Fostering Trauma Informed Care: A Look into the Implementation of Integrated Mental Health to Support Healing the Foster Care Environment

Presented by:
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Objectives

By the end of the conversation today, you will have gained information about:

1. The benefits of an integrated mental health child welfare team/program
2. The process of the implementation of integrated mental health into an established organization
3. Identifying system changes that may be needed to overcome barriers and solutions to an integrated approach.
Origins of DePelchin Children’s Center

- DePelchin is celebrating its 127th “Birthday” this year
- Since 1892 we have focused on services to vulnerable children in Houston
- We strengthen the lives of children by enhancing their mental health and well being.

Kezia Payne DePelchin
How we got started

We conducted a strategic review in 2015, asking “hard” questions:

- How effective are our services in truly improving the well-being of children in our foster homes?
- How should we focus our limited resources to help improve the stability of the placement in our foster homes?

Our conclusions:

- Build the highest quality program, including the utilization of integrating mental health through the use of trauma informed care interventions
Call to Action

• Developed and implemented Integrated Mental Health Program, originally FIRST (Family Integrated Relational Services Treatment)

• Integrated Mental Health Program has integrated therapy and targeted/intensive case management services to the children and families within the foster care programs of DePelchin Children’s Center

• The growth of Integrated Mental Health came as the expansion of services and locations came about within DePelchin, broadening the scope of reach (Houston, Spring, Austin, and potentially San Antonio)
In 2018, DePelchin provided Integrated Mental Health Services Program services to 1,181 children and adults, including 580 unique children.

Our rate of positive discharges (children left foster care to live with relatives, were adopted, or moved to a less restrictive setting such as moving from residential treatment to a foster family) increased from 87% to 94%.

Our rate of successful placements (2 or fewer moves) is 99.6% while the minimum standard is 80%.
Foster Families Supports

• Integrated Mental Health (IMH) takes a non-traditional role to support the ever changing needs of the foster families and working alongside the Clinical Case Manager:
  – Court proceedings
  – Transitional living supports
  – Biological family supports and communication
  – Mediation for legal and child welfare systems
  – Supports within educational arenas
  – Foster parent training and education on Trauma
Children in foster care do not have the “typical” parental dyadic system to be addressed in most therapeutic approaches.

Settings for the therapeutic interventions rarely can be traditional, as children in care are more transitory, reducing ability to maintain continuity of care.

Varied relationship dynamics in their living environments may not be conducive to “traditional” in home therapy. (Taussig & Raviv, 2014)

Data from a repository of Texas Open Data Portal indicates that 28,162 school-aged youth entered foster care in 2018.
Placement changes occur even more frequently for children with significant behavioral problems (James, Landsverk, Slymen, & Leslie, 2004), and make continuity of mental health services tenuous.

Foster care families often have more than one placement, increasing demand of the caregivers.

- Leads to decrease in availability to transport to multiple locations (Dorsey, Conover, & Cox, 2014)

Two-thirds of children and families who are enrolled in outpatient mental health services do not complete more than seven sessions (Miller, Southam-Gerow, & Allin, 2008), and for children in foster care, this rate is likely to be much higher (Burns et al., 2004; Dorsey, et al., 2014; Taussig & Raviv, 2014)
Complex Trauma
causes and effects

The effects of chronic trauma are often cumulative, as each event serves to remind the child of prior trauma and negative impact.

Often occur at developmentally vulnerable times and can disrupt the child’s development. Early trauma effects not only perception but the ability to learn.

Because they occur in the context of the child’s relationship with a caregiver, complex traumatic experiences interfere with the child’s ability to form a secure attachment bond.

Youth with complex trauma exposure often have more severe and complex emotional and behavioral responses than youth who have not been exposed to this type of trauma.

(From NCTSN Complex Trauma and Effects of Complex Trauma)
Children in foster care are about 2.5 times more likely to have mental health needs as compared to children in the general population (Burns et al., 2004).

Typical findings include a higher prevalence of mood and anxiety disorders, attachment disorders, developmental delays, and behavioral problems (Burns et al., 2004; Marx, Benoit & Kamradt, 2003; McIntyre & Keesler, 1986; Pilowsky, 1995).

Most children involved in child welfare have experienced at least one traumatic event and many have experienced multiple traumas (Greeson et al., 2011; Griffin et al., 2011).

Trauma exposure increases risk of multiple mental health symptoms and co-occurring diagnoses (Copeland et al., 2007; Ford et al., 2010; Lehmann, et al., 2013).
Mental Health Needs of Children in Foster Care

**contributing factors**

- Increased Risk of Co-Occurring Diagnosis
- Access to Quality, Coordinated Mental Health Services
- Trauma History
- Family and Relationship Problems
- Transition and Adjustment Issues

Mental Health Needs
Child Welfare Services at DePelchin

Key Question:

How can we do a better job at improving the well-being of children in the child welfare system in Texas?

The systemic challenges:

- System is underfunded in the state
- Limited availability of mental health services for children, especially in low-income families or in state conservatorship
- Limited knowledge within the community about impact of trauma on children and effective ways to respond to challenging behaviors
- Limited effective use of CANS and other assessments

Our Response:

DePelchin needs to build from the ground up, a new program of integrated mental health services for children in the child welfare system, with a focus on sound assessments, collaboration, trauma-informed services, and meaningful outcomes measurements. This program will need to be funded largely through private philanthropy.
## Developing a New Culture

<p>| <strong>THERAPISTS</strong> |<br />
| Licensed, with office-based / outpatient backgrounds |</p>
<table>
<thead>
<tr>
<th>From</th>
<th>To</th>
</tr>
</thead>
<tbody>
<tr>
<td>strict boundaries</td>
<td>more flexible</td>
</tr>
<tr>
<td>therapy sessions</td>
<td>therapeutic experiences</td>
</tr>
<tr>
<td>therapist only</td>
<td>therapist, case manager, skills trainer, etc.</td>
</tr>
<tr>
<td>dictated by office hours</td>
<td>determined by family convenience</td>
</tr>
<tr>
<td>45 minute transaction adhering to managed care requirements</td>
<td>service time and content vary according to needs of the child and family</td>
</tr>
</tbody>
</table>

<p>| <strong>CLINICIANS</strong> |<br />
| Licensed &amp; unlicensed, with child-welfare / home-based backgrounds |</p>
<table>
<thead>
<tr>
<th>From</th>
<th>To</th>
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<tbody>
<tr>
<td>no formal assessments</td>
<td>assessment</td>
</tr>
<tr>
<td>relatively unstructured service provision, all non-billable</td>
<td>timely completion of CANS, risk assessments and diagnostic assessments (licensed clinician only)</td>
</tr>
<tr>
<td>timely, but limited to a relatively unstructured narrative</td>
<td>detailed and structured clinical forms</td>
</tr>
</tbody>
</table>
Barriers/Challenges

- Funding/Grants
- Onboarding/Credentialing of IMH therapist
- Training of all staff
- Records
- Identification of roles IMH therapist and Clinical Case Manager
- How to address overlap of roles
- Family “buy-in” another person involved visiting your home
- Staff “buy in” and communication
Solutions to Barriers/Challenges

- **Solution to funding:**
  - Grant applications
  - Philanthropic foundations

- **Solution to onboarding**
  - Streamline the process by which the team is hired, trained and credentialed through recognition of previous stumbling blocks

- **Role clarification**
  - Required educating CPS, CASA and Residential Child Care Licensing of the functions of IMH team
Ongoing Quality Assurance Measures

• Communication: Clarified flow of communication, shared information through a distribution list internally, created access to information (CANS, case notes, Service Plan, incident reports) on shared children and families in Solutions/Kalidecare “integrated system”

• Surveyed IMH families who reported increased support and reduction in placement disruption, families liked the “team” approach under one agency (One stop shop)

• Clinical Case Managers observed the benefits of IMH firsthand and their participation and commitment increased through visits, training, service planning and staffing

• Records management process was remedied to ensure easy access for MCO audits
Implementation of Integrated Mental Health Model

- Parenting Training
- Community, office and school-based counseling
- Referral Services
- Coaching
- Wraparound Services
- Connect with Foster Parent Mentors

At risk and exposed children & families

Abuse & neglect

- Referrals
- Assessment
- Intensive Case Management
- Wraparound services
- Permanency plan support
- Trauma Informed Care Interventions

Strengthening families

Healing children

Building strong communities
### Currently

- **Management, program development and supervision:**
  - Five Master’s level licensed therapist (full time)
  - One Master’s level social worker (part time)

- **Integrated mental health service delivery**
  - Three master’s level, licensed therapists (full time)
  - One bachelor’s level clinician (full time)
  - Clinical Case Managers (17 part time)

- **Support services from:**
  - Administrative assistant (full time)
  - Quality improvement staff (2 part time)
  - IT staff (2 part time)
  - Accounting / billing staff (1 part time)
Deliberate Team Collaboration and Culture Shift

Dedicated Integrated Mental Health clinicians accompany Clinical Case Managers on home visits

Joint staff trainings
- Building meaningful use of the CANS
- Developing collaboration skills
- Increase placement stability
- IMH Therapist support stability of placement

On-going communication
- Staffing meetings-facilitated by Clinical Coordinator
- Workgroup meetings
- Monthly team meetings
- Emails and phone calls and touching base due to intentional co-location of offices
- Leadership meetings to share our vision/mission

Leadership meetings to share our vision/mission
### IMH Program

**key elements**

<table>
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<th>Comprehensive Features</th>
<th>Quality Assessment</th>
<th>Treatment Services</th>
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</thead>
<tbody>
<tr>
<td>- Trauma-Informed</td>
<td>- Child and Adolescent Needs and Strengths (CANS)</td>
<td>- Three tiers of service</td>
</tr>
<tr>
<td>- Relationship/Attachment-Focused</td>
<td>- Provides a shared understanding</td>
<td>- TBRI® &amp; other Trauma Informed Care approaches array</td>
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<td>- Collaborative</td>
<td>- Treatment planning tool</td>
<td>- Interventions matched with identified needs and strengths</td>
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<tr>
<td>- Family-Centered</td>
<td>- Completed within 30 days</td>
<td>- Team approach</td>
</tr>
<tr>
<td>- Strengths-Based</td>
<td>- Updated every 90 days and at discharge</td>
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<tr>
<td>- Culturally-Competent</td>
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TBRI® is an attachment-based, trauma-informed intervention that is designed to meet the complex needs of vulnerable children.

TBRI® consists of three principles:

**Empowering Principles**
to address physical needs and give children a voice

**Connecting Principles**
for attachment needs

**Correcting Principles**
to disarm fear-based behaviors
• Somatic Experiencing is an approach DCC is working to implement into the IMH interventions
  – Developed by Dr. Peter Levine the impact of trauma on a person biologically and
  – A method that is a body-oriented approach to the healing of trauma and other stress disorders.
EMDR (Eye Movement Desensitization and Reprocessing)

- Psychotherapy treatment that was originally designed to alleviate the distress associated with traumatic memories
- Adaptive Information Processing model posits that EMDR therapy facilitates the accessing and processing of traumatic memories and other adverse life experience to bring these to an adaptive resolution.
IMH Services

conceptual framework

INTENSE
- Comprehensive treatment plus Wraparound and Crisis Intervention

HIGH NEEDS
- Individualized treatment plan
- Treatment provided by dedicated mental health clinician(s)
- Wide array of mental health services available according to the needs and at the convenience of the child and family
- Skills training and targeted case management

FOUNDATIONAL
- All licensed staff are TBRI and most foster care clinicians are TBRI educated
- In-depth mental health assessment performed by a licensed therapist within 30 days of placement
IMH Program

*tier II and tier III treatment services*

- High Fidelity Wraparound
- Individual and Family Therapy
- Skills Training
- Trauma education and TBRI® support
- Academic Advocacy
- Cultural Competency Support
- Family Bonding Activities
IMH Program

foster care process

- New Placement (Ages 3+)
- Referral

Assessment

High Needs

- Treatment Planning and Provision of Tier II or III IMH Services
- Child Response to Treatment = Increased Strengths and Decreased Needs

Low Needs

- Provision of Tier I IMH Services: CCM provides TBRI education, coaching and support

If needs increase
**IMH Program**

**RTC discharge process**

- **Referral**
- **Assessment**
  - Low Needs: Provision of Tier I IMH Services: CCM provides TBRI education, coaching and support
  - High Needs: Treatment Planning and Provision of Tier II or III IMH Services
- If needs increase:
  - Planned RTC discharge
  - Create safety plan
  - Prepare for Tier III services
  - RTC D/C and Placement
- Preplacement Visit Review

- Child Response to Treatment = Increased Strengths and Decreased Needs
Questions
Contact

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