This presentation was provided as a Webinar for Health Home Care Coordinators which aired on April 10, 2014. Review of this PowerPoint presentation satisfies, in part, the required State-sponsored special training modules for Health Home Care Coordinators.

This presentation was developed by Andrea Parrish and focuses on coaching children and families. Andrea is the Program Manager and specialist on pediatric mental health with DSHS's Behavioral Health Administration.

Purpose:

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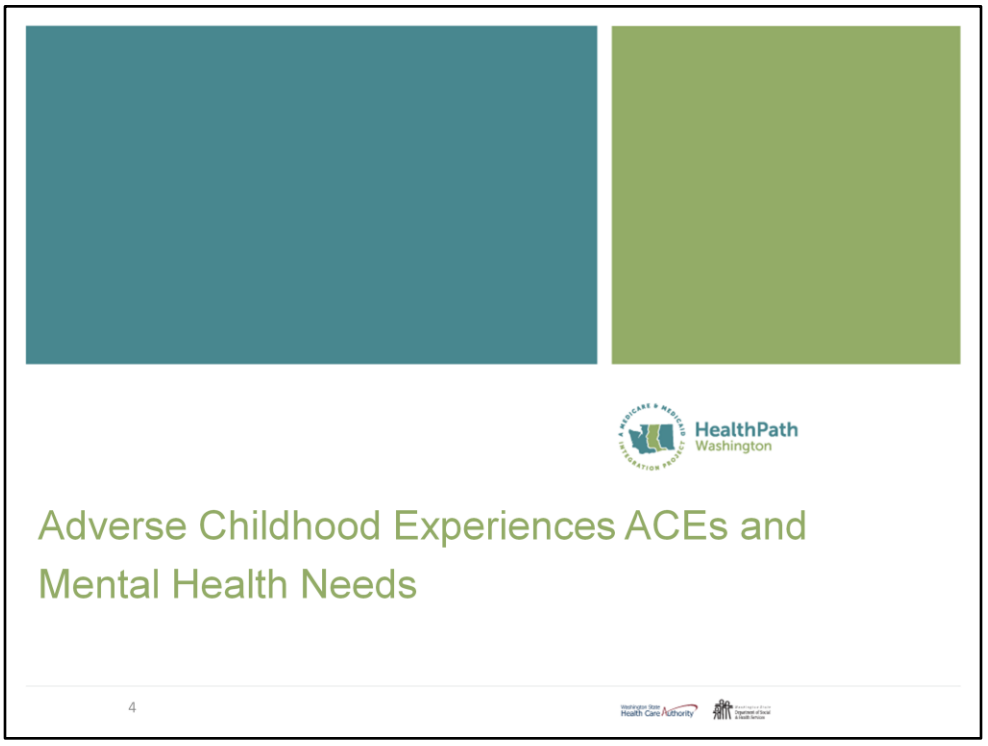
Overview of mental health needs in children and their families and how to address these needs

Training Objectives

- Describe ACEs, symptoms and behaviors a child may display as a result of a mental health need/diagnosis and how developmental stages effect what you will see
- Suggest ways that Care Coordinators may reach out to and engage children and their families
- Describe the mental health network and delivery system for mental health care for children



First let us consider Adverse Childhood Experiences:

- What it is?
- Symptoms of ACEs?
- How are ACEs tied to behaviors and symptoms?

Adverse Childhood Experiences (ACE) Study

- How ACEs impact health and well-being
- ACEs in context

History of ACEs

- Ongoing collaboration between CDC and Kaiser Permanente's Health Appraisal Clinic in San Diego.
- Original data collected between 1995 and 1997
- 17,337 adults with health insurance, questions asked as part of comprehensive physical exam

Adverse Childhood Experiences

- Emotional abuse
- Physical abuse
- Sexual abuse
- Emotional neglect
- Physical neglect
- Mother treated violently
- Household substance abuse
- Household mental illness
- Parental separation or divorce
- Incarcerated household member

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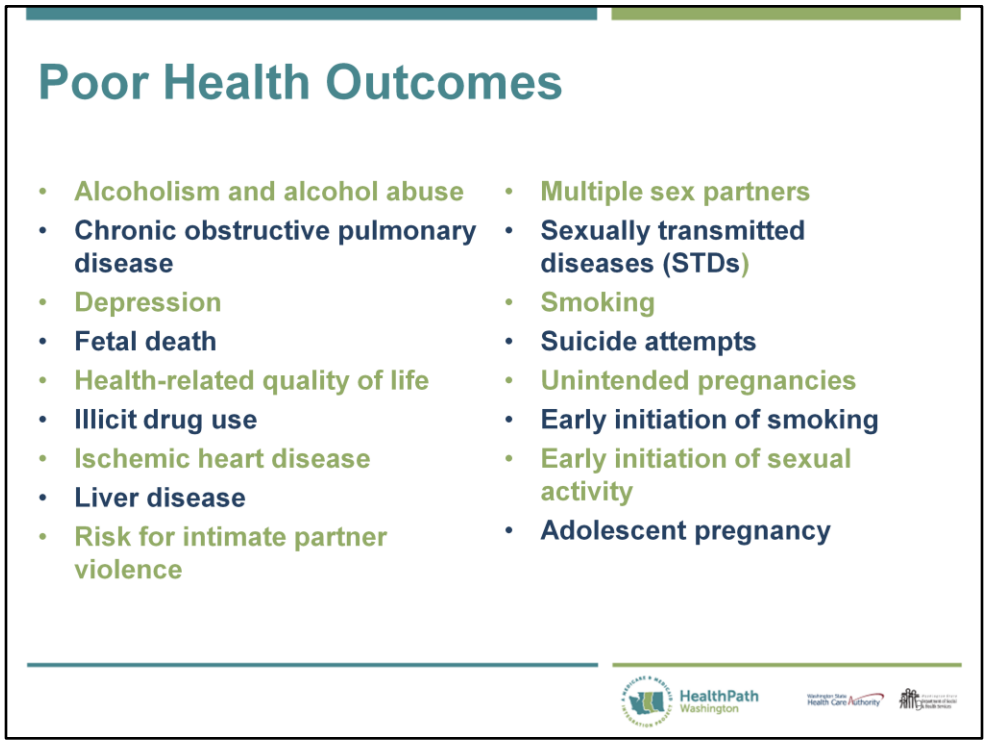
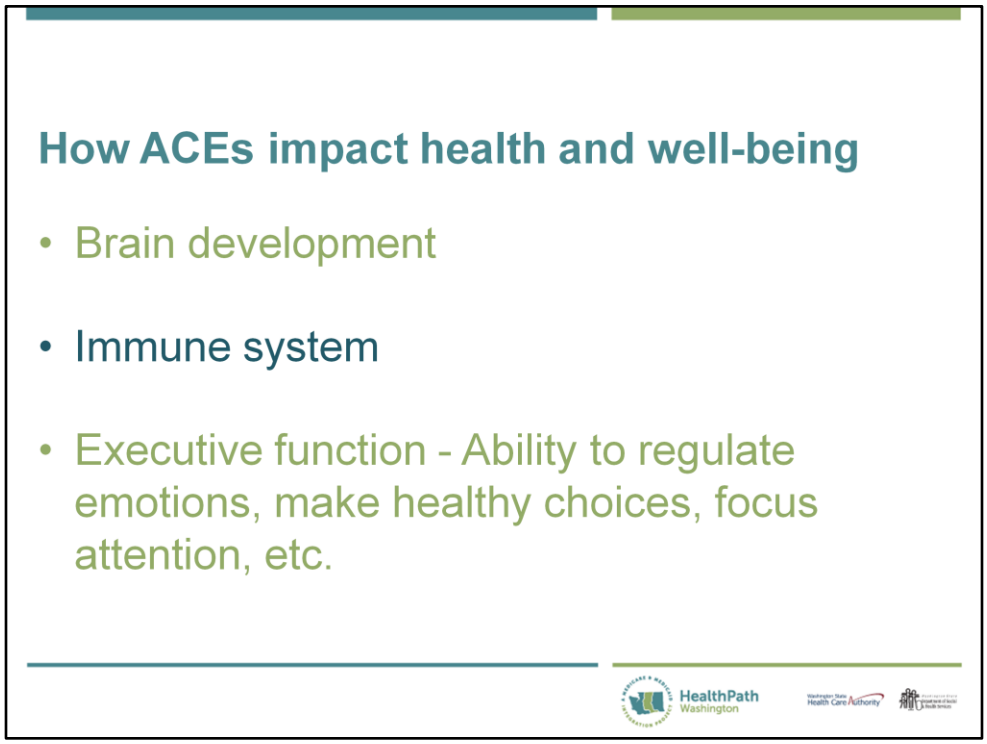
Poor Health Outcomes

According to the Center for Disease Control:

"…as the number of ACEs increase, the risk for the following health problems increases in a strong and graded fashion."



As the number of ACEs increase the risk for these health conditions also increases.

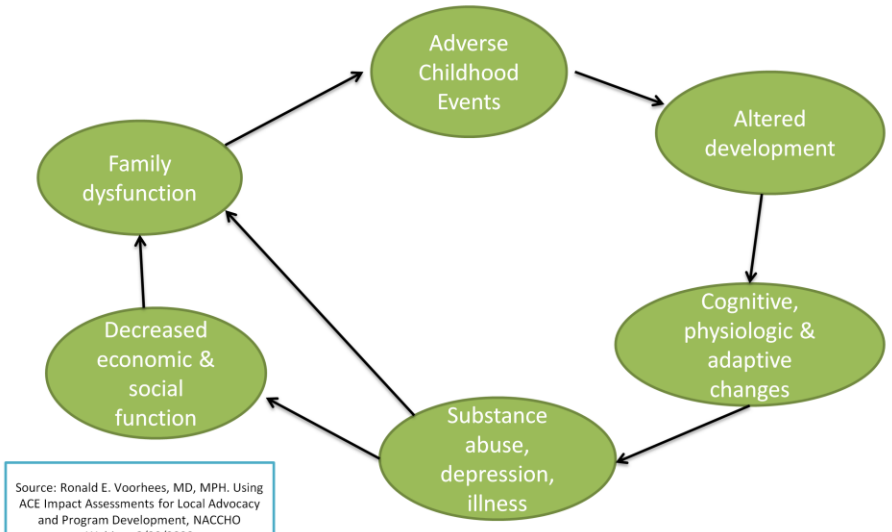


Healthy emotional and psychological development of young children requires that the child have a relationship with a nurturing, protective adult who fosters trust and security. This is an **attachment relationship**. A young child forms attachments during the period of early brain development, which sets the framework for emotional development. The professional literature3 identifies four types of attachment relationships:4

- **Secure attachment:** The child trusts that her parents are consistently available. When the child is frightened or unsure about something, she looks to her parents for reassurance. If the parent is calm, the child is no longer frightened. She may move closer to the parent to touch base but then will return to whatever activity she was engaged in before the threat.
- **Anxious-ambivalent attachment:** The child cannot count on his parents to respond consistently. Sometimes the parent is nurturing and sometimes she is not. The child uses two coping strategies interchangeably—clinginess and feigned independence—to demonstrate his insecurity.
- **Anxious-avoidant insecure attachment:** The child has learned that the parent is not there for her. She behaves as though she has no need for the parent's attention.
- **Disorganized attachment:** This form of attachment is associated with children who have been physically abused and is the most difficult to treat. Such a child has no strategy for dealing with his parents' failure to protect

and nurture him. He attempts proximity with his parent in odd ways such as approaching her backwards or simply falling in a heap near her.

ACE Cycle



Source: Ronald E. Voorhees, MD, MPH. Using ACE Impact Assessments for Local Advocacy and Program Development, NACCHO Webinar 8/20/2009

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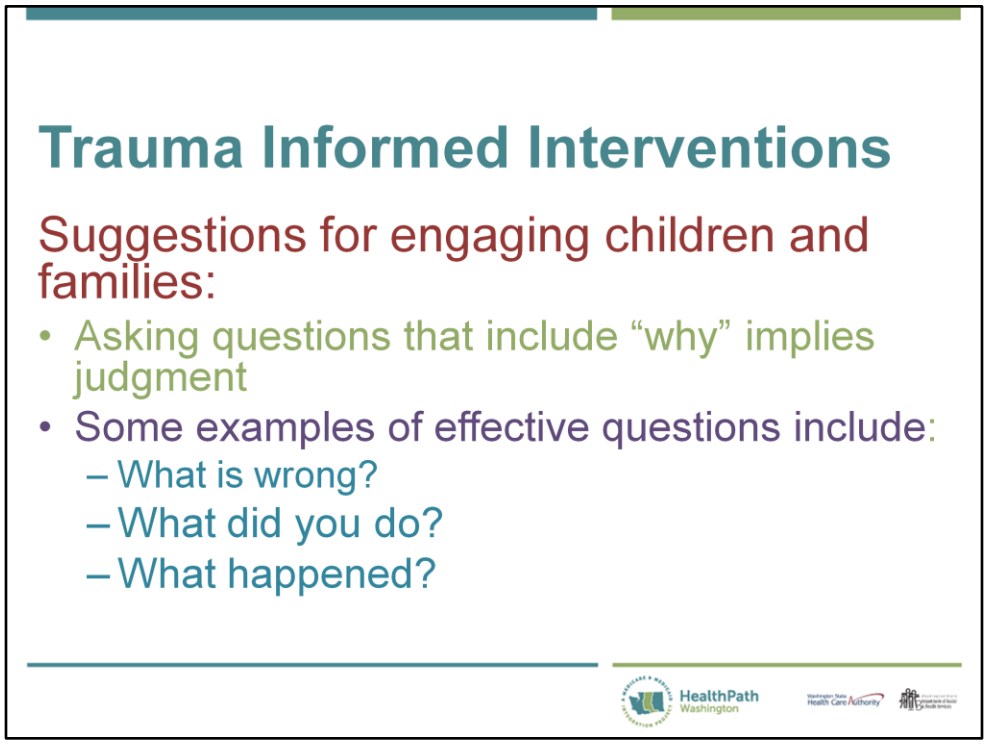
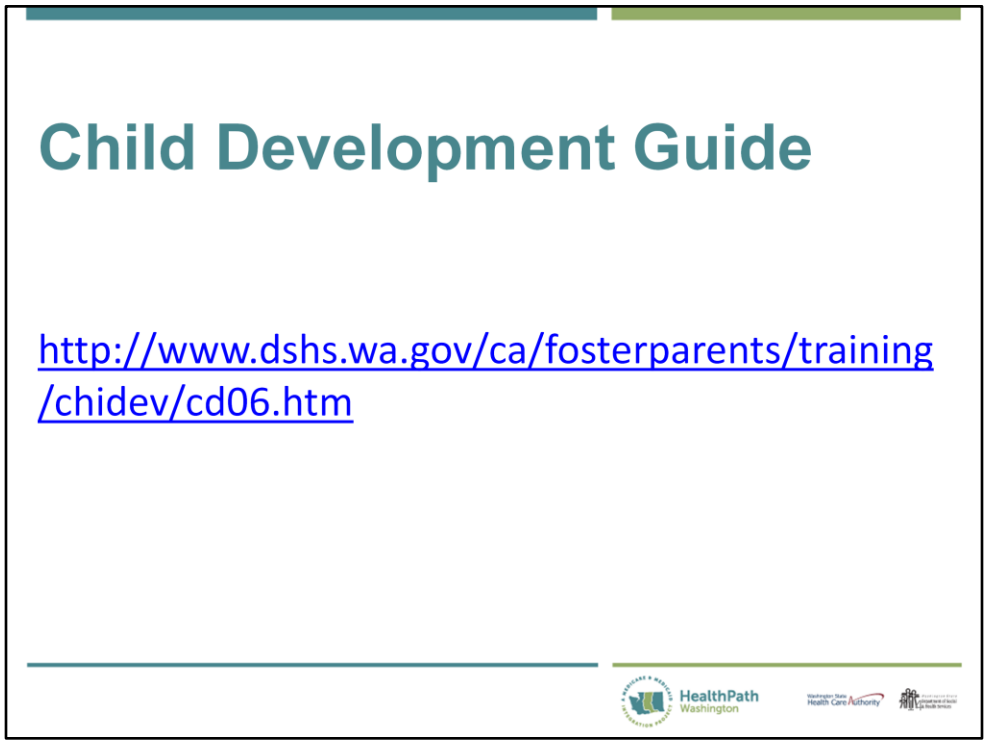
What is?

- Trauma Informed Care
- Trauma Informed Systems



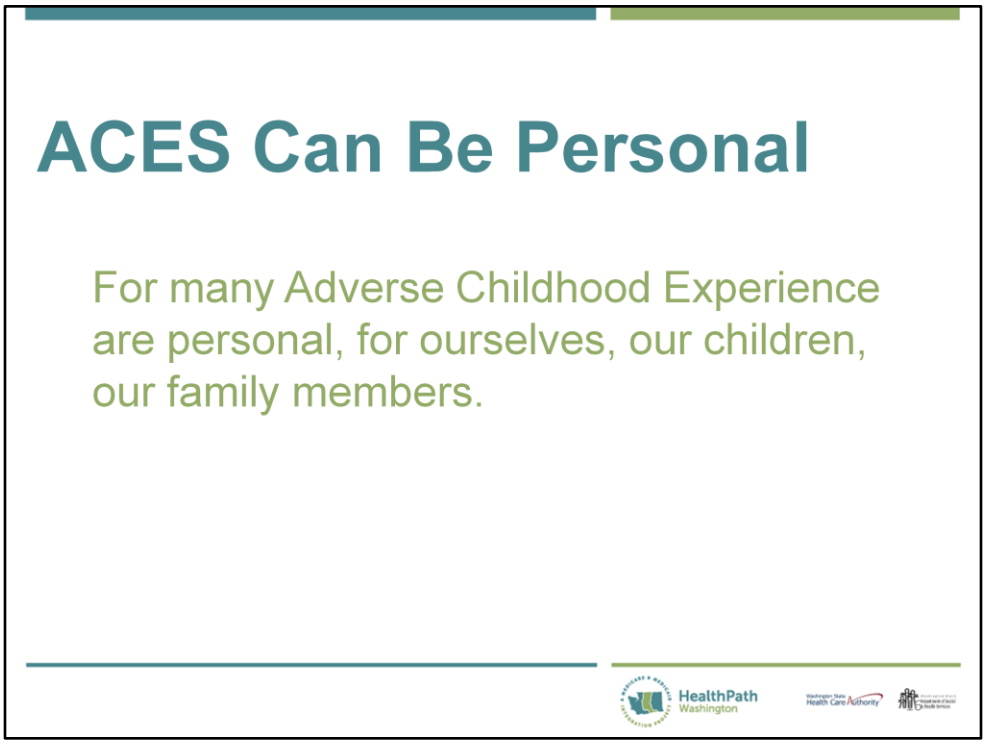
What is wrong/the matter and what happened to you. This is a great engagement question on may levels. You are not asking for an explanation you are asking for the child/youth experience



This will take about 10 minutes to review

Summary

- Development occurs in stages related to age.
- These stages are sequential, they can not be skipped.
- Each stage of development has certain tasks associated with it that must be accomplished before moving to the next stage.
- There are five areas of development:
  - Physical, Intellectual, Social, Emotional, and Moral
- A person can become "stuck" at a certain stage of development in one or more areas. Based in part, on when trauma occurs.
- Trauma can slow the developmental process.



Be aware that knowing how ACEs effect others may also trigger past experience for each of us.
Please find appropriate support for yourself

Techniques for Engaging Children, Youth, and Families

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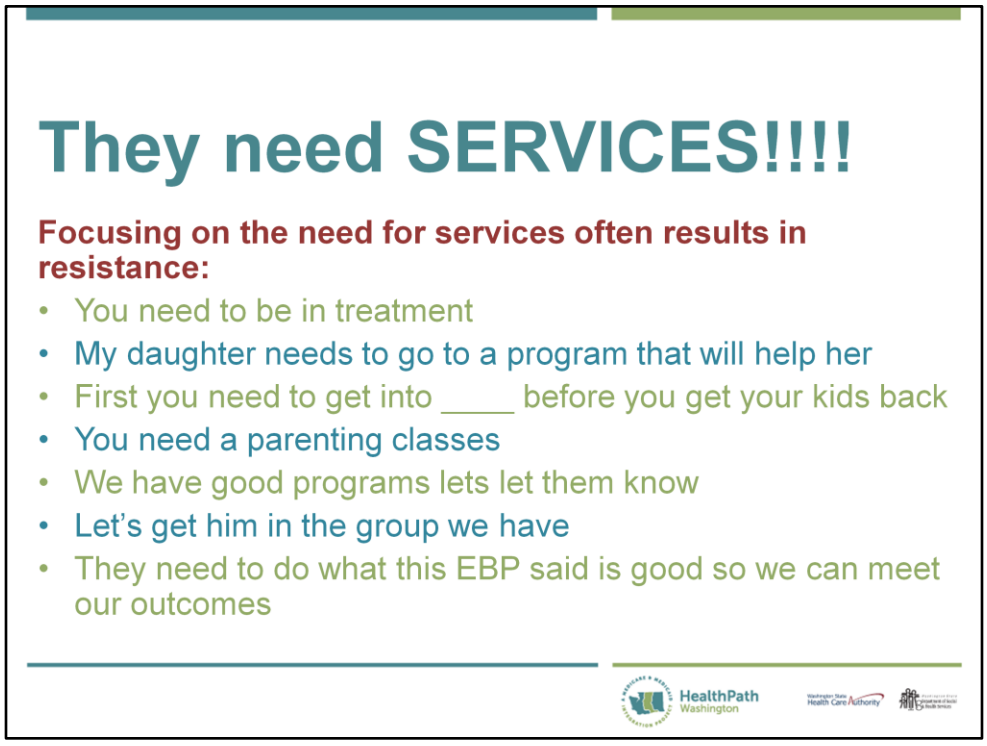


Do children, youth and families need services?
Or do we need to sell our services?
Do we need for families to accept the services we have?
What does the family need?
What does the youth need?

The child has many "individualized plans"

Little family/youth voice overlapping (and often contradictory) services…..

Kids and families pulled in many directions.

Services may be viewed as a waste of time, effort, and money.

Professionals may indicate that the family is resistive, when in truth, all of the "help" pulls them in many directions
adding more stress to an already stressful situation.

Engagement Ideas for Youth and Families

- Involve families in the treatment process
- Put youth interests on the top of the agenda
- Meet families and youth where they are at
- Identify youth needs and goals and empowered them work towards their goals
- Reduce stigma
- Connect to youth and family peer support

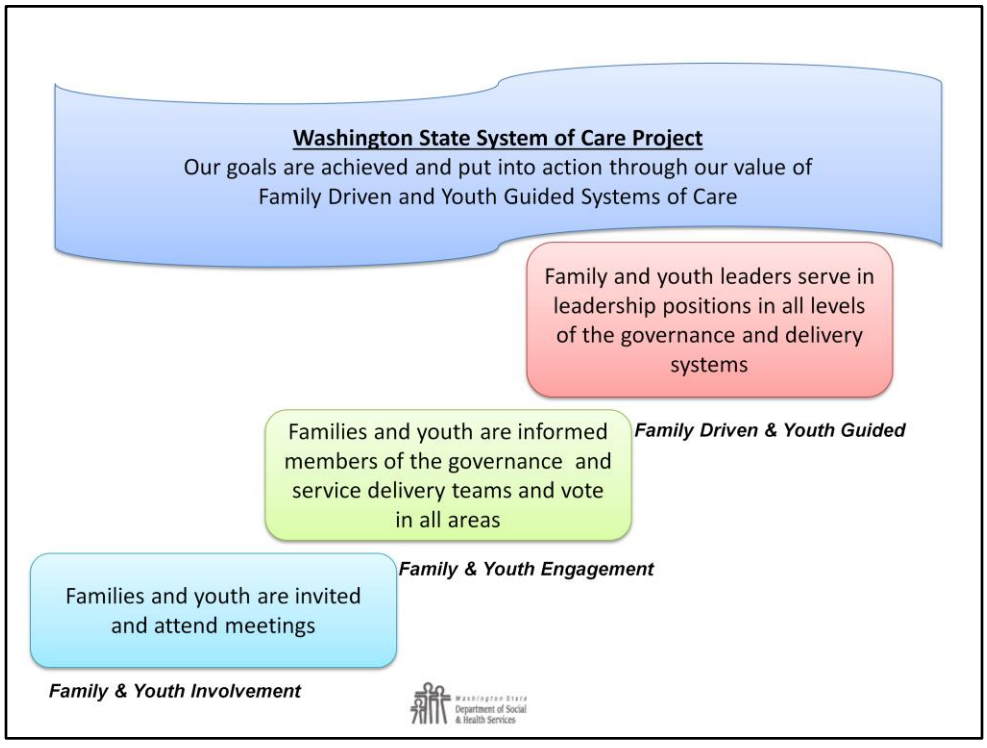
Perhaps the most important point is to understand the impact youth involvement has on youth. Ideas suggested by youth)

- Meet youth where they are at and help them go places
- Reduce stigma – youth do not have to feel alone or ashamed of what they are going through
- Show people that youth are not products of their environment – that they can be better

More ideas suggested by youth

- Provide structure and a positive place to grow
- Give youth something to be a part of and proud of
- Help youth help others … so the are more able to help themselves
- Empower youth to take charge of their recovery

What are youth and family partners?


Washington State System of Care Project
Our goals are achieved and put into action through our value of Family Driven and Youth Guided Systems of Care
Family and youth leaders serve in leadership positions in all levels of the governance and delivery systems
Families and youth are informed members of the governance and service delivery teams and vote in all areas
Family Driven & Youth Guided
Family & Youth Engagement
Families and youth are invited and attend meetings
Family & Youth Involvement
Washington State Department of Social & Health Services

How to get youth partners: Youth 'N Action!

Youth 'N Action is a Statewide youth advocacy program that brings youth voice to public policy. Through leadership and peer support Youth N Action empowers at risk youth ages 14-24 to make differences in their lives, communities and systems that serve youth.

Tamara Johnson
Director Youth 'N Action
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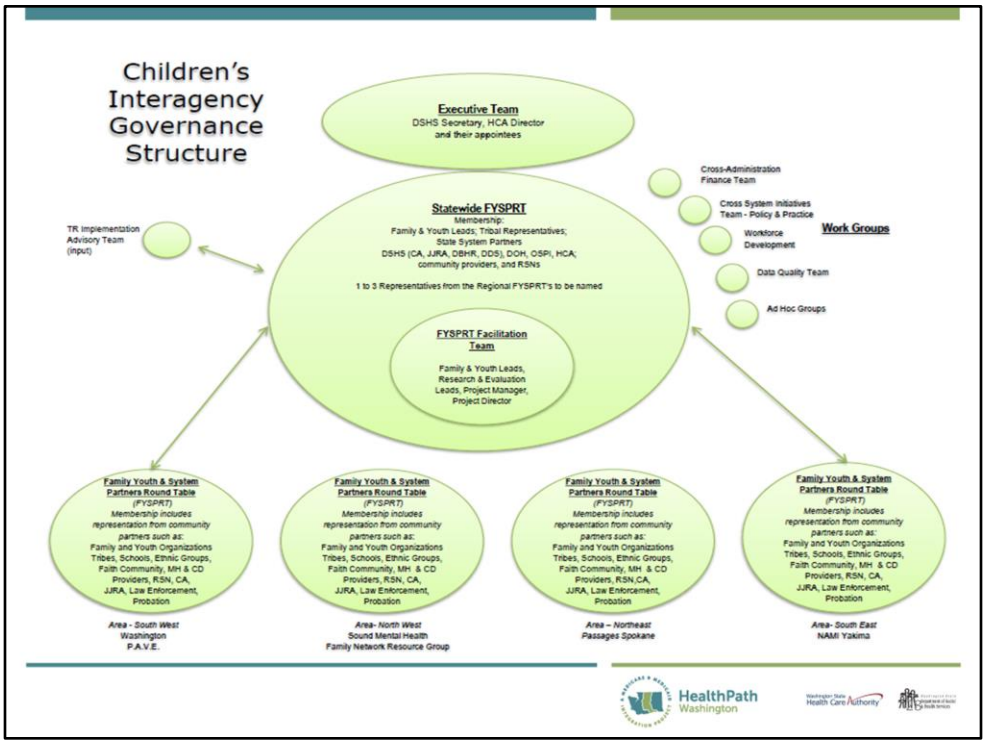
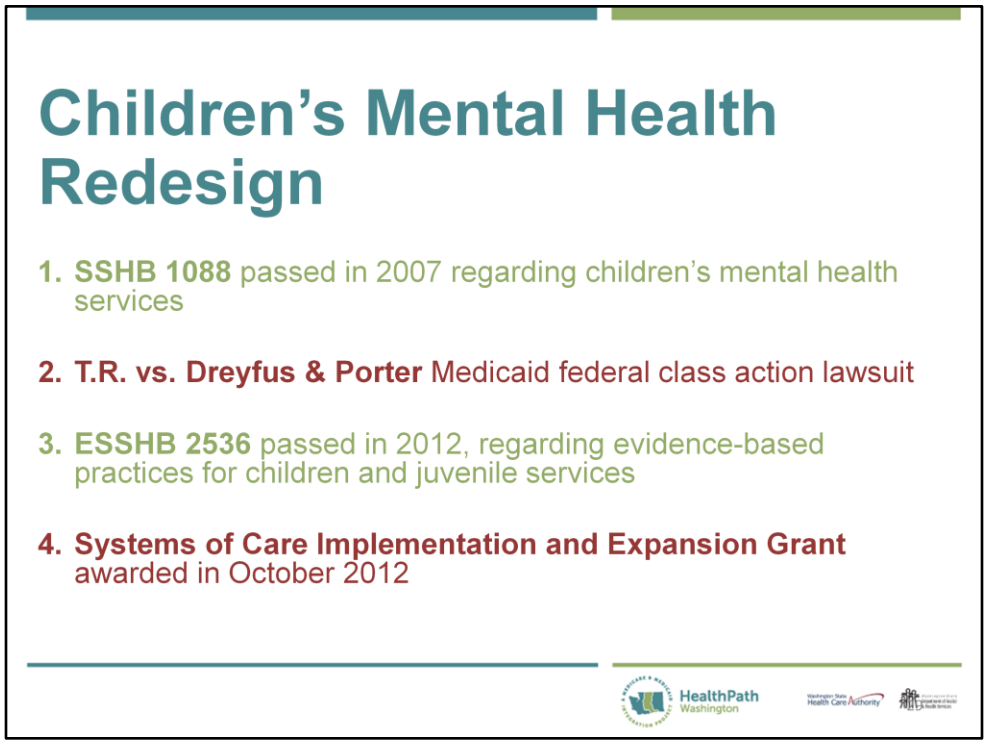
System of Care Values and Principles

1. Family driven and youth guided, with the strengths and needs of the child and family determining the types and mix of services and supports provided.

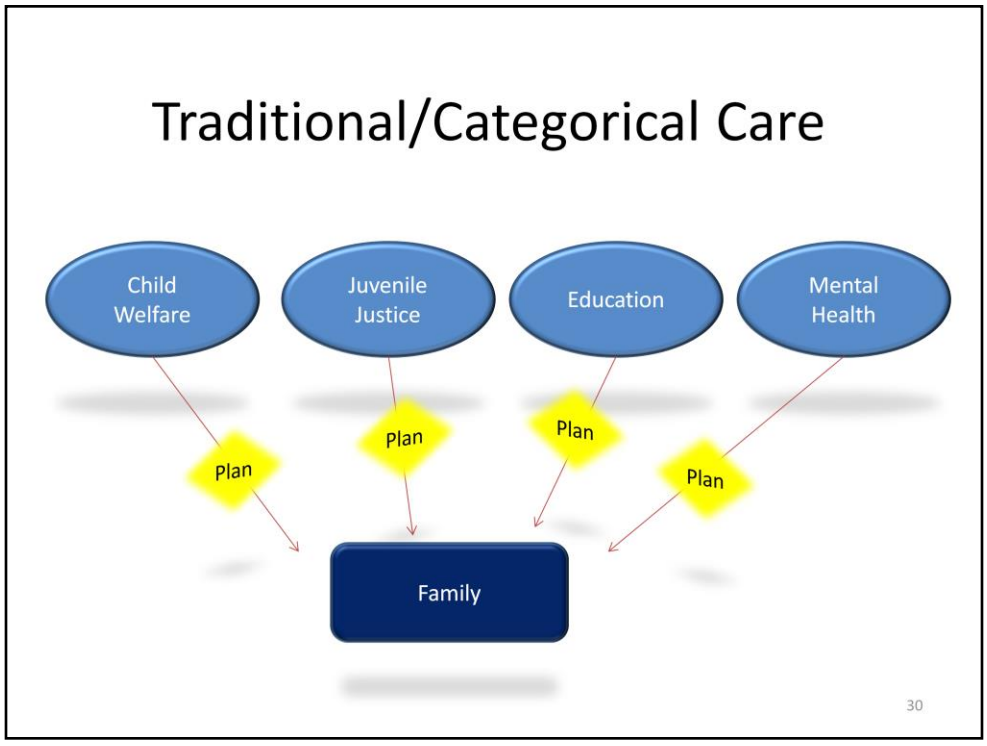
2. Community based, with the locus of services as well as system management resting within a supportive, adaptive infrastructure of structures, processes, and relationships at the community level.



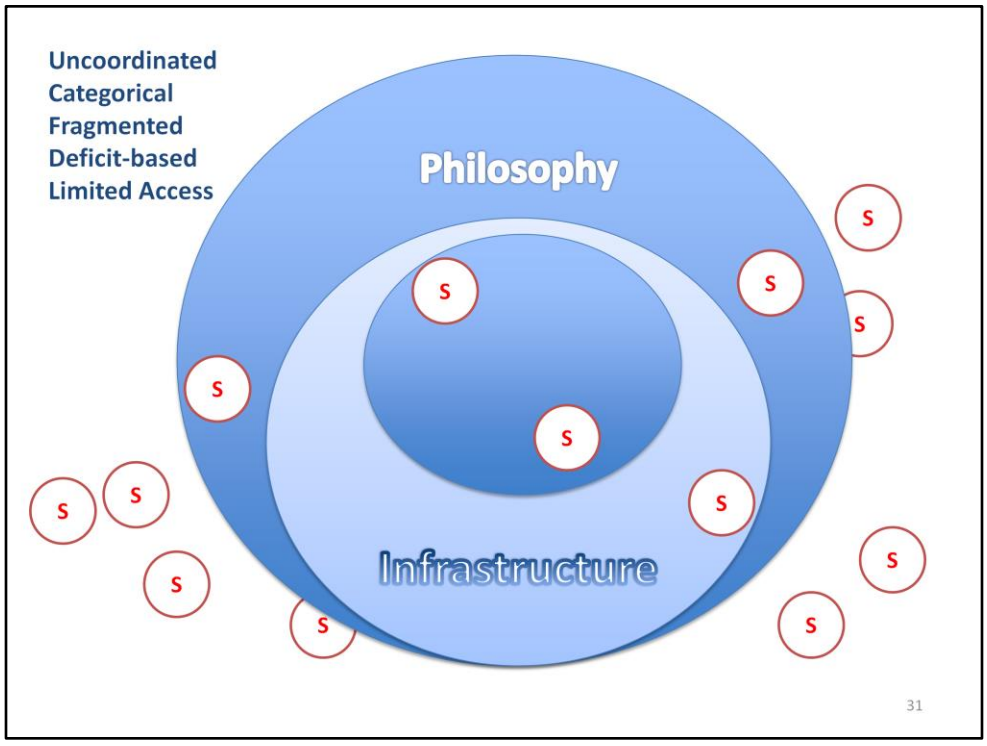
Development of an interagency Governance Structure



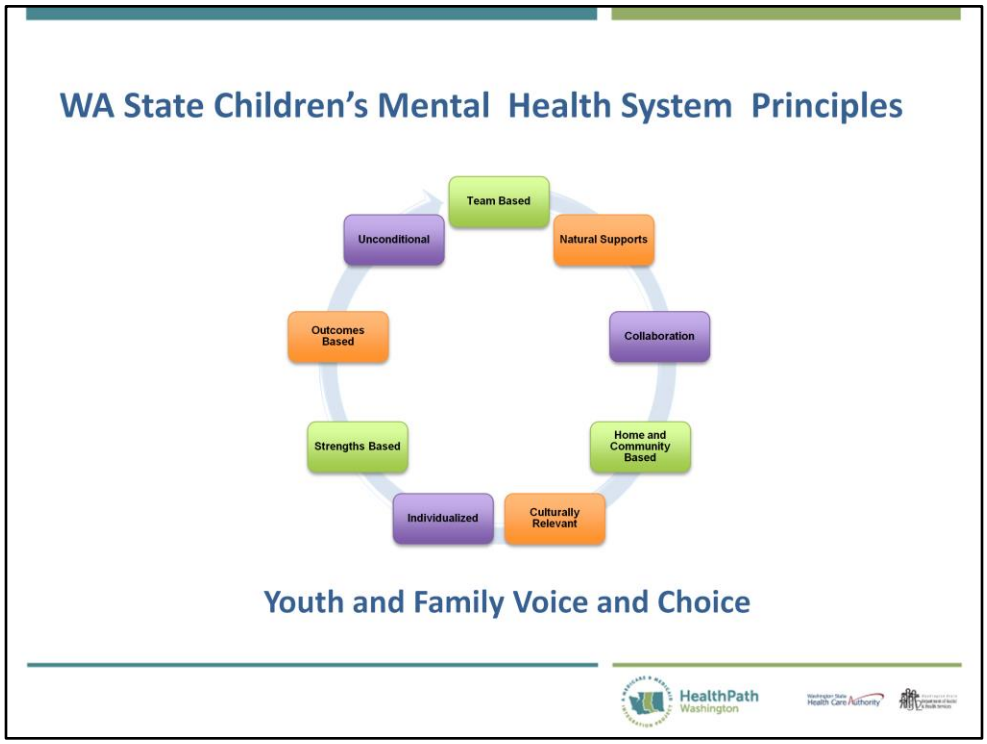
Legislation and court orders that have effected Children's Mental Health



Historically, Traditional/Categorical Care includes each system operating independently – resulting in multiple plans for a family.



The bubbles with an “S” represent services.



Building on the DSHS values…

Family and Youth Voice and Choice: Family and child voice, choice and preferences are intentionally elicited and prioritized during all phases of the process, including planning, delivery, transition, and evaluation of services. Services and interventions are family-focused and child-centered from the first contact with or about the family or child.

Team-based: Services and supports are planned and delivered through a multi-agency, collaborative teaming approach. Team members are chosen by the family and connected to them through natural, community, and formal support and service relationships. The team works together to develop and implement a plan to address unmet needs and work toward the family's vision.

Natural Supports: The team actively seeks out and encourages the full participation of team members drawn from family members' networks of interpersonal and community relationships (e.g. friends, neighbors, community and faith-based organizations). The care plan reflects activities and interventions that draw on sources of natural support to promote recovery and resiliency.

Collaboration: The system responds effectively to the behavioral health needs of multi-system involved children and their caregivers, including children in the child welfare, juvenile justice, developmental disabilities, substance abuse, primary care, and

education systems.

Home and Community-based: Children are first and foremost safely maintained in, or returned to, their own homes. Services and supports strategies take place in the most inclusive, most responsive, most accessible, most normative, and least restrictive setting possible.

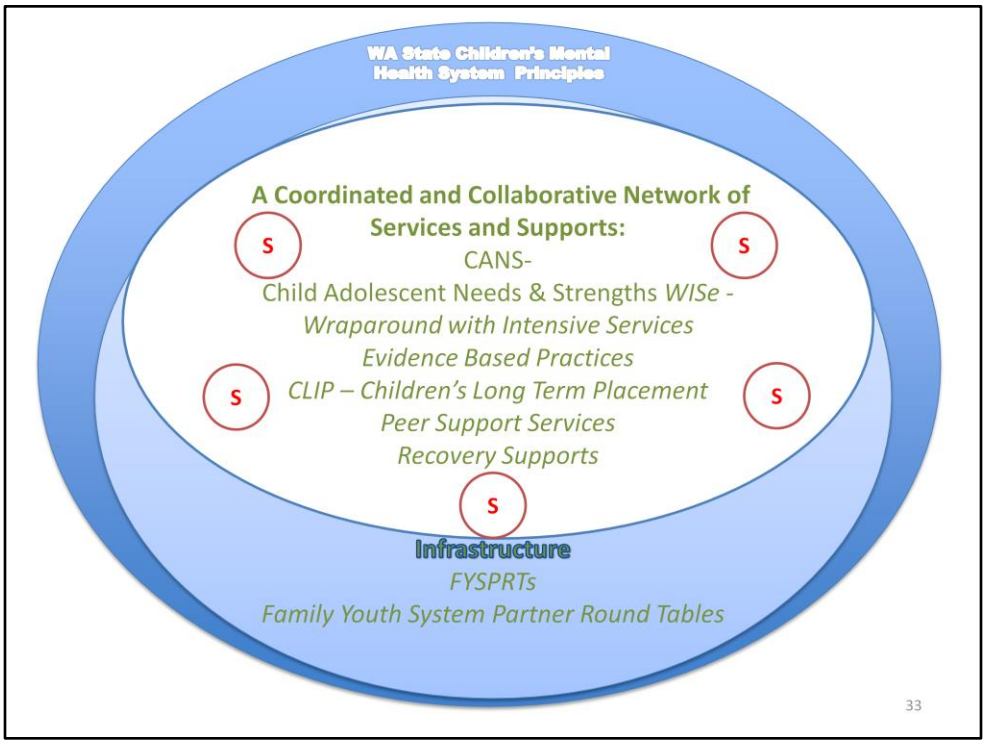
Culturally Relevant: Services are culturally relevant and provided with respect for the values, preferences, beliefs, culture, and identity of the child/youth and family and their community.

Individualized: Services, strategies, and supports are individualized and tailored to the unique strengths and needs of each child and family. They are altered when necessary to meet changing needs and goals or in response to poor outcomes.

Strengths-based: Services and supports are planned and delivered in a manner that identifies, builds on, and enhances the capabilities, knowledge, skills, and assets of the child and family, their community, and other team members.

Outcome-based: Based on the family's needs and vision, the team develops goals and strategies, ties them to observable indicators of success, monitors progress in terms of these indicators, and revises the plan accordingly. Services and supports are persistent and flexible so as to overcome setbacks and achieve their intended goals and outcomes. Safety, stability and permanency are priorities.

Unconditional: A child and family team's commitment to achieving its goals persists regardless of the child's behavior, placement setting, family's circumstances, or availability of services in the community. The team continues to work with the family toward their goals until the family indicates that a formal process is no longer required.


WA State Children's Mental Health System Principles
A Coordinated and Collaborative Network of Services and Supports:
S
S
CANS-
Child Adolescent Needs & Strengths WISe -
Wraparound with Intensive Services
Evidence Based Practices
S
CLIP – Children's Long Term Placement
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Peer Support Services
Recovery Supports
S
Infrastructure
FYSPRTs
Family Youth System Partner Round Tables
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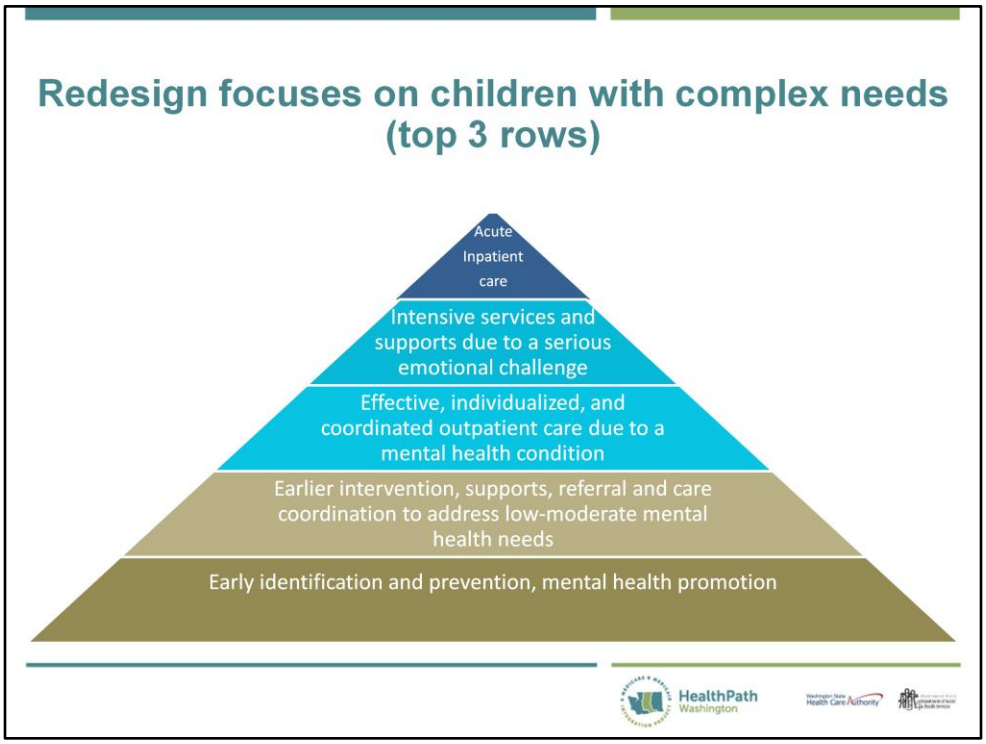

Health Plan providers address mental health concerns through identification, direct intervention, and referral to MH providers (for up to 20 sessions) or to RSNs for additional services.

Regional Support Networks and their contracted Community Mental Health Agencies address moderate to intensive / acute mental health challenges.

What will be different for families?

1. Access to a screening for Wraparound with Intensive Services (WISe)
2. Child and Family Team – single coordinated care plan
3. Increased availability of evidence- and research- based practices to meet their needs
4. Statewide access to Wraparound with Intensive Services (WISe) for those who need it
5. Increased voice and partnership with providers and system administrators

Children' Behavioral Health System

- Access points:
  - RSN's
  - Community Mental Health Providers
  - Crisis
  - CLIP - Children's Long term Treatment
  - DMHP – Designated Mental Health Professional

RSNs Mental Health Providers and Contacts

- MAP
- RSN ADMINISTRATORS
- RSN CHILDREN'S CARE COORDINATORS
- http://www.dshs.wa.gov/dbhr/rsn.shtml#dbhr

What are Autism Spectrum Disorders?

Autism Spectrum Disorders (ASD), most commonly diagnosed in children, fall in the category of difficulty in relating and communicating. Many will manifest in problems with social interaction both verbal and nonverbal

General Indicators of ASD

- becoming overly attached to a particular toy or object. If the toy or object is moved or lost
  - the child will become very upset, lose control, have extreme difficulty calming down
- not smile very often
- seem hearing impaired
- lose social skills apparent earlier in development, and
- crave rituals and/or order to their activities
- do not respond to their names
- lose language skills apparent earlier in development

Citations and Resources for Systems of Care

Systems of Care (www.tapartnership.org)

1. Stroul, B., & Friedman, R. (1986). *A system of care for children and youth with severe emotional disturbances (Rev. ed.)* Washington, DC: Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health. Reprinted.
2. Pires, S. (2002). *Building systems of care: A primer.* Washington, D.C.: Human Service Collaborative.
3. Stroul, B. (2002) Issue Brief: Systems of Care: A framework for systems reform in children's mental health. Washington, DC: Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health.

Citations and Resources for Wraparound

Wraparound (www.nwi.pdx.edu)

1. Walker, J. S., Bruns, E. J., VanDenBerg, J. D., Rast, J., Osher, T. W., Miles, P., Adams, J., & National Wraparound Initiative Advisory Group (2004). *Phases and activities of the wraparound process. Portland, OR: National Wraparound Initiative, Research and Training*

   Center on Family Support and Children's Mental Health, Portland State University.
2. Bruns, E. J., & Suter, J. C. (2010). Summary of the wraparound evidence base. In E. J. Bruns & J. S. Walker (Eds.), *The resource guide to wraparound. Portland, OR: National Wraparound Initiative.*
3. Walker, J. S. (2008). How, and Why, Does Wraparound Work: A Theory of Change. Portland, OR: National Wraparound Initiative, Portland State University
4. Bruns, E.J., Walker, J.S., et al (2004) Ten Principles of the Wraparound Process. Portland, OR: National Wraparound Initiative, RTC, Portland State University.

Further Information

Health Care Authority Health Homes:
http://www.hca.wa.gov/Pages/health_homes.aspx

Substance Abuse Mental Health Services Administration:
http://www.samhsa.gov/

Children's Behavioral Health Web site:
http://www.dshs.wa.gov/dbhr/childrensbehavioralhealth.shtml

Further information about ACEs

- **Centers for Disease Control and Prevention**
  www.cdc.gov/ace/index.htm
- **Family Policy Council:** www.fpc.wa.gov
- **ACEs Too High:** http://acestoohigh.com/
- **OSPI – Compassionate Schools:**
  www.k12.wa.us/CompassionateSchools/default.aspx
- **Frontiers of Innovation - Harvard Center on the Developing Child:**
  http://developingchild.harvard.edu/
- **Tory Clarke Henderson, ACEs Consultant DOH:**
  Tory.henderson@doh.wa.gov

Further Information

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