CHILDREN'S BUREAU'S PROGRAMS

CHILDREN'S BUREAU OF NEW ORLEANS

Founded in 1892, Children's Bureau is a small, private, non-profit (501(c)3 approved) United Way organization providing specialized programs for children and families in the greater New Orleans' area. The mission of the agency is as follows: "Children's Bureau is committed to improving the quality of life for children and their families through innovative programs that focus on child welfare and rights. Children's Bureau helps families give children love, roots and ultimately wings." Children's Bureau strives to provide quality, affordable intervention to individuals, children and families that will improve their quality of life and enhance family functioning; to participate in coalitions with agencies and organizations to provide coordinated interventions and services to families; to provide mental health intervention and community education aimed at the prevention of child and family dysfunction; and to advocate in the best interest of children and their families.

We are one of the few agencies in Louisiana accredited by the national accrediting agency, Council on Accreditation for Children and Family Services (COA). The comprehensive accreditation process requires that programs employ nationally recognized standards of best practices and complete a self-study/evaluation every four years in an effort to improve service delivery outcomes. Children's Bureau received reaccreditation in the Fall 2005, effective through 2009.

Project LAST (Loss and Survival Team)

Children's Bureau's Project LAST (Loss and Survival Team) provides community-based intervention to children and families who have experienced a traumatic event and/or death including children and families who have been impacted by Hurricane Katrina or other natural disaster; children and families who are survivors of homicide victims, witnesses of community violence and/or victims of community violence; families who have experienced a stillbirth or death of an infant; and/or children and families who have experienced a "non-criminal" traumatic event and/or death such as a suicide of a loved one, death from natural causes, or motor vehicle accident. Interventions include individual, group and family therapy to families with children ages zero to seventeen, and are provided by Licensed Clinical Social Workers, Master's level social workers, and graduate level student interns supervised by duly qualified social worker staff. Project LAST also provides specialized services to families with young children (ages 0 to 6) and employs a Licensed Clinical Social Worker who has extensive training in providing clinical interventions for young children and their caregivers who have experienced a traumatic event.

Project LAST utilizes a community-based approach in providing services to children and families in order to break down those barriers that might prevent a family from seeking out counseling services such as lack of transportation, lack of child care, and/or physical/mental disabilities that prevent caregiver or child from attending office sessions. Community-based services also provide Project LAST social workers with a unique perspective of the family dynamics which serves as a valuable tool in the treatment process. Providing therapy in the home also gives the social worker access to extended family members who have also been affected by the traumatic event/death but who would not normally participate in an in-office therapy session. In addition, Project LAST social workers often conduct school visits in order to provide individual therapy to the child, to gather assessment

information and work collaboratively with the school in order to implement interventions with the goal of reducing grief and/or trauma symptoms in order to increase the child's overall functioning.

Our Project LAST group model and individual and family interventions are grounded in the latest research and both utilize best/promising practices. In 2002, the National Institute of Mental Health cited Project LAST groups with youth as an effective intervention for victims and/or survivors of violence. This citation was based on a pilot study of the Project LAST group model which was published in the November 2001 Journal of the American Academy of Child and Adolescent Psychiatry (Salloum, Avery and McClain, 2001). The article was based on outcome data of Project LAST grief and trauma group interventions that occurred between 1997 and 2001. The study measured the effectiveness of a psychotherapy group model to decrease trauma symptoms among child survivors of homicide. The study found that after the group ended, participants reported a significant decrease in trauma symptoms and that group therapy may be helpful in reducing trauma symptoms among inner-city, African American youth. The child participants in the groups were all from the Greater New Orleans' area. Children's Bureau continues to make adaptations to the group model based on further analysis of the data from the pilot study (Salloum, 2005) and on the research to date of group interventions for children experiencing grief and trauma. In light of Hurricane Katrina, our model also has been revised to address the needs of children who have suffered losses and who are experiencing traumatic stress due to the hurricane. The original grief and trauma intervention model that was piloted with children experiencing grief and trauma due to homicide has been modified to address the clinical needs of loss and trauma due to the storm. Preliminary data from this research show that 91% of child participants showed a reduction in trauma symptoms. Final results of this study will be available in Summer 2007.

Project LAST consistently incorporates best practices in working with children and families. Therapeutic sessions are grounded in techniques from *Cognitive-Behavioral Therapy (CBT)*, which the National Center for Post Traumatic Stress Disorder has cited as the most effective treatment for PTSD, and *Narrative Therapy*. Furthermore, interventions are designed to be *developmentally specific* with an activity-based approach using art, drama, and play. Interventions are conducted in the ecological perspective which implies that the clinician has a broader understanding of the child in his or her environment. Therefore, clinicians are encouraged to intervene on multiple levels such as meeting with parents, teachers, and engaging in case management to address the needs of the child. Children's Bureau recognizes the need and ensures that its social workers provide culturally competent services to this area's children and families.

Project LAST specializes in working with children and families who have experienced a traumatic event and/or death, and interventions are designed to address the trauma/grief reactions that the child may be experiencing as a result of the event and/or death. Following are a list of program outcomes for individuals and families:

1. Children will show an improvement in mental health (physical, cognitive, emotional, behavioral and social) after experiencing a trauma/mental health crisis (e.g. improved concentration, less somatic symptoms, improved sleep, less guilt, less anxiety, less school problems, less behavior problems, improved ability to manage anger). Target 80%.
2. Children will show a reduction in trauma-specific symptoms/reactions. Target 75%.
3. Children/families will return to/improve toward their pre-trauma/crisis behavior pattern. Target 80%.

Children's Bureau continues to evaluate its service effectiveness by using standardized instruments. Two such instruments are the UCLA PTSD Reaction index (Steinberg, Brymer, Decker, Pynoos, 2004) and the Mood and Feelings Questionnaire (Angold et al, 1995). The UCLA Posttraumatic Stress Reaction Index is a 22-item, self-report, Likert scale that measures the level of severity of posttraumatic stress symptoms. This scale was chosen because it had been used with children who had been exposed to violence that resulted in a death and it was normed with inner city African American children (e.g., Pynoos, Frederick, et al., 1987). There is ample evidence demonstrating strong reliability and validity (Steinberg, Brymer, Decker, Pynoos, 2004). The National Child Traumatic Stress Network has selected this scale as the primary instrument to be used by all network members around the United States (Steinberg, Brymer, Decker, Pynoos, 2004). The Mood and Feelings Questionnaire (Angold et al, 1995) is a 33-item self-report instrument to measure child and adolescent depression. This measure has high internal reliabilities and high covergent and discriminatory validity compared with other self-report instruments for child depression. This measure has items to assist social workers in screening for suicidal ideation, and in light of the stress caused by Katrina and our own observations it is imperative to assess every child for depression.

In addition, at the beginning of the clinical intervention and with the assistance of the social worker, children and families set goals for what they want to achieve through the therapeutic process. The social worker and family review the goals on a regular basis, and together to determine whether or not goals have been met and, if necessary, to add a new goal or revise existing goals. The goals, and achievement of goals, are reviewed again at termination.

In addition to its therapeutic services, Project LAST provides Crisis Intervention Services to schools, families and/or community groups after a traumatic event has occurred, and provides training/education to parents, teachers and other mental health professionals on working with children who have experienced a traumatic event. Project LAST staff has presented at several annual conferences of national associations, such as the American Psychiatric Association (APA), International Society of Traumatic Stress Studies (ISTSS), National Organization for Victims of Crime (NOVA), National Association of Social Workers (NASW), and the National Center for Zero to Three.

Child and Family Counseling Program

The Child and Family Counseling Program offers individual, group and family therapy to families with children ages zero to seventeen. Interventions are child focused and provided by Licensed Clinical Social Workers, Master's level social workers and graduate level interns supervised by duly qualified staff. The Child and Family Counseling Program offers an opportunity for parents and children to identify problems and concerns, identify and acquire coping skills, and discover options that may ameliorate problematic behaviors and family patterns.

Due to identified community needs, the Child and Family Counseling Program continues to provide specialized interventions to survivors of domestic violence and their children. In addition, in recognizing the need to provide developmentally appropriate interventions for young children (ages 0 to 6), the Infant Mental Health Specialist who works with Project LAST, also provides direct clinical interventions and consultation and trainings for program staff. Currently, the Child and Family Counseling Program is also providing clinical services to youth and their families in Jefferson Parish who are involved in the Juvenile Justice system. Youth who are identified by their probation officer as needing mental health services are referred to Children's Bureau to participate in eight to twelve weeks of individual and family counseling services.

The Child and Family Counseling Program provides individualized treatment that addresses families and their environments. Program social workers focus on the person-in-environment concept that is the hallmark of effective social work practice, and places an emphasis on engaging parents and involving them in the counseling services, thus contributing to increased responsiveness of the parent to child needs, increased positive parent-child interaction, and increased parental knowledge of healthy childhood development. Therapy interventions are strength-based, culturally competent, and account for the ecological factors that influence the development and amelioration of mental illness.

Counseling services are provided in both office and community settings (schools, homes). Families who begin counseling will complete a thorough assessment where program guidelines are explained and client input regarding goals and desired methods of treatment are explored. Assessment will include examination of presenting problems, family social history, and children's developmental history, as well as use of assessment tools to measure child mental health symptoms i.e. the Achenbach Child Behavior Checklist (Achenbach and Rescoria, 2000), Moods and Feelings Questionnaire (Angold et al, 1995) and the UCLA Post Traumatic Stress Index (Pynoos et al, 2004), both of which are standardized instruments that are commonly used in the mental health field. An individualized treatment plan is then developed with the family and serves as a guide throughout the therapeutic process. In order to gain additional assessment information and to enhance community supports, service coordination for children is accomplished through ancillary and collateral contacts with teachers, day care providers, doctors, and other mental health professionals. The Child and Family Counseling Program will also link families to appropriate services that address needs beyond the scope of the program to ensure that basic needs such as safety, shelter and sustenance are being met.

The outcomes for the Child and Family Counseling Program are as follows:

1. Children will show an improvement in mental health (e.g. improved concentration, less somatic symptoms, less anxiety, less school problems, less behavior problems, improved ability to manage anger). (Target 80%)
2. Children/families will return to/improve toward their pre-crisis behavior pattern. (Target 80%)
3. Children/families are linked to appropriate services that address needs beyond the scope of direct services provided by Children's Bureau. (Target 80%)

If a family being seen through the Child and Family Counseling presents with trauma related issues, then Project LAST outcomes will also be utilized.

<u>Family Preservation Services</u>

Family Preservation Services (FPS) works in conjunction with state mental health services, through Metropolitan Human Services District (MHSD), in providing services to children and families who are in crisis. The primary goal is to maintain the family unit whenever possible by preventing psychiatric hospitalization or other out of home placement.

Families are referred to FPS through the public mental health clinics and other MHSD service providers, and direct contact with a family takes place within 48 hours after the case has been assigned to an FPS social worker unless the family is unable to meet or the social worker is unable to make contact. Intensive, direct services are provided to the family two to three times per week (ten hours per week); however, additional visits may be conducted for families with particularly

high needs. The majority of visits take place at the family's home, but can also occur at Children's Bureau or the MHSD agency if meeting at home presents an undue hardship on the family or impedes the therapeutic process. The FPS social worker also makes regular visits to the child's school if such visits are feasible. The intervention lasts for seven weeks, but can be extended for up to five extra weeks if additional visits are deemed clinically necessary.

The treatment model utilized is Cognitive Behavioral Therapy and is the basis for most of the program's interventions. There are numerous, additional interventions that may be employed during the therapeutic process and include the establishment of behavior modification plans with the parent or guardian; age appropriate talk and play therapy, journaling; anger management; family sessions, developing problem solving skills; and identifying environmental challenges.

Regular contacts are made with the client's primary MHSD social worker who referred the family to FPS, including a final meeting at the MHSD clinic. The FPS worker often employs different roles in serving clients, as the primary therapist, or functioning in a case management capacity. The worker may serve as a broker in linking children and families with needed concrete resources, such as housing, employment opportunities and social assistance. The FPS social worker may also act as an advocate when appropriate, ensuring the educational accommodations are put into place in order to assist the needs of a child, along with any other enhancement and implementation of community or social services that may be beneficial. While serving in these capacities, the FPS social worker is also empowering the clients in their ability to assist themselves.

There are several tools that measure a successful outcome in FPS. During the first visit, a pre-counseling survey is utilized that asks why the parent and client feel that the services are necessary and what they hope to obtain from the intervention. The family is also asked to rate the seriousness of the presenting problem and their expectations about help and improvement from the services. On the final session, a post-counseling survey is utilized and clients are asked to answer and rate the results of services that were provided. Additional pre- and post-measurements include FACES (Family Adaptability and Cohesion Evaluation Scale), the Achenbach Child Behavior Checklist, Moods and Feelings Questionnaire (Angold et al, 1995), and the UCLA PTSD Index (Pynoos et al, 1998). The family, with the assistance from the FPS social worker, also sets goals that are to be met during the intervention period, the first goal always being to prevent psychiatric hospitalization or other out of home placement. The progress of goal attainment is discussed throughout the FPS intervention.

Following is a list of outcomes and target percentages for FPS:

Outcomes for FPS:	Annual Target
Initial: Prevent hospitalization or other out of home placement of the identified client.	85%
Intermediate: Establish additional goals with the child and family, diffuse crisis situation, and restore equilibrium within household.	100%
Long Term: Make appropriate recommendations at the end of treatment and provide 3 month, 6 month, and 12 month follow-up calls.	100%

Custody Evaluation:

Children's Bureau's Custody Evaluation Program provides affordable child custody evaluations and family systems analysis for families referred through the courts to determine the best custody and

visitation arrangements for the identified child(ren). A flat fee for service exists for the Custody Evaluation Program.

Families are referred to Children's Bureau through the courts, after which each party completes an agency telephone intake. Upon receipt of the court order, the case is assigned to a Licensed Clinical Social Worker who then conducts a comprehensive set of interviews with the parents, child(ren), and other collateral contacts i.e. teachers, counselors, grandparents. The custody evaluation includes but is not limited to clinical interviews, observations, social histories, and/or psycho-social assessment tools. The role of the evaluator is always focused on "the best interest of the child," and the social worker evaluates all information according to that standard.

Upon completion of the interviews and data collection, the evaluator completes a comprehensive report for the court which includes the evaluator's recommendations for custody and visitation. The custody evaluation process may also require the evaluator's testimony in court should he/she be subpoenaed for testimony.

Intake Process

The entry point to receive services from any of the programs described above consists of a telephone intake which is conducted by social work staff and graduate social work interns. An Intake Form is completed at the time of the initial phone call from the client and includes the following information: date of call, caller's name, address, age, race, gender, employment, marital status, and income. Furthermore, intake calls allow social workers to screen for the caller's stated presenting problem and risks associated with family violence, suicidal ideation, homicidal ideation, and/or other potentially dangerous behaviors. Since Hurricane Katrina, Children's Bureau has experienced an increase in the number of caregivers who are reporting that a child(ren) is suicidal and/or homicidal and has implemented the following procedure in response to the lack of mental health resources in our community: If it is determined that the child is not in need of emergency psychiatric care, then an appointment is immediately scheduled for the caregiver to bring the child into Children's Bureau for an assessment and to determine the appropriate safety plan for that child.

Once the Intake Process is completed, clients eligible for individual, family, and/or group counseling are given information about the agency and the counseling process. If applicable, clients are informed of eligibility for services, fee schedules, waiting lists, and/or other services in the community that may be more appropriate.

Updated April 2009