



LifeworksFamilyTreatmentGroup

Behavioral Interventionist Program

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Introduction

- ▶ In the United States, approximately 50,000 children per year are admitted to residential treatment (Vaughn, 2005).
- ▶ One-fourth of the national funding on children's mental health is spent on residential treatment (U.S. Surgeon General's Report, 1999).
- ▶ Mental health experts agree that it is preferable to treat youth with serious mental disorders outside of institutional settings in general and outside of the correctional system in particular (Skowrya & Cocozza, 2007).
- ▶ These findings are echoed by the U.S. Surgeon General's Report on Mental Health (1999) which states that there is limited evidence that supports the effectiveness of residential treatment.

Challenges facing adoptive families (and foster families):

- ▶ Research indicates that adoptive families are three to four times more likely to seek counseling for their children, and five to seven times more likely to seek residential treatment, than are birth families (Price & Coen, 2012; Vandivere, Malm, & Radel, 2009; Howard, Smith & Ryan, 2004; Landers, Forsythe, & Nickman, 1996).
- ▶ While some of these differences may be due to a greater willingness to seek help, they also point to a higher level of challenges. For example, while approximately 10 percent of children in the general population receive mental health services, the National Survey of Adoptive Parents reported that these figures for adopted children age 5 and older were much higher -
 - ▶ 46 percent of foster care adoptions,
 - ▶ 35 percent of international adoptions
 - ▶ and 33 percent of private domestic adoptions.
 - ▶ For adopted adolescents, these percentages were higher still - 57 percent of teens adopted from foster care received mental health services (Vandivere, et al., 2009).

- ▶ The challenges faced by these children and their families may lead to post-adoption instability. A study by the Donaldson Adoption Institute (“Keeping the Promise: The Case for Adoption Support and Preservation”) published jointly with this report (“Supporting and Preserving Adoptive Families: Profiles of Publicly Funded Post-Adoption Services”) reviewed available research related to post-adoption needs and instability (Smith, 2014b). A synthesis of this study’s overall findings supports the following conclusions about youth adopted from the child welfare system:

- ▶ Approximately 10 percent re-enter care at some point, and the adoptions of a minority of them (one-quarter to one-third of the 10%) are legally dissolved
- ▶ An additional 10 percent or more leave their homes after adoption for either short- or long-term periods other than through the child welfare system. (This preliminary conclusion is based primarily on the LONGSCAN study² and requires further empirical exploration.)
- ▶ An additional 20-30 percent of youth and their families, face significant challenges that would likely benefit from specialized adoption-competent and trauma-based therapeutic counseling.

Lori

- ▶ Foster/Adoptive mom since 1985
 - ▶ Foster parent to more than 400 children in 30 years
 - ▶ Adoptive parent to 23 kids from foster care
- ▶ Child welfare agency director since 2000
 - ▶ Provide post adoptive services in Missouri and Kansas
 - ▶ Provide child specific recruitment services in MO
 - ▶ License foster/adoptive homes in MO
 - ▶ Create, Pilot and Disseminate innovative strategies to address needs of foster/adoptive kids and the families caring for them. Always start creative process from a place of 'what would I need, what does my family need?' with the assumption that if I need it, so do lots of other people.

Shannon

- ▶ Removed from her parents care at 8 months
 - ▶ Difficult birth, parents' homelessness, lots of time in a car, hiding from the CPS
 - ▶ Five foster homes before coming to our home at 13 months.
- ▶ Obvious trauma and mental health issues from before she could talk including
 - ▶ Violent and extended tantrums
 - ▶ Self injurious behavior (scratching, hitting, head banging, biting herself, etc...)
 - ▶ Inability to be soothed
 - ▶ Inability to regulate herself when faced with any difficulty at all
- ▶ Adopted by our family before age 2. Is the third oldest in a sibling group of 8 total from that bio family in our home. All children have some emotional disturbance. Shannon and one other sibling are the most severely impacted, although the oldest four all have significant mental health and developmental issues.
- ▶ IEP for Emotional Disturbance from preschool on
- ▶ First residential stay was a 3 month evaluation at age 7
- ▶ Extended hospital stays (6 weeks plus) on several occasions including genetic testing for medication efficacy. Clozaril was tried...and failed. No medication or combination of medications was effective.
- ▶ Residential treatment at age 9. Only facility that would take her was a level 4 facility 3.5 hours away from home for older girls (she was the youngest child there) and was placed at level 4+ with a one-on-one.
- ▶ Horrifying condition during visits
- ▶ Placed in a second facility in St. Louis (also 3+ hours from home), and remained there for more than a year with no improvement in functioning.

Shannon

- How much money is being spent on residential services for Shannon and her siblings?
- What do I need to be able to bring Shannon and her siblings home?
 - How can I keep them safe?
 - How can I keep their other siblings safe?
 - How can I keep my home in one piece?
 - What services will need to be in place to make all of that possible?
- Can I create a program that would give my kids a better chance to develop into people who can live in the real world with some level of success?
- And if so, can that be done within the dollars already being spent on programs that aren't working and will the CD be willing to fund it?

Shannon

- I wrote a letter to the Children's Division Director asking her to "Put her money where her mouth is.." in slightly nicer words.
- Told her I needed:
 - One on one assistance in the home provided by an adult who was skilled in understanding the principles of trauma and emotional regulation (based on new work done by Bruce Perry, Dan Siegel, etc...). I needed that assistance during all waking hours that the kids were not in school.
 - I needed those Behavioral Interventionists to provide neural developmental activities to my children during their shifts working with the children in my home.
 - I needed those Behavioral Interventionists to be able to de-escalate crisis safely and keep the children from being hurt, and keep my home from being destroyed.
 - I needed my children to be able to participate in activities that normal children participate in (offered one on one since team sports were not an option for them).
 - And I needed a safe time out room, built in my home, where my children could go when they were physically out of control so as to not destroy things or hurt themselves.

Shannon

- ▶ She responded (about a year later) and said...
 - ▶ We can give you the one-on-one you need
 - ▶ No money for individualized activities
 - ▶ No money for a safe time out room

- ▶ I drafted a program document, wrote an application to fit within a funding stream (Children's Treatment Services) that the CD had available, and then asked Susan Peach and Lifeworks to provide the service for me, so that it could be used in my home with three of my children (Shannon and two siblings) serving as the guinea pigs for the program.
- ▶ Susan agreed, submitted the program document and got approved as a CTS provider, and started the process.
- ▶ Shannon and her two siblings came home for a pass for Christmas 2012, and I didn't take them back. Our services started in January of 2013.
- ▶ Based on the success of the program, Lifeworks added clients to the program.
- ▶ March of 2015, with the success of the program, and the demand for additional services growing, MFCAA implemented the program as well (the second service provider offering the program in the KC area and beyond)
- ▶ In June of this year, I met with the Children's Division to explore other options for funding for this program with the goal of being able to serve a much larger number of kids currently in residential treatment in their homes/communities throughout Missouri.

How Lifeworks Fit into this Story

History of clinicians at Lifeworks in their past work in Residential Treatment

- ▶ There is a uniqueness in adoptive families' experiences when placing children in residential treatment.
- ▶ There is an overall lack of understanding across the board related to the children belonging in a family and the role of the parents of children living within residential treatment that leads to systemic breakdown of the family unit.
- ▶ Children could most often be managed within the structure and boundaries of the residential living situation which often would deepen the rift between family and professional care givers.
- ▶ Children would get the message that only professional staff could manage their behavior and that they were "sick".
- ▶ Separation of children and their parents only deepened attachment strains and further damaged family relationships.

Lifeworks Philosophy . . . A Family Centered Approach

- ▶ The greatest potential for change lies within the context of the child's family—not one hour per week in a therapist's office.
- ▶ The role of the professionals is to provide the support, guidance and knowledge needed by families to build strong foundational skills and relationships.
- ▶ The understanding that when one child has been impacted by trauma and neurological impairment, a ripple effect occurs, touching upon each member of the family.
- ▶ The need to utilize interventions that work to not only build weak or lacking foundational skills within the child, but that strengthen the family unit as a whole.
- ▶ The need for family throughout a person's lifespan and, therefore, there is a need to support families in order to foster this lifelong commitment between family members.

The Behavioral Interventionist Program PERFECTLY FIT OUR PHILOSOPHY

- ▶ With the Behavioral Interventionist services, caring, supportive supervision filled with neurologically stimulating activities that structure the environment is provided WITHIN THE FAMILY which allows for healing in the home, and a hope filled future.

The Lifeworks Behavioral Interventionist Program

- ▶ Since January 2013, Lifeworks has served 31 clients and 23 families. Of these 31 clients, 3 were facing adoption disruption, and 21 were in residential treatment or alternative out of home placements.
- ▶ Four of these children have been adopted from foster care due to the support of this program after living nearly half their lives in residential settings.
- ▶ Two children have returned to residential treatment with the expectation of a short stay to better regulate medication management than can be allowed in a very short hospitalization stay, and then returning home with behavioral interventionist support.

The MFCAA Behavioral Interventionist Program

- ▶ Since March 2015, MFCAA has served twenty-two (22) clients and seventeen (17) families. Of these twenty-two (22) clients, four (4) were facing adoption disruption, and seven (7) are, or had been, in residential treatment.
- ▶ Currently, we have a sibling set of three (3) that have transitioned home from residential placement to their paternal grandmother's home with the help of the Behavioral Interventionist Program.
- ▶ Four (4) of these children have a selected adoptive resource provider willing to give them a forever home, with the assistance of the Behavioral Interventionist Program added to their subsidy. Two (2) of those clients are currently transitioning from a residential treatment facility with the help of the Behavioral Interventionist Program.
- ▶ There has been one (1) successful adoption from foster care due to the support of this Behavioral Interventionist Program.
- ▶ One (1) client has returned to residential treatment with the expectation of a short stay to better regulate his medication and then will return home to his adopted parents with behavioral interventionist support.
- ▶ The Behavioral Interventionist Program receives an average of two (2) referrals a week. This includes referrals for clients currently in states custody and clients that have been adopted through the state.

Program Basics:

- ▶ Accept referrals from therapists, child welfare workers, adoptive families, families of children with significant trauma histories, behavioral issues and mental illness.
- ▶ Evaluate each child and family situation individually to structure a plan for services which integrates the clinically supervised therapeutic treatment plan with the activities of daily living for the child/family. Serves primarily adoptive families, but also works well for foster families (who demonstrate a commitment to the child), and birth families.
- ▶ Identify sources of funding for the particular child/family:
 - ▶ Self pay
 - ▶ Adoption subsidy
 - ▶ Children's Treatment Services dollars
 - ▶ Mental health levy funding
 - ▶ Medicaid rehab dollars
- ▶ Identify, interview, train and match BI (individual providing service) with the child/family to ensure most effective fit. BI's typically hold bachelor's degrees, have a few years of experience in working directly with this population, and range in age from early 20's through 40's. (Significantly more educated and experienced than milieu staff in residential treatment facilities).
- ▶ Provide direct service to the child within the home and community based on the treatment plan, including several neural developmental activities each shift.
- ▶ Document daily shift logs and critical incidents which occur.
- ▶ Provide supervision and consultation to in home BI's bi weekly.
- ▶ Meet with families regularly to assess progress and problem solve.
- ▶ Consult with treating therapist weekly (therapist has access to all shift logs and critical incident reports).
- ▶ Re-evaluate for progress and ongoing service/continued funding every 3-6 months based on the level of need of the child/family. Re-evaluation includes standard tools to measure child functioning, and progress on therapeutic and Daily Living goals.

Neural Developmental Activities:

- ▶ BI's are provided a list of activities from which to choose and may add others that they think of. Categories include:
 - ▶ Music
 - ▶ Movement
 - ▶ Repetition
 - ▶ Touch
 - ▶ Anxiety Reduction
 - ▶ Individual Activities
 - ▶ Under Music, for example are the activities below:
 - ▶ Singing
 - ▶ Dancing
 - ▶ Instruments
 - ▶ Lullabies
 - ▶ Learning song CD's
 - ▶ MP-3 players with repetitive songs

Tim Decker

- ▶ **Director of Missouri Children's Division since November 2013**
 - ▶ **Child Welfare agency responsible for child abuse/neglect hotline, investigations and assessments, family-centered services, foster care, adoption, and childcare.**
 - ▶ **Ad-hoc member and active participant in the Missouri State Youth Advisory Board and Multi-System Crossover Youth Policy Team.**
- ▶ **Former Director of the Missouri Division of Youth Services**
 - ▶ **Winner of the 2008 Harvard Innovations in American Government Award for Child and Family Systems Reform.**
 - ▶ **Hosted site visits from over 25 states focused on therapeutic and developmental approaches to treating children and youth with behavior problems.**
 - ▶ **Frequent presenter on topics such as leadership and organizational culture change, youth and family partnerships, multi-system collaboration, and results-based planning and accountability.**

What are the Benefits of the Behavior Interventionist Program?

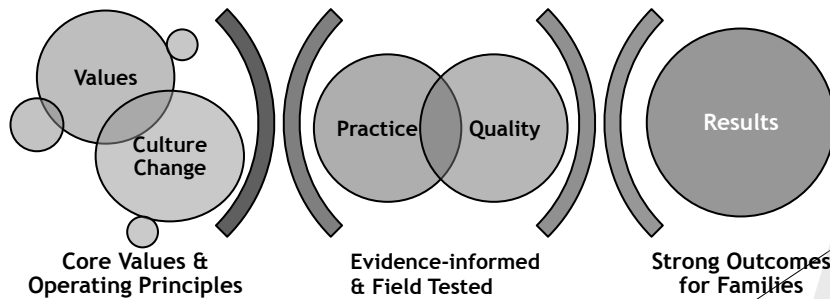
- ▶ Promotes permanency, safety, and well-being as inter-connected and inter-dependent goals.
- ▶ Increases placement stability by moving the resources to the child and family versus moving the child.
- ▶ Effectively supports relative/kinship placements and serves as an effective post-adoption support.
- ▶ Reduces the impact of trauma and re-traumatization of the child and family.
- ▶ Supports healthy brain development and normalized developmental opportunities for children and adolescents.
- ▶ Builds the capacity/skills of child and family by teaching, modeling, and reinforcing skills in areas such as self-regulation, communication, planning, emotional connection/support, and conflict resolution.

What Makes the Behavior Interventionist Program Effective?

- ▶ Combines strong values/principles with evidenced-informed and field-tested practices.
- ▶ Focuses on long-term wellbeing of children and youth; effectively balancing tradeoffs and providing the opportunity for normalized experiences and development.
- ▶ Strengthens relationships and builds family and community capacity.
- ▶ Utilizes a developmental and trauma-informed approach to changing behavior.

System change often involves starting from a fundamentally different place ...

Values/Culture Change x Practice x Quality = Results



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Core Values and Operating Principles Are Essential

values driven ↔ *what works*
“What do we want for our children?”

- ▶ ***People desire to do well and succeed*** - even the most resistant and challenging children and youth hunger for approval and acceptance.
- ▶ ***We are more alike than different*** - everyone has fears, insecurities, and basic needs including safety, attention, control, and belonging. Growth and change requires connection, understanding, and “unrelenting compassion”.
- ▶ ***All behavior has a purpose*** - behavior is often a symptom of unmet needs.
- ▶ ***People do the best they can with the resources available to them*** - we must understand behavior in the context of the limited behavioral and emotional options/resources, and the trauma children and youth have experienced.
- ▶ ***Family and community provide vital supports and opportunities*** - durable and caring relationships and a normalized environment are essential for healing, learning, change, and wellbeing.

Adapted from Missouri Division of Youth Services

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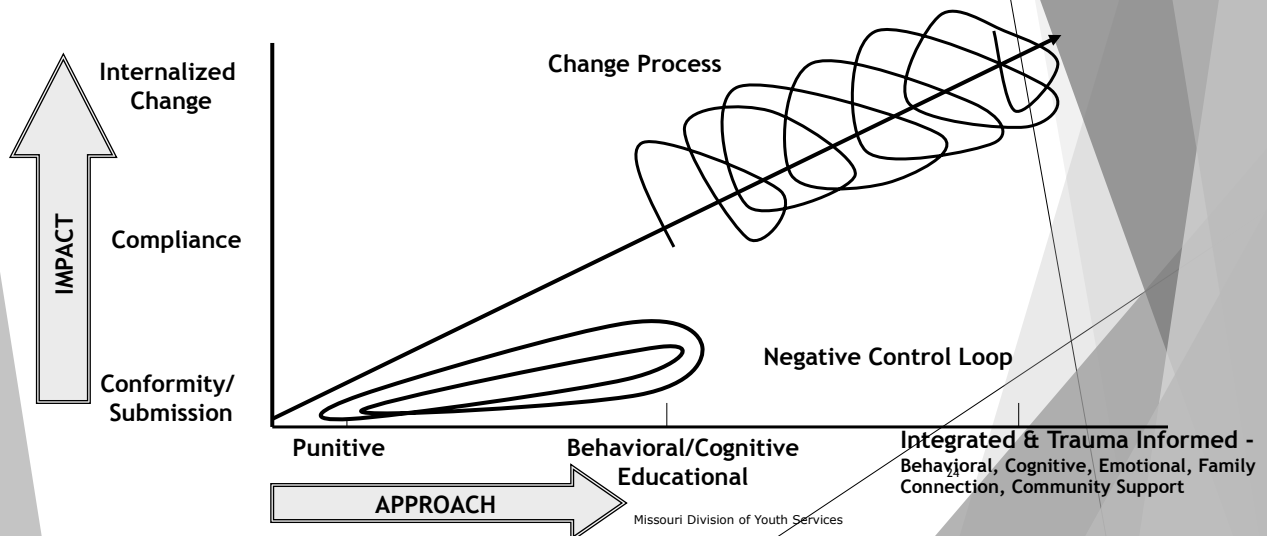
Wellbeing Involves Balancing Tradeoffs

Five Domains of Wellbeing
 Breaking inter-generational cycles of poverty, violence and trauma requires we simultaneously support progress in these Five Domains - at the individual, family and community levels.



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Sustaining Change Involves a Developmental and Trauma-Informed Approach to Changing Behavior: *Completing the Puzzle*



Overcoming the negative effects of trauma on the developmental trajectories of children and youth in the child welfare system

The research is clear that the experience of abuse or neglect leaves a particular traumatic fingerprint on the development of children that cannot be ignored if the child welfare system is to meaningfully improve the life trajectories of maltreated children, not merely keep them safe from harm.

- Bryan Samuels, Fm. Commissioner for the Administration on Children, Youth and Families,
Testimony to House Ways and Means Subcommittee on Human Resources, Congress on 6/16/2011

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Understanding Traumatic Stress in Children

- ▶ Early childhood and adolescence are critical periods for brain development.
- ▶ Brain science shows that repeated exposure to trauma impacts brain functioning, creating strong “fight, flight or freeze” responses.
- ▶ Children who have been exposed to trauma expend a great deal of energy responding to, coping with, and coming to terms with the event.
- ▶ This may reduce children’s capacity to explore their environment and master age-appropriate developmental tasks.
- ▶ The longer traumatic stress goes untreated, the farther children tend to stray from appropriate developmental pathways.
- ▶ Children exposed to traumatic events are at higher risk for future trauma and may become less resilient to the impact of trauma.
- ▶ Early and repeated trauma leads to negative social and health outcomes as an adult.

Commitment to Core Principles of Trauma-Informed Care

Safety - ensuring physical and emotional safety.

Trustworthiness - maximizing trustworthiness, making tasks clear, and maintaining appropriate boundaries.

Choice - prioritizing developmentally appropriate choice and control for children, youth, families and adults.

Collaboration - maximizing collaboration and sharing of power with children, youth, families, and adults.

Empowerment - prioritizing child, youth, family and adult empowerment and skill-building.

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Implementing and Sustaining the Behavior Interventionist Program

- ▶ **Champions for change** are essential to gain support, and organizations philosophically aligned and committed to successful implementation will do what it takes to make it happen - *"Innovation is not for the faint-hearted"*.
- ▶ **Resources may come from various sources depending on the jurisdiction. Some potential funding sources:**
 - ▶ **Medicaid** - Missouri has a unique Medicaid Rehab State Plan amendment aimed at providing services to meet the needs of children who are in residential care or are exhibiting behaviors for which residential placement is being considered. Individual states may have similar amendments or waivers.
 - ▶ **Social Services Block Grant** - SSBG funds can be used to support programs that allow communities to achieve or maintain economic self-sufficiency to prevent, reduce or eliminate dependency on social services. States define services and eligibility.
 - ▶ **Title IV-B** - The Stephanie Tubbs Jones Child Welfare Services Program (Title IV-B Part 1) provides grants for programs directed toward the goal of keeping families together. The primary goals of Promoting Safe and Stable Families (PSSF) (Title IV-B Part 2) are to prevent the unnecessary separation of children from their families, improve the quality of care and services to children and their families, and ensure permanency for children by reuniting them with their parents, by adoption or by another permanent living arrangement.
 - ▶ **Adoption Incentive** - State expenditure of awarded adoption incentive payments is limited to the cost for services (including post-adoption services) and activities allowable under title IV-B and title IV-E of the Act.
 - ▶ **Title IV-E Waiver Demonstration Projects** - States may propose using federal Title IV-E dollars for services to prevent children from entering or returning to foster care.
 - ▶ **State General Revenue Funds or Local Grants** - Children's Health & Mental Health Funds, Private Foundations.

Shannon:

- ▶ Is a 13 year old 8th grader at a treatment school.
- ▶ Still needs BI assistance every day, but....
- ▶ Has decreased self injurious behavior to almost none.
- ▶ Has decreased physical aggression against people to almost none.
- ▶ Has decreased physical aggression to property significantly.
- ▶ Has decreased cursing to almost none, and name calling significantly.
- ▶ Has decreased stealing and lying significantly.
- ▶ Still tantrums, but now maybe once a week, rather than several daily.
- ▶ Can have interactions with siblings without fighting for short periods of time.
- ▶ Has decreased psychotropic medication slightly (with hopes to decrease more over time).

Today:

- ▶ Instigating (minding other people's business), constant attention seeking, and disrespectful communication are her biggest regular daily challenges (which can set off tantrums).
- ▶ Can express sympathy and empathy.
- ▶ Can talk about how she feels.
- ▶ Can sometimes identify her own thinking and behavioral errors and accept responsibility for her behaviors.
- ▶ Is still working to learn how to regulate her emotions when she's upset, by mirroring the emotions of the BI's working with her, practicing the tools she learns in therapy, and processing the situations when she's calmed down.

For more information about the BI Program©:

- ▶ Contact Lori Ross at <http://www.mfcaa.org>
 - ▶ MFCAA, 18600 E. 37th Terrace S., Independence, MO 64057
 - ▶ 816-350-0215
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 - ▶ Lifeworks, PO Box 860764, Shawnee, KS 66286
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