functioning
- Very cost effective



Parent Management Training (PMT) Programs

- Teach parents to manage their children's behavior problems at home and in school
- Based on research indicating that ineffective/maladaptive parent-child interactions, especially in disciplinary practices, foster and maintain children's conduct problems



- Use operant principles of behavior change and instructs parents to monitor and track both prosocial and problem behaviors and reward those that are incompatible with deviant behaviors, while ignoring or punishing deviant behaviors
- The most effective parent training programs use a combination of written materials, verbal instruction in social learning principles and contingency management, modeling by the clinician, behavioral rehearsals of specific skills



Outcomes

- 1 of the most extensively studied interventions
- Reductions in oppositional, aggressive, antisocial behavior
- More effective and enduring in reducing antisocial behavior and increasing prosocial behavior than other interventions (e.g., family therapy, play therapy, etc.).
- Beneficial effects maintained for yrs following cessation of tx and generalize to areas not focused on during tx (e.g., sibling behavior, marital relationships).
- Relatively low cost
- Rapid response rate (improvements seen w/in 3 months)



Examples of PMT Programs

- Parent Management Training-Oregon Model (PMT-O)
- Parent-Child Interaction Therapy (PCIT)
- The Incredible Years
- Parenting Wisely (PW)
- Helping the Non-Compliant Child

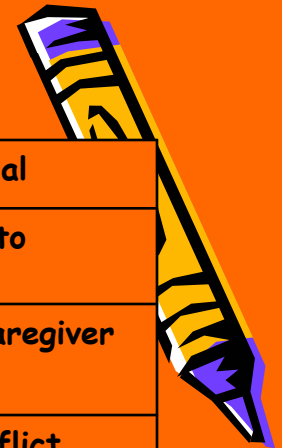


Prevention & Early Intervention

- Mitigate risk factors
- Enhance Protective Factors
- Build Resiliency



Risk Factors



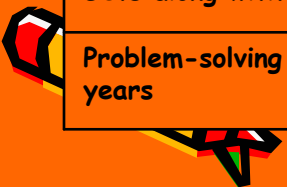
Child	Family Characteristics	Family/Experiential
Fetal drug/alcohol effects	Poverty	Poor infant attachment to mother
Premature birth or complications	Large family; 4 or more children living in overcrowded space	Long term absence of caregiver in infancy
"Difficult" temperament	Siblings born within 2 years of the child	Witness to extreme conflict, violence
Shy temperament	Parental mental illness, especially maternal depression	Substantiated neglect
Neurological impairment	Parental substance abuse	Separation/divorce/single parent
Low IQ (IQ <80)	Parental criminal behavior	Negative parent-child relationship
Chronic medical disorder		Sexual abuse
Psychiatric disorder		Physical abuse
Repeated aggression		Removal from home
Substance abuse		Frequent family moves
Delinquency		Teen pregnancy
Significant levels of truancy and school retention challenges		
Poor academic performance		



Protective Factors



Child	Family Characteristics	Social Support From Outside The Family
Positive, "easy" temperament type	Living at home	Adult mentor for the child outside immediate family
Autonomy and independence as a toddler	Secure mother-infant attachment	Extra adult help for caretakers) of family
High hopes and expectations for the future	Warm relationship with a parent	Support for the child from friends
Internal locus of control as a teenager	Inductive, consistent discipline by parents	Support for the child from a mentor at school
Interpersonally engaging, "likable"	Perception that parents care	Support for the family from faith-based organizations
Sense of humor	Established routines in the home	Support for the family from work place
Empathy	Family cohesion	
Perceived competencies	Clear, open communication among family members	
Above average intelligence (IQ>100)	Spirituality/faith	
Good reading skills		
Gets along with others		
Problem-solving skills during school-age years		



Prevention

- **Universal:** target the general public or a whole population group that has not been identified on the basis of individual risk
- **Selective:** target individuals or subgroup whose risk of developing mental disorders is significantly higher than average (early intervention)
- **Indicated:** target individuals who are identified with signs, symptoms, genetic markers related to mental disorders, but do not yet meet diagnostic criteria



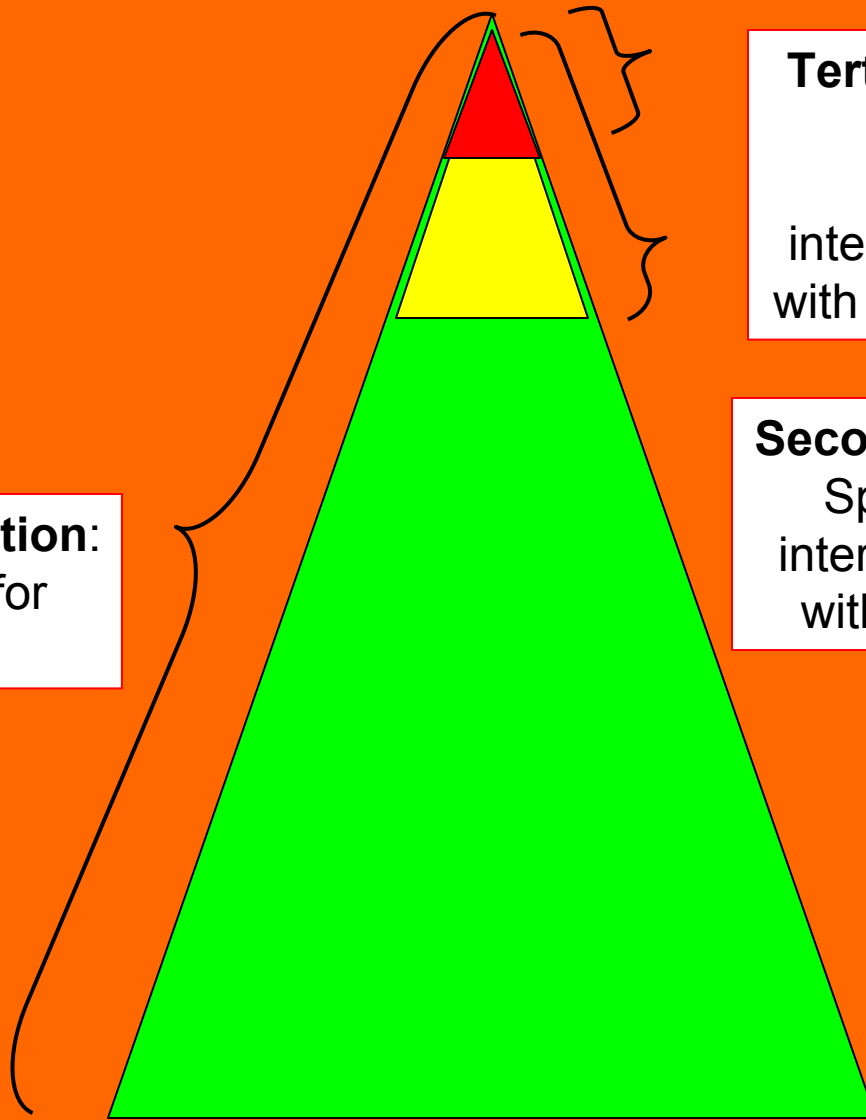
Public Health Approach



Primary Prevention:
Interventions for
all

Tertiary Prevention:
Specialized
individualized
intervention for youth
with high-risk behavior

Secondary Prevention:
Specialized group
interventions for youth
with at-risk behavior



Effective Methods for Prevention and Early Intervention

- Provision of mental health consultation in child care and early learning programs (e.g., giving child care providers increased access to mental health consultants and clinical supervision)
- Inclusion of mental health components in home visiting programs
- Provision of mental health consultation in pediatric and obstetric health care settings



- Multi-component
- Multi-year (sustained benefits)
- Ongoing intervention during early childhood (preschool yrs) may help prevent serious conduct problems
- Targeted to reducing risk factors and promoting protective factors, rather than concentrating on elimination of negative behaviors
- Focus on fostering + changes in home and school domains (rather than child alone)



- Integrated with tx programs and other community care systems (educational settings)
- Center-based early education programs that use low teacher to child ratios and enriched programming
- Comprehensive and implemented prenatally
 - Prenatal counseling for mothers
 - Focus on parenting, care giving, health care
 - Incorporate periodic health screenings to monitor growth and development and parent-child interactions
- Use culturally relevant individualized plans of service/support developed and implemented in partnership with families
- Include components for both children and families



Impact of Parental Mental Illness

- Women with mental illness experience high %age unplanned pregnancies
- Mothers with schizophrenia experience higher rates of reproductive losses from miscarriages, stillbirths, induced abortions
- Parents with mental illness vulnerable to custody loss (rates as high as 70%-89%).
 - Fear of loss of custody may stop parents from seeking services
 - Separation from children and loss of custody may undermine motivation for recovery and be a factor in decompensation



- Successful parenting may be compromised by symptoms of trauma
- Parents with mental illness more likely to live without their partners
- Often feel responsible or blamed for their children's difficulties
- Family members may be regarded as either a resource or source of stress
- Tendency to attribute everyday childrearing stressors and challenges to their illnesses
- May prioritize their children's needs and neglect their own.
 - Women may stop taking psychotropic medication during pregnancy due to fears of fetal harm
 - May worry about the impact of the illness on their children
- Describe relationships with their children as fulfilling and important; parenthood identified as significant contributor to recovery



Effective Services & Supports

- Available on an ongoing basis (no time or age limits)
- Entire family = focus of services and supports; inc. extended family members
- Interventions focus on development of natural supports
- Services/supports consider impact of stigma associated with mental illness, (prejudices faced by parents and children who also face rejection and discrimination from peers and other parents)
- Prevention of loss of custody (or dealing with loss of custody, visitation, placement)



- Family CM to coordinate services/supports for family as a unit, and for individual family members
- Access to a comprehensive array of services and supports:

- 24 hr. crisis intervention
- Housing
- Employment
- Parenting skills training
- Marital and family counseling
- Reproductive decision-making
- Perinatal health care
- Assistance with school related issues
- Benefits and entitlement counseling
- Peer support
- Medication management
- Advance directives planning and support



Child Maltreatment



- **Primary prevention**

- Public awareness campaigns - educate about where and how to report suspected child abuse and neglect
- Public service announcements - encourage parents to use nonviolent forms of discipline

- **Secondary prevention**

- Parent education programs for teen mothers provided in high schools
- Substance abuse treatment programs for parents with young children
- Respite care for families who have children with special needs
- Family resource centers offering information and referral services to families living in low-income neighborhoods

- **Tertiary Prevention**

- Intensive family preservation services with MH tx staff available to families on a 24-hr a day basis for several weeks
- Parent mentoring programs that use stable, non-abusive families who function as role models and provide support to families experiencing crises

MH services for children and families affected by maltreatment to improve family communication and functioning



Family Support Services

Parents Anonymous

- Provides mutual support and resources to families who are overwhelmed by everyday stressors
- Rated as a promising approach for prevention, education and as intervention for child maltreatment
- Consists of weekly parent meetings lead by a professionally trained facilitator and co-led by a parent group leader



- Participants determine the agenda for each meeting which includes topics related to basic parenting skills
- Group members offer 24 hr support for parents experiencing a crisis or stress
- Children's program includes activities to assist with the acquisition of skills
 - conflict resolution
 - appropriate peer interactions
 - identification and communication of thoughts and feelings



Respite Services

- Temporary relief provided to primary caregivers in order to reduce stress, support family stability, prevent abuse and neglect, minimize need for out-of-home placements
- Planned respite services = scheduled
- Crisis respite services = provided on emergency basis



- In-home respite = sitter or companion for child, siblings, homemaker, or informal network of assistance
- Out-of-home respite models = services offered in respite providers' homes, foster homes, group daycare centers, residential treatment centers, crisis and emergency facilities, parent cooperatives (parents volunteer to care for each other's children on a planned or emergency basis)



Mentoring

- Adult role models can have a + impact on development and socialization of children / adolescents at risk for delinquent and aggressive behaviors
- Mentors often provide linkages to mental health services and supports



Quantum Opportunities Program (QOP)

- Participants involved during all 4 yrs of high school for 250 hours per yr in 3 areas:
 1. Educational support
 2. Community service activities
 3. Developmental activities
- Operates yr-round
- Combines features of CM, mentoring, computer-assisted academic assistance /instruction, work experience, community service, financial incentives



Components:

- Education-related activities (tutoring, computer-assisted instruction, homework assistance)
- Development activities (acquiring life and family skills; planning for college and jobs)
- Service activities (community service projects, helping with public events, holding regular jobs)
- Hrly stipends and bonuses for completing each segment of the program

Outcomes:

- Less likely to drop out of high school, become teen parents, get arrested
- More likely to graduate, attend post-secondary school, receive honor or award



Suicide Prevention

- Public health priority
- 3rd leading cause of death among 15-19 Y/Os
- Suicide attempts highest during mid teen yrs
- About $\frac{1}{2}$ associated with depression
- Males under 25 more likely than females to complete suicide



Effective Suicide Prevention Efforts

- Case-finding (at-risk adolescents)
- Risk reduction (restricting access to lethal methods of suicide)
- Training primary care providers to recognize suicide risk and treat depression, substance abuse, other mental illnesses associated with increased risk for suicide
- Training mental health, health, substance abuse, human service professionals (clergy, teachers, corrections officers) to conduct suicide risk assessments and make referrals for intervention
- Encouraging family members of those deemed at risk to obtain assistance; intervening with the family as whole
- Prevention programs in educational settings that incorporate peer support
- Intervention for mental illnesses and substance use disorders to mitigate risk



Interventions

- Rx:
 - Lithium, clozapine associated with reductions
 - SSRIs to treat depression
- Interpersonal Psychotherapy for Adolescents (IPT-A)
- CBT
- Dialectical Behavior Therapy for Adolescents (DBT-A)



Violence Prevention

- **Anger management and problem-solving skills training** provided via educational or modeling approaches
- **Gender-specific programming** (female aggression is different from that of males)
- **Social skills training** and choosing prosocial peer relationships (needs to be part of a multimodal approach)
- **Family interventions** (MST, FFT) that improve relationships and parenting skills
- **Therapeutic foster care** - effective in modifying aggressive behaviors in adolescents




- **Bullying prevention programs** that use limit setting in schools to alter bullying behavior and responses by victims through use of increased monitoring and enforcement of consequences for bullying behavior
- **Interventions that target multiple domains** (e.g., individual, family, peers, community relationships) - more effective, especially when coordinated in a collaborative manner with all relevant service sectors
- Interventions with the most robust evidence of effectiveness for reducing violent behavior:
 - **CBT + skills training**
 - **IDDT**
 - **FFT**
 - **MST**
 - **Tx Foster Care**
 - **Intensive CM**



Sex Offender Prevention/Intervention

- **Impulse control and coping skills** (manage sexual and aggressive impulses)
- **Assertiveness and conflict resolution skills** (manage anger, resolve interpersonal disputes)
- **Social skills enhancement** (promote increased self-confidence, social competency)
- **Empathy enhancement** and improved appreciation of the negative impact of sexual abuse on victims and their families



- 
- **Relapse prevention:**
 - Teach understanding of cycle of thoughts, feelings, events antecedent to the behavior
 - Identify environmental circumstances and thinking patterns to be avoided due to increased risk of reoffending
 - Identify and practice coping and self-control skills for management of behaviors
 - Clarifying and teaching **values** related to respect for self and others, commitment to cease interpersonal violence, promotion of a healthy identity, mutual respect in male-female relationships, respect for cultural diversity
 - **Sex education** to understand healthy sexual behavior and correct distorted or erroneous beliefs about sexual behavior



- **MST, CBT**

Fire Setting

- Early intervention to prevent escalation in number and intensity of fires for children who have set fires or display an unusual interest in fire (children do not usually outgrow the behavior)
- CBT
- PMT
- Fire safety awareness education



0-5: Early Intervention

- Home visitation & family strengthening programs
 - Nurse-Family Partnership Program (NFP)
 - Toddler-Parent Psychotherapy (TPP)
 - Parents as Teachers (PAT)
 - Healthy Families America (HFA)
 - MELD
 - HOMEBUILDERS Program
 - DARE To Be You (DTBY)
 - Perry Preschool Project
 - Strengthening Families Programs (SFP)



Nurse-Family Partnership Program (NFP)



- Targets families who are young, single-parent, socioeconomically challenged
- Provides home visits by public health nurses to enhance maternal, prenatal and early childhood health, mental health, family and peer supports, parental roles, and well-being of 1st-time mothers



Outcomes:

- Nurse home visits both during and subsequent to pregnancy lead to improved birth outcomes (reductions in pre-term and low birth weight babies), more involvement with children
- Reductions in quickly recurring and unintended pregnancies, incidents of child abuse, behavioral problems, arrests, convictions, alcohol consumption, # of lifetime sexual partners
- Children display reductions in conduct disorders, involvement in crime, delinquent behaviors



Toddler-Parent Psychotherapy (TPP)

- Preventive intervention to promote secure attachments in the offspring of mothers with depression
- Intensive intervention - addresses difficulties with attachment
- Designed to modify caregivers' inappropriate perceptions regarding their infant's/toddler's developing mental health by changing care-giving behavior



- Based on premise that caregivers tend to repeat insecure early childhood attachments, parenting behaviors experienced with their own caregivers - Caregivers helped connect past experiences to current behavioral interactions with their infants/toddlers, recognize, integrate previously unresolved negative experiences
- 10 to 20 sessions for 2 - 6 months
- Home or office-based



Outcomes

- Increased maternal empathy (linked to reduced avoidant and angry behavior in children)
- Enhanced care giving attachments
- Improvements in quality of dyadic relationship
- Shown to be helpful in improving children's cognitive functioning
- Studies lack randomized control trials



MELD

- A family strengthening, parent education program
- Uses peer support groups to develop parenting skills
- Targets parents of preschool aged children and has been adapted to meet the needs of 1st-time adult parents, parents of children with special needs, young, single mothers, single fathers



MELD Curriculum:

- Health
- Child development
- Child guidance
- Family management
- Use of community resources
- Home and community safety
- Balancing work and family
- Other issues related to the parenting needs of the specific group



Outcomes:

- More appropriate expectations of children's abilities, increased knowledge of child development
- Increased empathic awareness of children's needs and appropriate responses
- Decreased belief in value of corporal punishment
- Reductions in social isolation, parental depression
- Increased awareness of parents' purpose to respond to needs of children (children do not exist to please/love their parents)



Perry Preschool Project

- Started in 1962 in Ypsilanti, MI to promote social and cognitive development of African American preschoolers at risk for school failure
- Resource Mothers program links older experienced mothers with teenage girls during pregnancy to nurture trusting relationships, offer education and skills for parenting, health, nutrition, child development, community resources throughout the 1st years of childrearing



- Core components:

- Sessions on social relations, decision-making, problem-solving, dealing with conflict, expressing one's feelings, group participation, and sensitivity to the needs and feeling of others
- Weekly home visits for 1 $\frac{1}{2}$ hours by classroom teachers
- Preschool Monday - Friday for 2.5 hours per day for 2 yrs
- Monthly small group parent meetings



- Outcomes:

- Increased rates of

- high school graduation
 - college attendance
 - employment

- Lower rates of

- criminal behaviors
 - arrest and juvenile court petitions
 - teen pregnancy
 - reliance on welfare benefits



Strengthening Families Program (SFP)

- Family-skills training
- Uses family systems and cognitive behavioral elements
- 3 versions of the program for children 3 - 14
- Focuses on enhancing family relationships, parenting skills, improving children's social and life skills



- 3 separate courses:
 - Parent Training
 - Children's Skills Training
 - Family Life Skills Training
- Supportive services
(transportation, child care, family meals) provided to retain families in treatment
- Incentives for attendance, desired behavior in children, homework completion offered to increase recruitment and participation

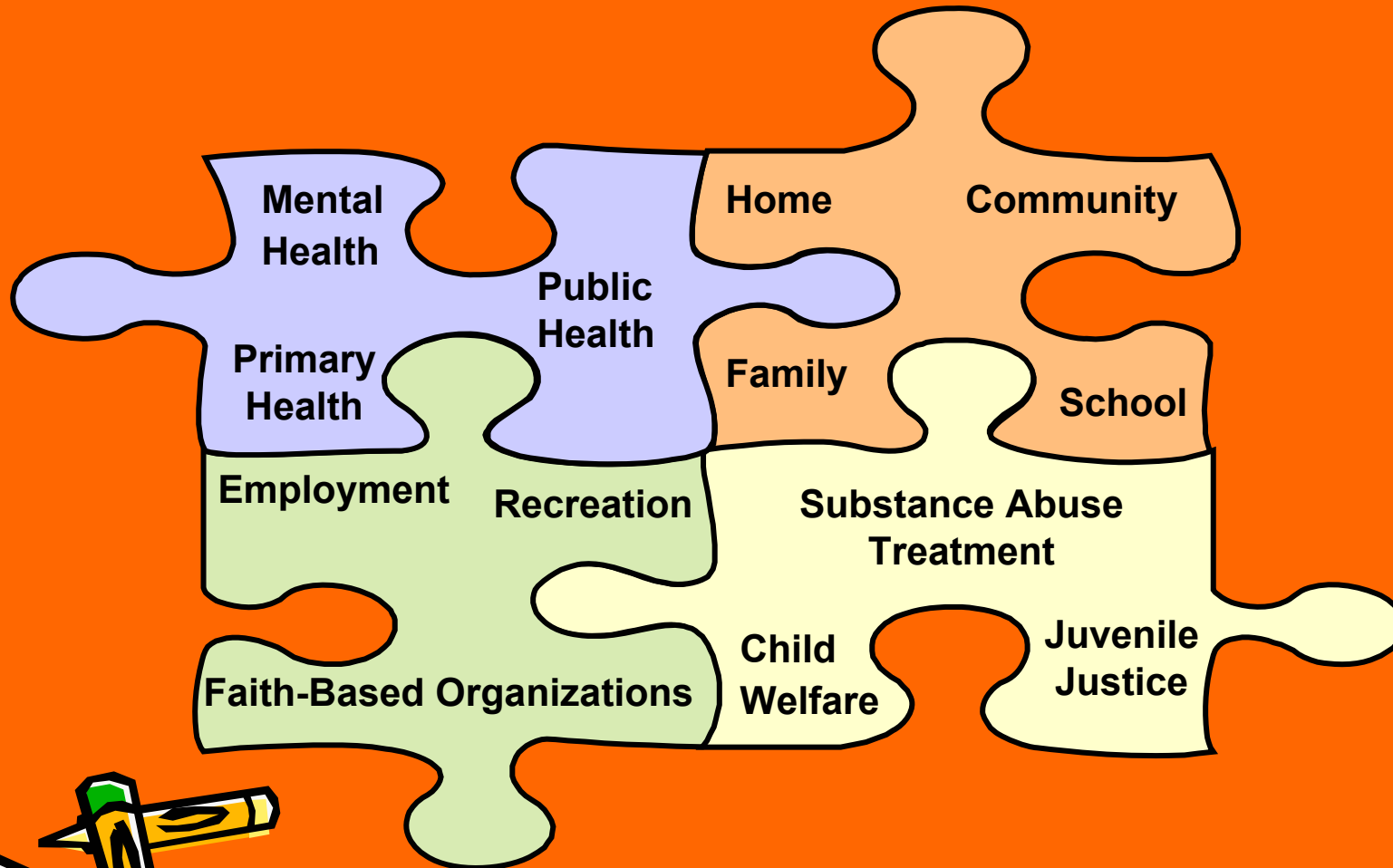


Outcomes:

- Parents: decreases in drug use, depression, use of corporal punishment, increased parental efficacy
- Children: reductions in behavior problems (e.g., aggression, impulsivity, conduct disorders), improved social skills (e.g., communication, problem-solving, peer pressure resistance, anger control).
- Reductions in substance abuse for both parents and children



Systems Collaboration



Collaboration

- Improve access and service monitoring
- Expand available resources through cooperative planning, information sharing, joint training, shared facilities and personnel
- Opportunity to incorporate variety of perspectives on children / families



- Alleviate burden on single agencies, tendency to place blame when results not optimal
- More + community perceptions with improvements in outcomes
- Improved consumer satisfaction
- Cost reductions (elimination of unnecessary service duplication)



System of Care (SOC)

The responsibility for children's mental health is dispersed across multiple systems:

- ❖ Primary Care
- ❖ Education
- ❖ Juvenile Justice
- ❖ Public Health
- ❖ Child Welfare
- ❖ Substance Abuse Treatment System
- ❖ Mental Health Treatment System



SOC Key Principles

- **Child & Family-Centered:** Needs of child / family dictate types and mix of services/supports provided; services adapted to child/family rather than expecting child/family conform to preexisting service/support configurations; **family involvement** integrated into all aspects of service planning and delivery; driven by the needs and preferences of the child and family
- **Individualized:** Unique service plan developed for each child/family which assesses strengths & needs, prioritizes needs in each life domain, responsive to cultural, racial, ethnic identity





- **Community-Based:** Services provided within or close to home community in least restrictive setting, coordinated /delivered via connections between providers
- **Broad array of services/supports** provided in individualized, flexible, coordinated manner
- **Strengths-based perspective**



- **Multi-agency collaboration**
(integration and coordination between child-serving agencies)
- **CM** to ensure service coordination, integration, system navigation
- **Early identification/intervention** to maximize potential for + outcomes
- **Smooth transition** to the adult service system planned
- **Rights protected**



SOC Outcomes

- Reductions in the use of residential settings
- Improvements in functional behavior
- Parents report greater levels of satisfaction



Wraparound

- Family-centered process for identification, selection, provision of unique set of services/supports to children / families based on strengths and needs, woven seamlessly into an individualized plan of care
- Not a program, model, or service
- Places families in decision-making positions as core members of the team



Values of Wraparound

- **Voice and choice** for child & family
 - **Access** - parents and children have valid options in the decision-making process
 - **Voice** - parents and children are heard and listened to during all planning stages
 - **Ownership** - parents and children agree with and committed to plans made



- Integration of services & systems
- Compassion for children and families
- Flexible approaches to funding, service provision, working with families
- Focus on safety, success, permanency in home, school, community

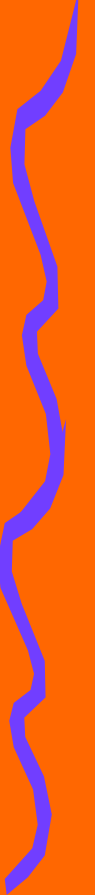


- Care that is:
 - Unconditional
 - Individualized
 - Strengths-based
 - Family-centered
 - Culturally competent
 - Community-based (with services close to home in natural settings)



- A relationship with the child and family characterized by:

- A lack of blame
- A lack of shame
- Dignity
- Respect
- Empathy
- Listening
- Support
- Meaningful options
- Self-determination



Collaboration with Schools

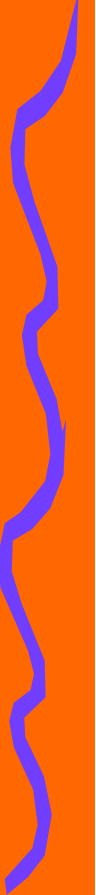


- Schools = primary providers of mental health services for children
 - 70% - 80% of children who receive mental health treatment do so in a school setting
 - Schools = ideal setting for early identification of children at risk for serious emotional disturbances



School-Based Prevention and Intervention Programs

- Promoting Alternative Thinking Strategies (PATHS)
- Fast Track
- Anger Coping Program
- Coping Power
- The Good Behavior Game (GBG)



- I Can Problem Solve (ICPS) Program
- Families and Schools Together (FAST)
- School Transitional Environmental Program (STEP)
- Olweus Bullying Prevention Program
- Therapeutic recreation: after school and summer camp programs

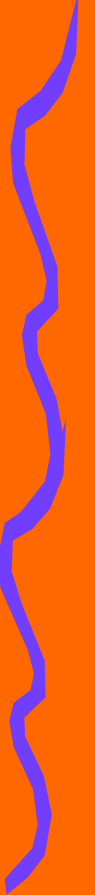


Promoting Alternative Thinking Strategies (PATHS)

- Multiyear, curriculum-based, prevention program
- Kindergarten - 6th grade (ages 5 - 12)
- Used by educators and counselors
- Lessons:
 - Instruction on identifying and labeling feelings
 - Expressing feelings
 - Assessing the intensity of feelings
 - Managing feelings



- Understanding difference between feelings and behaviors
- Delaying gratification
- Controlling impulses
- Reducing stress
- Self-talk
- Reading and interpreting social cues
- Understanding perspectives of others
- Using steps for problem-solving, decision-making
- Maintaining a + attitude
- Self-awareness
- Nonverbal and verbal communication skills



- **PATHS curriculum** = 6 volumes cover 4 conceptual units:

- **Readiness and Self-Control "Turtle" Unit** (1 volume) fosters the development of self-control and the ability to identify problems
- **Feelings and Relationships Unit** (3 volumes) teaches students to recognize a wide variety of affective states and enhance empathy
- **Problem-solving Unit** (1 volume) teaches students to follow a series of steps to seek solutions to problems
- **Supplementary Lessons** (1 volume) includes optional lessons, review, and extensions of previous lessons. Topics include teasing and fair/unfair treatment



Outcomes

- Improvements in
 - self-control
 - understanding and recognition of emotions
 - ability to tolerate frustration
 - use of more effective conflict-resolution strategies
 - thinking and planning skills
- Reductions in
 - symptoms of anxiety, depression, conduct problems



Anger Coping Program

- A cognitive-behavioral individual or group intervention
- Can be used in schools and mental health settings
- Group sessions with 4 - 6 students conducted by 2 co-leaders who alternate between monitoring behaviors and leading group activities
- Consists of 18 sessions conducted on a weekly basis for 60 - to 90 minutes



Sessions

- Session 1: Introduction and Group Rules
- Session 2: Understanding and Writing Goals
- Session 3: Anger Management: Puppet Self-Control Task
- Session 4: Using Self-Instruction
- Session 5: Perspective Taking
- Session 6: Looking at Anger
- Session 7: What Does Anger Feel Like?
- Session 8: Steps for Problem-Solving
- Session 9: Problem-Solving in Action
- Sessions 10-18: Video Productions I-VIII and Review



- Outcomes:

- Reductions in aggressive and disruptive behaviors & increases in on-task academic behaviors in school
- Increases in self-esteem and problem-solving skills
- Reductions in rates of substance use/abuse



Families and Schools Together (FAST)

- Multifamily group interventions
- Parents and 4 - 12 Y/Os
- Components
 - Outreach to recruit families to attend 8 weekly multifamily support groups and monthly multifamily meetings
 - Multifamily support groups
 - Multifamily meetings held monthly after families graduate



- Outcomes:

- Child benefits: reductions in aggression and anxiety; increases in academic competence, attention span, social skills at 1 and 2-year follow up
- Parental benefits: self-referral to SA or MH tx, pursuit of adult education, development of ongoing friendships (natural supports)





Olweus Bullying Prevention Program

- School-based
- Prevent or reduce bullying in elementary, middle, junior high school
- Targeted to children 6 - 15
- Uses behavior modification and altering the structure of the school environment to reduce occasions and reinforcements for bullying behaviors



Interventions:

- Individual life and social skills training
- Family task-oriented education sessions to improve family interactions (parental involvement in program homework assignments, etc.)
- Peer-resistance education
- Classroom-based skills development
- Comprehensive school programs to increase parental involvement, change classroom management and/or instructional style, improve student participation and school bonding



- Parents attend school-wide and classroom-level meetings and are taught about bullying from the perspective of both victim and bully and ways the school is being organized to combat bullying
- Students participate in a series of regular classroom meetings about bullying and peer relations



Outcomes:

- Reductions in student reports of antisocial behaviors (e.g., vandalism, fighting, theft, truancy)
- Improvements in classroom orderliness and discipline, more + attitudes toward schoolwork and school



Collaboration with Child Welfare



- Children in foster care utilize significantly more mental health services
- Children in foster care at higher risk for MH problems (esp. 0-to-5 age group) due to abuse/neglect suffered which led to placement



Fostering Individualized Assistance Program (FIAP)

- Provides wraparound services and support to 7 - 12 Y/Os in foster care with emotional and/or behavioral disorders and their families (biological, adoptive, foster)
- Designed to improve permanency outcomes for foster children



Components:

- A strength-based child and family assessment to address individualized needs
- Service planning for each life domain to support and enhance permanency plans
- Case management of wraparound service plans
- Follow-along supports and services to maintain permanency and improve overall adjustment

Outcomes:

- Placement maintenance
- Reductions in emotional and behavioral symptoms
- Fewer days of out of home for those with hx of running away



Collaboration with Primary Care



- Primary care settings - opportunities for early identification of difficulties and provision of interventions for both parents and children
- Primary care providers (rather than MH providers) see the most children who have mental health difficulties
- Studies show that less than a 1/3 of eligible children receive a full EPSDT screening; even fewer receive a screen that includes behavioral health



Health Promotion Pediatric Primary Care Practices



- Nutrition:
 - WIC (Women, Infants and Children) supplemental food program
 - Food Stamps
 - Child and Adult Care Food Program (CACFP) provides services to licensed non-profit child care facilities or those that maintain 24% Title XX enrollment



- **Early and periodic screenings:** Early identification of health and developmental difficulties, referrals for appropriate services / supports
 - Age-appropriate screenings and periodic well-child visits with follow-up are critical components
- **Required immunizations**
- **Consultation and assistance to parents:**
 - Early and continuous prenatal care to improve pregnancy outcomes
 - Nurse home visiting programs



Collaboration with Juvenile Justice



Therapeutic Jurisprudence
Diversion

Balanced and Restorative Justice
(BARJ)

Peer Courts

Juvenile Mental Health Courts

Family Dependency Treatment Courts
(FDTC)



Juvenile Mental Health Courts

- Based on adult mental health courts
- Judges, attorneys, staff collaborate to develop treatment regimens
- Probation officers ensure sentences of medication and counseling are carried out



Models:

- Screenings conducted by MH professionals, probation officers, district attorneys, defense attorneys
- Multidisciplinary teams operating in SOC framework to develop tx plans
- Implementation of tx plans that include probation conditions and MH services
- Judicial reviews of the minor's progress conducted regularly (usually q 90 days)

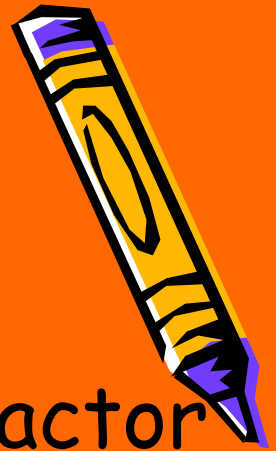


- Probation supervision provided face-to-face
- Community-based aftercare services / supports
- Court reviews conducted regularly (q 2 weeks - 90 days)
- Reviews/revisions made to treatment plans as needed
- Graduated justice interventions or increases in MH tx for probation violations
- Dismissal of cases after consistent participation/compliance with terms / conditions of probation, adherence to tx recommendations (medication, counseling)



Family Dependency Treatment Courts (FDTC)

- Substance abuse - estimated factor in 75% of all foster care placements
- Children with parents who abuse substances almost 3X more likely to be abused, more than 4X likely to be neglected
- Developed to help parents with SUDs at risk of losing custody due to abuse and/or neglect



- Collaborative approach to therapeutic jurisprudence
 - Teams include judges, substance abuse treatment providers, child welfare specialists, attorneys (prosecution, protection agencies, parents, children), MH practitioners, others
- Incorporate the needs of both children and parents; entire family viewed as client
- Decisions always made in best interests of child; parallel focus on interests of parents maintained



Models

- Individuals with civil cases vs. both civil and criminal cases
- Can function under jurisdiction of family, juvenile, or general jurisdiction courts
- All pending cases involving any member of the family placed under oversight of FDTC judge vs. multiple judges from FTDC, other criminal and civil courts in which family members have matters pending
- Fully integrated within dependency court vs. complement dependency court case process, intervene at a specific point in the process to review parental compliance with court orders



- Specific focus (mothers of infants exposed to drugs) vs. broader focus (consider any dependency case in which parental substance use contributes to abuse/neglect of children)
- Frequent judicial review of cases
- Graduated system of sanctions/incentives used to maintain parental accountability
- Team meetings (staffings) held on regular (usually weekly) basis
- Aftercare planning begins when family 1st enters program



Peer Courts

- Located in schools, juvenile courts, probation departments, community agencies
- Designed to provide education, motivation, empower youth while holding them accountable for their actions through restorative (rather than punitive) justice
- Sentences involve community-based restorative actions to repair harm inflicted rather than incarceration
- Restorative actions - community service, letters of apology to victims, etc.



- Youth provided with linkages to MH, primary health, educational, vocational, recreational, other resources to address issues that led to JJS involvement
- Charges usually dismissed upon successful completion of peer court's sentence
- Outcomes
 - Cost-effective
 - Significant reductions of recidivism



Transition Services: Preparing for Adulthood

Transition Supports

- Housing
- MH and SA tx
- Independent living skills/supports
- Balancing need for independence with need for family support
- Vocational supports (SE)
- Educational supports for completion of high school/GED, post-secondary education/Career Planning
- ACT
- Service Coordination/CM
- Child care (for young parents)
- Peer leadership/mentor supports
- Primary health care
- Legal assistance (for those involved in justice system)



Shared CM Approach

- CMs develop expertise re: unique needs of transition age population
- CMs provide services to young adult consumers throughout transition period (adolescence - young adulthood)
 - Cross training staff from both children's and adult service systems (each system has expertise that can be shared)

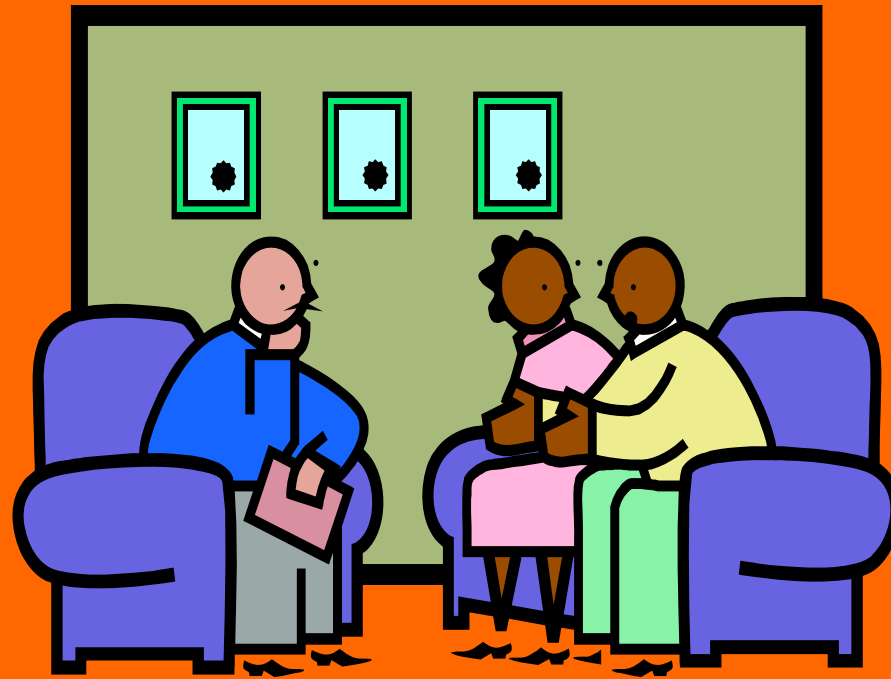


Transition to Independence Process (TIP)

- Manualized
- Consistent with SOC principles
- Engages youth in future planning (self-determination inherent)
- Strengths-based
- Developmentally appropriate services/supports
- Transition facilitators work with youth, family, formal, informal community supports (=safety net)
- Outcomes:
 - Completion of education
 - Employment
 - Reductions in criminal justice system involvement, reliance on public assistance, use of MH/SA services



Psychotherapy



Aggression Replacement Training (ART)

3 main components:

1. Skillstreaming curriculum implemented with small groups of adolescents via **modeling, role-playing**, opportunities to practice and rehearse behaviors, performance **feedback** using praise and reinstruction, **transfer training** to increase the use of skills learned in vivo



- **Curriculum:**

- **Beginning social skills** - starting a conversation, introducing yourself, giving a compliment
- **Advanced social skills** - asking for help, apologizing, giving instructions
- **Skills for dealing with feelings** - dealing with another person's anger, expressing affection, dealing with fear
- **Alternatives to aggression** - responding to teasing, negotiation, helping others
- **Skills for dealing with stress** - being left out of activities, accusations, preparation for a stressful conversation
- **Planning skills** - goal setting, decision making, setting priorities for solving problems



2. **Anger Control Training** - 10-week component; teaches various ways to manage anger:

- **Identification of triggers** - external events and internal self-statements that provoke anger
- **Identification of cues** - individual physical responses, (tightened muscles, flushed face, clenched fists) that indicate the emotion experienced
- **Use of reminders** - self-statements (*Stay calm, Chill out, Cool down*) or non-hostile explanations of others' behavior
- **Use of reducers** - to lower the level of anger (deep breathing, counting backward, imagining a peaceful scene, imagining the long-term consequences of one's behavior)
- **Use of self-evaluation** - considering how effectively the hassle was responded to by identifying triggers and cues, using reminders and reducers, followed by self praise for effective performance



3. **Moral Education** = group intervention conducted with 12 adolescents comprised of procedures to increase one's sense of fairness, justice, concern with the needs and rights of others (moral reasoning).

➤ **Outcomes**

- Promotes skills acquisition and performance
- Improves anger control
- Decreases frequency of acting-out behaviors
- Increases frequency of constructive, prosocial behaviors
- Reductions in re-arrests when parents and siblings participate simultaneously in their own ART groups



Coping Cat

- Manualized
- Short-term
- Cognitive-behavioral intervention for childhood anxiety
- Components:
 - **Psychoeducation** - assist child/family understand ways abnormal levels of anxiety are learned, maintained, treated
 - Children maintain a diary
 - Children use learning techniques from the Coping Cat Workbook



- **Somatic Management techniques** - relaxation techniques to calm the fight or flight response to external stimuli perceived as threatening/fearful
- **Cognitive Restructuring** - investigate, uncover, challenge anxiety-provoking thoughts to learn new ways to deal with feared situations

- Techniques:

- identification of automatic thoughts (ATs)
- gathering evidence to dispute negative ATs
- keeping a diary to monitor daily thoughts

- » **The Fear Plan** - 4 steps incorporate use of behavioral experiments that challenge ATs that create anxiety/fear in very young children:



- **F** - "Feeling frightened?" Children note the physical symptoms they are experiencing in response to this question
- **E** - "Expecting bad things to happen?" Children note their self-talk and consequences or outcomes they fear in response to this question
- **A** - "What Actions and Attitude will help?" Children generate a list of different cognitions and behaviors that can help in response to this question, then select and implement a coping strategy
- **R** - "What are the Results of my coping actions?" and "How can I Reward myself for trying to cope with this situation?" Children realistically evaluate their chosen solution, reinforce themselves for coping in response to these questions



- **Problem-Solving Training** - teach child to identify real life problems, then list and evaluate actions for resolving a specific problem
- **Graduated Exposure** - gradual and systematic exposure to a feared stimulus or situation
 - Can use **guided imagery** (step-by-step visual imagery of confronting the feared situation) through **symbolism** (use of pictures or props), **simulation** (role-playing a feared situation), or **in vivo** exposure
- **Response Prevention** - interventions that obstruct escape from feared object/ situation; participant encouraged to confront anxiety provoking thoughts, situations/objects to show connections danger unrealistic
- **Relapse Prevention** - follow-up to maintain treatment gains (maintaining diary of ongoing progress, challenging stress-provoking thoughts)



Coping with Depression (CWD)

- Manualized
- Group-based
- Cognitive-behavioral
- Designed for adolescents
- Areas covered:
 - Relaxation
 - Pleasant events
 - Irrational and negative thoughts
 - Social skills
 - Communication
 - Problem-solving



- Methods of instruction
 - Lectures by a group leader
 - Discussions
 - Role-playing exercises
 - Homework assignments
- Outcomes

70% of participants show improvements;
maintained 1 yr post tx



Trauma Focused Cognitive Behavior Therapy (TF-CBT)

- To help 3 - 18 Y/Os and parents overcome negative effects of traumatic life events (child sexual or physical abuse; traumatic loss of a loved one; domestic, school, or community violence; exposure to disasters, terrorist attacks, war trauma)
- Provided in individual, family, and group sessions
- Targets PTSD symptoms



- Addresses issues commonly experienced by children who have been traumatized (poor self-esteem, difficulty trusting others, mood instability, self-injurious behavior)
- Incorporates learning principles, CBT, stress inoculation training



Components

- **Psychoeducation** about child abuse, typical reactions of victims, normalization of reactions, safety skills, healthy sexuality
- **Stress management techniques** - focused breathing, progressive muscle relaxation, emotional expression skills, thought stopping, thought replacement, other cognitive therapy interventions
- **Constructing the Trauma Narrative** - gradual exposure techniques including verbal, written and/or symbolic recounting (using dolls, puppets, etc.) of abusive event(s)



- **Cognitive processing** (cognitive reframing) - exploration and correction of inaccurate attributions about cause of, responsibility for, results of the abusive experience(s)
- **Parental participation** - parallel or conjoint treatment including psychoeducation, gradual exposure, anxiety management, correction of cognitive distortions
- **Parental instruction** - child behavior management strategies
- **Family work** - to enhance communication and create opportunities for therapeutic discussion about the abuse



Outcomes:

- Reductions in:
 - behavior problems
 - posttraumatic stress disorder
 - depressive symptoms
 - negative attributions (such as self-blame) about the traumatic event
 - defiant and oppositional behaviors
 - anxiety
- Improvements in:
 - social competencies
 - accurate and helpful cognitions
 - children's personal safety skills
 - parental distress regarding their child's experience
 - preparation of children to anticipate and cope with reminders of traumatic loss



Problem-Solving Skills Training (PSST)

- Uses modeling and reinforcement to help children and adolescents develop and use appropriate cognitive problem-solving skills
and
- Skills that reduce the extent to which children/adolescents attribute hostile intent to the actions of others and develop non-aggressive responses to perceived provocations by peers



Outcomes:

- Significant reductions in aggressive and antisocial behavior at home, school, community
- Reductions in depression, self-injurious behaviors, social isolation, aggression
- Increases in effective problem-solving and interpersonal skills
- More effective with older children (11-13)
- Less effective for adolescents who display higher levels of difficulty in all domains (academic delays, lower reading ability, severe parental and family problems)

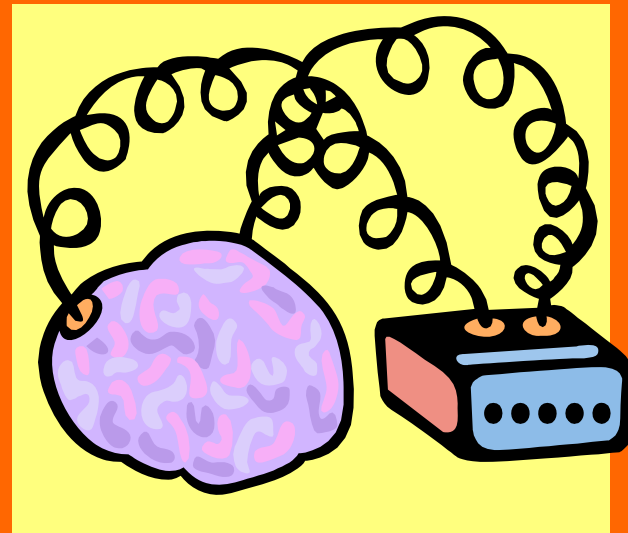


Somatic Therapy

Psychopharmacology



ECT



Psychopharmacology



- Lack of information related to short and long-term effects of psychoactive agents on the developing brain
- Most drugs studied have been in open trials (as opposed to randomized controlled trials)
- Longitudinal studies almost nonexistent
- Off label usage
- Lack of testing, especially for very young children
- Psychosocial interventions often recommended as 1st line tx
- Rx should be part of a multimodal approach



- Stimulants effective for ADHD and co-occurring conduct and anxiety disorders
 - Only effective for the duration taken
 - Need to evaluate cardiac abnormalities
- Antidepressant Medications
 - SSRIs effective for short-term tx of severe persistent depression
 - Monitor for suicidality
- Mood Stabilizing Medications
 - Lithium effective for adolescents
- Antipsychotic Medications
 - Risperidone for the treatment of schizophrenia in adolescents 13 - 17, short-term tx of manic or mixed episodes of bipolar I disorder in children and adolescents 10 to 17 (1st FDA approval of SGA to treat either disorder in these age groups)



ECT

- Most effective for bipolar illness
- Not used in younger children
- Effective for adolescents with bipolar disorder who do not respond to at least two 8 - 10 week trials of pharmacotherapy
- Second opinions, discontinuation of medications, administration on an inpatient basis recommended by AACAP



- Modifications:

- Unilateral electrode placement to the non-dominant hemisphere (to minimize post treatment memory problems)
- Use of a brief pulse (instead of a sine wave)
- Lower dose of electricity



Algorithms

- Children's Medication Algorithm Project (CMAP)

- ADHD
- MDD
- information:

<http://www.dhs.state.tx.us/mhprograms/CMAP.shtm>



- Treatment Recommendations for the Use of Antipsychotics for Aggressive Youth (TRAAY)

- antipsychotic medications for children and adolescents who display aggressive/assaultive behaviors
- Information: www.columbia.edu



Crisis Intervention and Out-of-Home Settings

- **Mobile Urgent Treatment Team (MUTT)**
 - Wraparound Milwaukee team approach (MDs, MSWs, RNs, CM, psychiatrist)
 - 24/7
 - Short term CM
- **Home-Based Crisis Intervention (HBCI)**
 - Based on HOMEBUIDERS program
 - Short term, intensive
 - Prevent out-of-home placement, hospitalization
- **Partial Hospitalization Programs (PHP)**
 - Effective alternative to inpatient
- **Residential Care**
 - **Teaching-Family Model (TFM)**
 - **Foster Care**
 - **Respite** - short-term for emergencies, assessment or preparation for long-term placement; medium term respite; and long-term respite
 - **Specialized foster care (MTFC)**
 - **Kinship Care**
 - **Family-to-Family Program**



• **Therapeutic Foster Care (TFC)**

- Trained foster parents function as primary interventionists, provide care in their homes
- Foster parents receive extensive pre-service training, in-service training, supervision, support
- Biological parents/legal guardians taught how to provide effective supervision, discipline, support, encouragement, use daily behavioral management point systems, conflict management, communication and problem-solving skills
 - Regular home visits allow for practice of skills
- Progress in school monitored



- Coordination with probation/parole officers
- Therapeutic foster parents given higher stipend
- Frequent contacts between participants and their biological parents/legal guardians, home visits
- Frequent contact between case managers/care coordinators and foster families
- Psychiatric consultation, medication management available
- Peer associations closely monitored; access to negative peer associations restricted
- Individualized daily program - scheduled activities and behavioral expectations designed by CM in conjunction with foster parents



- Appropriate and positive behaviors reinforced
 - Point system assigned - specifies # of points that can be earned for acceptable performance
 - Points removed for misbehaviors and rule violations
- Close supervision provided at all times
- Clear, specific, consistent rules and limits set
- Consistent follow thru with consequences
- Development of academic skills, + work habits encouraged
- Family conflict and communication skills taught



Teaching-Family Model (TFM)



- Children/adolescents within juvenile justice and child welfare systems
- Teaching parents live with children/adolescents in group home and teach essential interpersonal and living skills
- Services/supports provided by trained staff in homes located in the community where participants can attend local schools
- Individual psychotherapy, group therapy, behavior modification provided
- Outcomes: effective while in the home; Δ s rarely maintained post D/C



Measurement



Functional Status

- Child and Adolescent Functional Assessment Scale (CAFAS) (Hodges, 1990)
- Children's Global Assessment Scale (CGAS) (Shaffer et al., 1983)
- Residential Living Environment (Roles) and Placement Stability Scale (Pressley Ridge School, 1992)

Family Functioning

- Family Adaptability and Cohesion Evaluation Scales (FACES III) (Olson et al., 1982)



Clinical Symptoms

- Achenbach Questionnaires (Achenbach, 1991)
- Child Behavior Checklist (CBCL)
- Teacher Report Form (TRF)
- Youth Self-Report (YSR)

Diagnosis (Structured Interviews)

- Kiddie Schedule for Affective Disorders and Schizophrenia (K-SADS) (Puig-Antich & Chambers, 1978)
- Diagnostic Interview Schedule for Children (DISC) (Costello et al., 1982; 1984)
- Diagnostic Interview for Children and Adolescents (DICA) (Herjanic & Reich, 1982)



Symptom-Specific Scales

- Center for Epidemiologic Studies-Depression Scale (CES-D) (Radloff, 1977)
- Beck Depression Inventory (BDI) (Beck, 1961)
- Conner's Parent & Teacher Rating Scales (Conners, 1969; 1973)
- Yale-Brown Obsessive-Compulsive Scale - Children (Y-BOCS) (Goodman et al., 1989b, 1989c)
- Revised Children's Manifest Anxiety Scale (RCMAS) (Reynolds & Paget, 1981; 1983)

Consumer Satisfaction

- Client Satisfaction Questionnaire: CSQ-8 (Attkisson et al., 1989)
- Family Empowerment Scale (FES)
- Family Satisfaction and Needs Questionnaire



Outcomes



- 3 leading goals identified by parents who seek services/supports for their children:
 1. Behavioral improvement
 2. Improvement in school and academic achievement
 3. Living a productive life based on societal norms



- Families tend to define tx success in terms of:

- ✓ Meeting basic needs and other identified goals
- ✓ Individual achievements by their children
- ✓ School success
- ✓ Improvement in children's self-esteem, interpersonal relationships with adults (esp. authority figures)
- ✓ Their ability to solve problems independently



Indicators used to ascertain the effectiveness of intervention strategies:

- The family perceives the intervention made a difference in the child's life
- The family perceives the intervention made a difference in the family's life
- The family has a positive regard for the professional and service system



- The intervention enabled the family to help their child grow, learn, and develop
- The intervention enhanced the family's ability work with professionals and advocate for services
- The intervention helped the family develop a strong support system
- The intervention fostered an optimistic outlook for the future
- The intervention enhanced the family's quality of life



Questions? Comments?



Thank You!

