Resource Provider Training Script

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Welcome to the Non Pharmacological Intervention Training for Resource Providers. I'm Jill Pingel and I'm a member of the Children's Division's Health Information Specialist Unit. We have Dr. Patsy Carter, clinical psychologist with the Center for Excellence presenting this training. Before Dr. Carter begins I'd like to provide some background information about Children's Divisions policy as it pertains to non pharmacological interventions.

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Healthcare treatment decisions for children, including the use of medication, are always important and should be made thoughtfully, considering relevant information available. Just as non-pharmacological interventions, those without medication, should be considered for any condition, pharmaceutical intervention for behavioral health issues should never be the first nor sole intervention for children in Children's Division custody. A case manager shall not consent to the use of psychotropic medications without first having sought alternative interventions to aid the child, resource provider or parents. Those may include, but are not limited to therapy, skills building, parenting assistance, or family therapy.

Every child prescribed a psychotropic medication shall receive a concurrent non-pharmacological treatment at the frequency and duration recommended by the prescriber. The case manager should discuss this with the prescriber at the child's appointment and document the recommendation on the informed consent for psychotropic medication form the CD 275. This training explains non-pharmacological treatments and when they can and should be used, as psychotropic medications are not meant to be a standalone treatment.

The purpose is to educate resource providers on types of evidence based non-pharmacological treatments. This course has been developed to increase knowledge and understanding of resource providers about different non-pharmacological treatments, when to use them, and how they can help children. This course is a required training for licensed resource providers and successful completion of a quiz is required at the end of this training. Dr. Carter, I'll go ahead and turn it over to you. Thank you Jill.

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So, as Jill has mentioned, our best evidence, suggest that psychotropic medications should not be a stand-alone treatment, rather non pharmacological interventions should be attempted first. Research and developing these medications is limited to adults. These medications were not tested during development on children or youth. So, particularly for children, the long term impact of using psychotropic medications is not really known. Even on adults, most research on medications is based on a limited timeframe, typically, 6-24 weeks. The effects of long term use therefore, years is not really known.

It behooves us then to start with non-pharmacological treatment as the first line intervention for children and youth. There are times when a child cannot benefit from these types of interventions due to their impairments in focused concentration or their ability to regulate their emotions or a body. Using a medication to assist in calming the brain and the body can then be a benefit.

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So, we also need to consider that medications basically manage symptoms. And if you take away that medication, the symptoms will likely reemerge. Instead, if we partner, if we're using psychotropic medications with a non pharmaceutical intervention, those are skills, a child and youth can learn that they can take with them wherever they go and can last a lifetime.

So, in addition to using medications, we should always be using other interventions that help them learn the skills to change their thinking, change their perceptions, change their ability to regulate their emotion and body through these non-pharmaceutical interventions. They can be used as a way that the medications can be used as a way to temporarily manage symptoms while these other treatment interventions begin to impact the child's mood and behaviors.

So, again, you can see, it makes sense that medication is only one part of a comprehensive treatment plan, and prior to trying medication, because we don't know the long term impact on children's developing brains, we should try non pharmaceutical interventions first.

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It always behooves us to better engage youth in their treatment, which then increases their probabilities of compliance and success when we include them in these decisions. So, we want to talk just briefly about engaging youth in making these decisions, whether it's about psychotropic medications or whether it's about other types of non pharmaceutical interventions.

So, some of the things that we can do is share information about the intervention with the youth. And, of course, with the informed consent process, this is important information that should be shared routinely with the caregiver and with the youth. Allow time for the youth to ask questions. They may have some erroneous information. They may have learned things through peers or on the Internet that is not accurate. So we want to give them time to ask questions so that they can get the actual facts about the different interventions, the side effects, and possible benefits.

If they have concerns listen to those concerns, it may be that you can plan with them how to address any type of side effects that they may be fearful about, or help them alleviate some of those fears just because again, giving them more accurate information.

When they talk about their symptoms or their behaviors make sure that you're not using any information against them, or to judge them in any way. If they have fears about the medications, if their concerns about their feelings of suicide, don't use that information against them later on. Again, we want to encourage open honest discussions about their engagement in any of these types of interventions.

We're working hard to help everybody understand the long term impact of trauma and how to help youth manage this. So, if you don't understand trauma, you may see some of the behaviors as more symptomatic or intentional, rather than being a trauma reaction that may have been triggered by something in their environment.

So understanding the long term impact of trauma can help us engage in different types of interventions, interact with that child in a different way so that we may not need the psychotropic medications, but instead can teach them skills to help them calm and regulate their brain, increase their attention and focus.

Again, don't negatively characterize their symptoms. No blaming. Remember that these children have experienced some very difficult challenges in their life, whether that is significant neglect, physical abuse or sexual abuse so that we should be supportive, giving them the types of treatment to help them overcome these challenges that have been placed before them.

So, it's important that we allow time for adjustment to change before we seek treatment for that child. I had the honor privilege to meet with our state youth advisory board to talk about their experiences with psychotropic medications and many of them noted that there was a time when they needed those medications, but almost every single one said that initially what they really needed was time to adjust to the changes to be removed from the home that they know, to be placed with people who though may be caring for them, are strangers to them. And don't know about their history or their previous life ahead of time. So its important prior to thinking that they have some type of clinical diagnosis, or need some type of intervention, it's important that we just allow them to adjust to the changes, significant changes that they have recently experienced in their life by coming into the custody of the Children's Division.

We always want to reduce stigma around mental health, and it's often easy to talk to a child about their concerns if we use the analogies of physical health. For example, if they had diabetes or, if they had asthma that they might be on certain medications. They might have to change their lifestyle to meet their physical health needs. The same thing with mental health is that they may need medication, but they also may need to make changes in their life. They may need to learn new skills to manage that. And if we show the similarities between management and physical health issues to managing mental health issues, it can help reduce some of that anxiety and stigma.

Finally we want to listen to how they feel once they're engaged in that intervention. So if they're seeing a therapist or working with a mentor, talk to them about how they're feeling about those interactions. Are they feeling heard and understood? If they're taking medications how is that making them feel? Are they experiencing side effects? Talk to them about whether the side effects are temporary. For example many medications when started can make a person feel drowsy or sleepy. But with time a couple of weeks, that usually goes away. For others perhaps, they have a dry mouth and we need to encourage them to use hard candies, or gum, or drink more to help them with managing those side effects. The same thing with other interventions is perhaps we can help them change their interactions with their therapist or mentor by helping them work through some of these issues. So, it's important to really listen to the children and youth about their concerns about any type of medication, or other interventions as well as once they're engaged in these interventions to find out how they think its going, the side effects or concerns that they have.

I've listed here two links to information. One is about helping youth, be engaged more in their treatment and learning about their treatment. The other is about engaging care givers and how they can talk to the youth and children about these interventions. Again, with the hope that with understanding these interventions and being engaged in the decisions around these interventions youth will be more compliant, which we know increases the likelihood of success.

So what are some of these interventions that we're talking about? Well, there's different categories. We'll spend some time on each one. There's evidence based therapies. There are approaches that really focus on skills development. There are family interventions where the whole family is the focus of the intervention, and there are environmental interventions modifications or changes that could be made that can assist a child in functioning successfully. So we'll go over each one of these here in just a moment.

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So, we'll start off with the evidence based interventions and it's important to understand what we mean by an evidence based interventions. There are a variety of different types of interventions, depending upon the issue that is being addressed. So, there can be evidence based practices for depression. There can be evidence based practices for delinquency. It depends upon the focus will help us select that intervention to be used. They vary in complexity. Some are fairly simple and straight forward. Others are a little bit more complex and have multiple components, but all require that we are true to how it was developed and implemented in the original research. So we call that fidelity so that they're actually following and implementing the practice as it was designed.

So, when we talk about having evidence based interventions, these are interventions that had been studied and researched and shown to have positive outcomes, targeting specific symptoms or behaviors on a specific population. The success of the outcome is based on this fidelity that we're talking about, to the practice or basically implementing it the same way that it was implemented in the studies. So, Fidelity is always important when we're discussing evidence based practices.

You should always feel comfortable in asking the provider of the practice, how they were trained and if they are certified or rostered in a specific practice. We should know if they're actually certified or rostered, which means that they have gone through the full training for that specific intervention and have achieved some level of success in their competencies and applying this intervention. And therefore can apply the intervention successfully.

We all need to be doing our due diligence or asking people questions and finding out about their expertise just like we would in a lot of different other fields, whether it's a contractor working on our house, our beautician, a doctor. We want to know that they have the appropriate training for the specific area of need that we have. So, it's not necessarily important that we vet an electrician if we're actually having plumbing done in the house. So, the same way is for any therapist.

You want to ask them specifically about their expertise, training and if they are rostered or certified in any evidence based practices for the specific target symptoms. Again, that can be behavioral issues. It can be anxiety. It can be delinquency. It can be substance use, but whatever is the target we want to make sure that they have the appropriate expertise in that area.

It's important to understand again, it's not only an evidence based practice, because it's targeted to a specific symptom, but it's also targeted for a specific population. Now, we see that many evidence based practices start off with a population in a specific age range. Perhaps a specific race, gender, geographic area, and many will then try to expand into other population so that they adapt the intervention to meet the needs of them. So we should always also know what population a practice was designed for.

So there are many therapy practices that were designed for adults and have not been tested on youth. So we want to make sure that these are practices that were shown to be effective when working with youth. It may be a race issue. It may be an urban population versus a rural population, but having some familiarity there, and hopefully the, the therapist or the provider will have that expertise as well. And you can talk with them about the effectiveness with different populations for these practices. So, I'd like to go over just a few of these practices, particularly highlighting some information around some of the major clinical issues that we may be addressing.

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For example, particularly for children that are in the care and custody of Children's Division, many of them show, attachment issues and it's important to understand the research that has been done around these attachment issues.

So, there are no established clinical or laboratory assessments to rule in, or out a diagnosis of the defined attachment disorders in DSM such as the reactive attachment disorder, or the disinhibited. The materials have been developed through these research studies and some have been adapted but they don't seem to be incorporated into the actual clinical practice. We're not actually assessing for the specific issues pertaining to attachment.

It's also important to understand that many of the symptoms of many other symptoms can co-occur with attachment issues or attachment disturbances that may be best treated by evidence, based practices that focus on those specific symptoms that are being displayed or shown by the individual. It's important to understand with all of this, the difference between what is labeled as reactive attachment disorder in DSM 5, which is predominantly a diagnosis of very young children around their relationship with their specific caregiver. For reactive attachment disorder there are evidence based practices, such as child parent relationship therapy, or dyadic developmental psychotherapy.

There are also youth who do not meet the criteria for reactive attachment disorder either due to the way they present, or because of their age that also have very significant attachment issues that are often related to trauma. So we may need to consider whether what we're really looking at is attachment issue related to their trauma history, which may mean that we're directed to some type of trauma specific intervention while, simultaneously addressing the attachment needs to the child.

So attachment issues are not limited to reactive attachment disorder but there are some evidence based practices that can be used for reactive attachment disorder. And for reactive attachment disorder you're always including the caregiver in the intervention, because it is about that specific relationship between that child and caregiver. For children who have a broad attachment issues that may go across a wider variety of relationships and so our interventions maybe need to look a little bit different.

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I also want to focus a little bit on anytime that we're working with very young children, under the age of four. Again, this group should always include the proposed caregiver actively in that treatment. With children, again, their brains, particularly the young children are so vulnerable that we want to change their environment and their interactions, so that their experiences are positive and can help build that resilience. And to do that we need to have an adult caregiver that is a tune to that child and responsive to that child.

So, they need to be engaged in these interventions to generalize that learning across a variety of different populations, and with a variety of different individual's. Some of the evidence based practices for this specific age group, and there are not as many for this age group, is attachment and bio behavioral catch up, or called A. B. C. which is for children age six months to two years. There's also child parent psychotherapy, which is designed for children between the ages of zero to five. I'm seeing an increase in the number of therapists that are being trained in providing child parent psychotherapy. So hopefully this will increase accessibility across the state.

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Another area to focus on is when we're dealing with youth that are exhibiting problem sexual behaviors. There are several different evidence based practices that can be used with this population, multi systemic therapy for youth with problem sexual behaviors is one that is for youth aged ten to seventeen. Multi systemic therapy is one evidence based practice that has different models for different populations. So that you want to make sure that with multi systemic therapy you're matching the specific type of MST with that child's specific concerns.

Other evidence based practices includes Sexual Abuse: Family Education and Treatment Program or SAFE-T which is designed for children age, twelve to nineteen. Children with problematic sexual behavior, cognitive, behavioral therapy. Excuse me, cognitive, behavioral treatment program, and this is designed for kids for the ages six to twelve. And then there is trauma focused, cognitive, behavioral therapy, which is designed for children from three to eighteen.

Now, I would note that trauma focused CBT is also a trauma specific intervention for those who may be victims of sexual abuse. So it's often important to ensure that we're not mixing those populations together, because we don't want to do any further harm to those who have experienced or a victim of sexual abuse. Now we know many children are both a victim and then develop problem sexual behaviors. But again, we want to make sure that those who have not become perpetrators are exhibit these problems sexual behaviors are exposed to those, or increase their risk of being we traumatized.

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I also think it's important for us to think about evidence based practices for substance use. Multi systemic therapy again has been proven to be effective with this population and focusing on kids from age twelve to seventeen. Multi-dimensional family therapy is in another evidence based practice for substance use and that is for kids from eleven to eighteen. Functional family therapy has shown to be effective in the treatment of substance use along with some other things. And that is for children age eleven to eighteen and obviously many of these are going to engage the family as a strong component of their treatment. Adolescent community reinforcement approach, or ACRA is designed for individuals aged twelve to twenty five. It has been shown to be effective in addressing substance use. Adolescent focused family behavior therapy, which is designed for eleven to seventeen year olds again, engaging their family in the intervention.

There's also what's called brief strategic therapy that can be effective in addressing substance use and this is designed for children age six to eighteen.

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As I mentioned before, many children that come into the care and custody of Children's Division, have experienced a level of trauma. And so it's very important that we understand what trauma can look like how it may manifest itself. And in all honesty, there are so many different ways it is kind of hard to limit it. It can show up in their mood. They may be sad. They may be anxious, irritable, and angry. It can show up in their behavior. They may isolate or withdraw themselves. They may be oppositional maybe aggressive they may engage in self injurious behavior or voice suicidal ideation.

The DSM does not really typically talk about etiology of any of the diagnoses. The exception is post-traumatic stress disorder. And some of the other stress disorders, in the DSM the here there does have to be some type of event or experience prior to the diagnosis. So it's with that etiology, that we may decide that these behaviors this mood dysregulation is due to their trauma history and so a trauma specific evidence based practice is appropriate. There's many and we're seeing increasing access to many of these interventions. I won't read through this entire list, but just know that there's different formats. There's groups, there's individual some engage parents more than others all are again designed for a specific age group.

So you can see that the integrated treatment for complex trauma there is both the child and adolescent model. For dialectical behavioral therapy there is now a child, adolescent, and adult model. It's important to understand again, what type of training that provider has had in that specific model of whether it's dialectical behavior therapy or the integrative treatment for complex trauma or any of these, that have multiple age groups. Because how we present the information, the components included in that model very by the age group, that's the target.

So, if they have been trained in the adult model of dialectical behavior therapy, and we're looking at, treating a, a seven or eight year old there may, it may not be effective, particularly as effective as one where the therapist is trained in the child model of DBT. Which has a stronger parental component will focus more on some developmental issues.

So, child parent psychotherapy, we've mentioned that before. Eye movement desensitization and re processing, actually, that has been proven to be effective in very young children as you can see it goes down to the age of two. And then we have trauma adapted family connections, which is really an, in home or a home visiting type program, not limited to early childhood when I say home visiting. So we have a variety of different types of tools that we can use to be addressing trauma. And this is just a limited list of some of those designated as effective for trauma.

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There are also different types of interventions that we can use. We mentioned skills development is one. There has been a growth in the state of Missouri in what we call behavior interventionist who have training in behavior interventions. And the goal ideally is to transfer that knowledge to the caregiver. So, whatever skills the behavior interventionist working with the child, teaching them those skills to use, whether it's anger management or increasing their focus, or doing deep breathing and calming their mind down.

We want that information be transferred again to the caregiver who will be the long term support of that child. So, that, this again is not dependent upon having the behavior interventionist always

available, but that the parent can support and help that child, practice those skills because it's with that practice that it gets wired into the brain so, to speak. And it's, how we learn, it is how we learn to play a musical instrument. Its how we learned to ride a bike is by practice, practice, practice and with that practice, we get better and better at it particularly so that we can call it up when our brain perhaps is not calm, and our brain is stressed. That it has become so ingrained in our brain that we can almost automatically call those skills up to be used to help us when we are challenged.

So, that's why it's important to practice these skills on a daily basis when the child is calm. So, when their brain becomes dysregulated, anxious, scared, fearful, it can still call up these skills because it's an almost automatic response.

There are other types of skills training used. I believe there are several organizations in our state now that are using trust based relation interventions. This is a model where again, it trains the caregiver to provide effective support and treatment for the youth and they help monitor that parents use of the skills. You will also see that they may be talking with the children and youth about the use of these skills. But once again, it's very important to transfer this knowledge to the longer term caregiver so that they can assist that youth in practicing it and utilizing it when needed.

You'll also find is, we're seeing more programs basing themselves on the neuro sequential model of therapeutics, which includes an assessment that folks often call a brain map, or they give them the brain metrics. With that assessment then very specific recommendations are offered that may not be anything around a type of therapy, but instead are some skills that need to be practiced again on a daily basis so that it gets wired into the brain. And this can range from issues, like doing repetitive rhythmic behaviors, bouncing a ball, throwing the ball back and forth, rocking, swinging, sometimes it will be to engage them in different types of activities that are available in the community. Perhaps swimming, soccer, other sports events, perhaps, something more rhythmic in dancing, drumming. All of these types of skills development interventions can be identified to this brain map. It can be very effective. Again, if we are helping that youth, practice them on a daily basis as a way to calm their brain and their body.

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Mentoring is another type of intervention that can be used. The one caution I have for folks is that the research has shown that mentoring can be very effective if its long term mentoring. If we're engaging in short term mentoring programs, or one where there is a high level of turnover in the mentors that can actually do more harm than good for the children. Because again, they have experienced so many losses in relationships and connections that to start a relationship and then have it end abruptly or frequently can just be more stress and trauma that that child is facing.

But there are some good evidence based mentoring programs and as long as they have a consistent committed mentoring population or providers; that can be very effective for youth. So, Fostering Healthy Futures, Big Brothers, Big Sisters of America, and Friends for Youth one to one mentoring, have been deemed as evidence based practices in the area of mentoring.

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We can also talk about is alternative interventions, parenting youth with challenging behaviors and what that may entails. So there are many parenting programs out there again listing several of them here. You may have heard of some of these, the Chicago parent program. Here is an example of a program that

was designed to be used with a minority population in an urban setting. So to take Chicago parenting program and put it in a rural area of the state will no longer being an evidence based practice because it has not necessarily been shown to be effective with that population. So, again, know the population on which these practices have been tested when you're trying to select which option to choose.

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So Incredible Years, Parent Child Interaction Therapy is also becoming more common in our state, the Positive Parenting Program or Triple P, they have several different components. The Level 4 Triple P is determined as an evidence based practice in this area. And the level three for children ages, zero to twelve with mild to moderate emotional or behavioral concerns is also deemed and evidence based practice.

Then two others that we have are Tuning into Kids and Tuning into Teens as evidence based practices. And again, you can see the age ranges for those interventions.

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When we talk about parenting programs, there are other programs that we can look at such as common sense parenting, guiding good choices, strong African American families program. Again. You can see that this even in the name is targeted to a specific focused population. Family checkup, which is designed for youth and families that are functioning at the low to middle social economic status. And then there is a generation PMTO, which used to be called parent management training and still incorporates many of that. It has both individual and group component for that intervention. So, there are some different types of programs again across the state. We have available things like parent, child interaction therapy, some positive parenting, triple P and some of these others.

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We also want to be sensitive to assisting resource parents, particularly in thinking and understanding trauma as I had mentioned previously. So we love our resource parents we know that they go in with the right intentions, but sometimes they may unintentionally exacerbate the child's trauma response when they really want to be helpful and understanding that child's behavior, and maybe understanding their trauma history.

So there are many environmental and relational activities, skills, responses that a resource parent can do every day to address a child's trauma responses, to help them heal from their past trauma both in conjunction with or is a stand-alone from any type of formal treatment intervention. There are two programs out there now, in the state of Missouri that are available. One is what is called the resource parent curriculum, which was developed through the national child traumatic stress network.

Children's Division invested in training of facilitators in this curriculum. And we should have facilitators that both of trained by Children's Division, whether it's Children's Division staff, therapist, community members. But we always like to have a resource parent, or a foster parent as a co-facilitator in this curriculum. So you can reach out to your local Children's Division office to find out who has been trained and if there are any offerings of the resource parent curriculum in your area.

Another model that is being utilized by a number of providers in our state, and is very focused on understanding trauma, is the trust based relational intervention. This is out of the Karen Purvis Institute

of Child Development. I have seen where the individuals are working with caregivers and again, sometimes working with the children to really help them understand the child's perceptions, their thoughts, their feelings, and responding to them in a way that better reflects what that child may be going through. So both are very effective in supporting resource parents supporting the children.

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So there are also a number of just natural interventions that can be used and, as I noted earlier in the presentation that we may want to give a child sometime to adjust before thinking that they may need more formal interventions. So these natural interventions can be used initially, or paired with other type of more formal intervention.

So, meditation, use of exercise to get energy, using music, either in a formal way, music therapy, or just as a way to calm or energize the brain. Social connections are very therapeutic, and particularly for individuals who have become more withdrawn. We need to encourage their continued engagement with their friends, as appropriate with their families, and if they're not having access to their family or friends, because of distance, we need to make sure that they're creating other social connections because we are social creatures and we need that social connectedness even those of us who are extreme introverts need a level of social connection.

Spirituality can be very supportive and a natural intervention. It doesn't really matter whether you're going to church or not going to church. Doesn't really matter, which, you know, belief system that you would adopt. It's the fact that you have a set of core beliefs that help you make sense of the world and give you that spiritual empowerment.

Volunteering giving back to others can be a very rejuvenating type of intervention. We know that when we give to other certain kind of feel good chemicals get released in our body, which makes us feel good. So, giving back to others is a very powerful and natural intervention.

The use of art again, whether formally or just informally is possible, whether it's taking an art class, or actually going to our therapy, or just doing some doodling or drawing pictures that really express their emotions how they're feeling can be very powerful.

We always want to make sure that if a child is not sleeping first off, we want to make sure every child is getting a good night's sleep, but if they're not, we need to engage in some intentional focus on their sleep hygiene. Are we turning off the electronics, you know, at least two hours before they should be falling asleep? Are we limiting kind of any type of real rejuvenating, invigorating type of activities? Are we reducing the use of caffeine early enough in the day? Are we able to engage them and calming relaxing activities such as meditation, mindfulness, deep breathing, and muscle relaxation? So we know in particular for adolescents sleep can be a real challenge. Their natural clocks keep them up later and want them to sleep in later. Plus they need more sleep, so it's really important for our mental health to pay attention to our sleep pattern and try to adjust that as one of our very first natural interventions. Because a lot of times, even for kids who have serious psychiatric diagnoses, if they're sleep becomes disrupted, there's symptoms become much worse. So we always want to make sure that we're helping the children and youth engage in a regular sleep hygiene type program.

Journaling can be another powerful tool to use where a child or youth can write down their thoughts, their feelings, help them process problems. You know, some will even as I mentioned before, just

Doodle or draw, which helps them express their emotions. Community mentoring again is a natural intervention, engaging them in any type of mentoring program within the community that any child may be eligible for. So it's important to again, look at what's available in your community, engaging them in a healthy diet again, having too many processed sugars, too much caffeine a lot a heavy high fat diet any of these can impact their social or, excuse me, their emotional health.

Interventions like yoga can also be very helpful in helping calm the mind and calm the body. These are simple interventions that do not require a whole lot of efforts or planning, but can be implemented easily within the home in the community.

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We also want to think about the different types of professionals that are available to assess youth in their caregivers around any social and emotional issues. So, school counselors can be a significant, and a first line professional to work with children. Research has typically shown that the majority of children get there, counseling or mental health services through schools, and it can be through the school counselor, or it can be through school, based mental health services. And now that we have Medicaid billing for services provided in the school in, particularly for those, it's always been available for those students under an IEP but the school had to make the match and so there was a cost to the school. Medicaid here in Missouri is now paying for school based mental health services for students that are not under an IEP and they will pay the full cost. So, there is no additional cost to the school. This can really help in increasing access for those individuals where transportation, time is a barrier to them being able to be engaged in any type of therapy. It may not be for everyone many or some students may not want to attend therapy services at their school. But it is a very viable option for many.

We have our community mental health centers, or community behavioral health centers that can provide services. There are private mental health providers that can provide services. The community, mental health centers, have a package, or what we call a rehab option that can include a variety of different types of services that may not be available through other providers because of their Medicaid rehab option. But therapy services can be provided both from private mental health providers as well as the community, behavioral health centers as well, as federally qualified health centers. Now, those vary across the state, all community mental health centers provide services to children.

Federally qualified health centers may provide physical healthcare for children, not all provide mental health, but we are seeing an expansion in that. So if you have a FQHC or federally qualified health center in your community, you may want to see what type of therapy or psychiatry services they have available for children and youth.

So, in addition to the counselors and school based providers in understanding, who can provide these services, we also need to find out how frequently can the child be seen? There are some providers because of their caseload are only able to see a child once every two weeks, or once a month, and they have to understand whether that's going to be a significant enough intensity for the child to benefit. So, how frequently can the child be seen? Again, asking what types of therapy that they provide and specifically noting, if they are trained and certified or rostered in any evidence based practice.

No therapist should take offense at being asked regarding their credentials. Again think about asking the same types of questions around expertise, education training, as you would for a contractor working on

your home. And also talking with the provider about how the families engaged, and what are the expectations for the family or the caregiver. So, is the resource parent expected to attend, is the biological family going to be attending. You need to talk these issues out, so that you have the right therapist providing the right type of treatment in the right format at the right time.

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So, when you think about providing finding a provider, I often get asked this question, and I'll get phone calls asking to identify providers in an area. So I know it takes a little bit of work to understand maybe how to find different providers. So, I always encourage each circuit or county to create a list of providers in their areas, keeping track of the information such as is it a social work, or a psychologist? A license professional counselor? What type of insurance do they take? Do they take Medicaid, or do they have any eligibility criteria? Some provider's services maybe provided through a specific grant funding so that they can only serve a certain population of kids. So you need to know what their eligibility is again. What type of evidence based practices are provided? Their time you know, what days of the week are they open? Do they have any evening hours? Do they have Saturday hours?

If as people are learning and using providers, they all pool this information to have that type of kind of a list made for their local providers it can be very helpful to everybody across that circuit or community. But there are a couple of directories that you can also tap into. I have put those links here and you can connect with those. Missouri dialectical behavior therapy directory was started years ago, even before there was a national directory. This is maintained by Dr. Rhonda Wright who is the state trainer of dialectical behavior therapy through the Department of Mental Health. She tries to keep that up to date. You're always welcome to contact her if you have any questions. But there is also now a national directory for dialectical behavior therapy. You can put in a zip code, a city, put in how many miles from that zip code that you're comfortable traveling and you may be able to identify a therapist trained in dialectical behavior therapy through that directory.

The University of Missouri St Louis Mo ACTS directory is also available. This is around a predominantly evidence based practices for trauma. I know specifically that it lists people who are trained and rostered in trauma focused cognitive behavioral therapy. I believe they have also included or expanded their list to some other trauma specific therapies. Again, you can just go to this link, put in your zip code or community put in a mileage range, and a list of providers will pop up. So, those are three directories that you can use right now. And if not again, reach out to your Children's Division caseworker, to see what they might recommend, they should be involved in the decision about accessing mental health services. So, that you'll be having that conversation just naturally. And with that, I'll turn it back over to Jill.

Slide 21

Thank you Dr. Carter. Here on this slide is a list of our Health Information Specialist team members. Our team members cover different areas in the state of Missouri. So, you may not be sure which one to reach out to, at the bottom of this list is, our Children's Division, psych, med, settle email address if you have any questions about this training or about anything in general you could email us at that email address and we could get back to you. I would also like to remind you that a piece of this training includes successful completion of the attached quiz. Thank you for your par