PA CASSP Newsletter

Pennsylvania Child and Adolescent Service System Program

A comprehensive system of care for children, adolescents and their families

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Functional Family Therapy Strengthens Communication

By Erik Perrino

Amanda was just a teenager when referred by her caseworker to the evidence-based Functional Family Therapy (FFT) program at Family Services of NW PA. After repeated issues with truancy, drug and alcohol use, and a strained relationship with her mother, Amanda's caseworker felt it was time for an intervention.

An assessment revealed that Amanda's mother was experiencing significant medical challenges. In the absence of an appropriate caregiver, Amanda was trying to provide necessary medical care for her mother. This led to an increase in unexcused absences from school, and made her issues with drugs and alcohol even worse. Over time, Amanda's inability to provide proper medical care to her mother only hurt their already strained relationship.

The FFT staff at Family Services of NW PA quickly learned there were other factors leading to Amanda's poor attendance and overall difficulty in school. Amanda didn't feel supported by her mother, her friends and even school administrators. Therapists learned she was afraid to share these difficulties with her mother, and instead used drugs and alcohol to cope. Even though her mother had completely recovered from her medical issues, their relationship continued to worsen. Amanda and her mother constantly argued over Amanda's lack of attendance at school and her unwillingness to comply with rules at home.

The FFT staff focused on teaching Amanda and her mother a variety of new communication skills to help them calmly discuss difficult topics. They also learned to understand the other person's intentions, and to respond with affirmation even if they did not agree. With these foundational skills in place, Amanda and her mother were able to strengthen problem-solving and negotiation strategies to more productively deal with conflict. Near the end of treatment, Amanda was able to tell her mother about issues at school. After calmly discussing the situation and negotiating various solutions, Amanda's mother agreed to allow Amanda to switch schools. This was a major turning point for both of them.

Three months later Amanda is excelling at her new school. She has more support from both her mother and her new school, and is excited to be participating in a curriculum that is better aligned with her goals. Amanda is proud that her mother no longer fears her daughter will drop out of school, and she has been drug-free since the treatment ended. Thanks to the evidence-based FFT curriculum and Family Services' dedicated staff, Amanda and her mother are much more prepared to resolve conflict with positive communication and negotiation skills.

Amanda's success is not uncommon among those referred to Family Services of NW PA. The FFT program includes interventions and preventive services aimed at working with the entire family of at-risk youth. The curriculum focuses on building skills that address issues including defiance of rules at home and school, parent-child conflict, drug and alcohol use, and verbal/physical aggression. The

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The Future of Behavioral Health Rehabilitation Services

When what are now as Behavioral Health Rehabilitation Services (BHRS) were developed in Pennsylvania more than 15 years ago, the focus was on making it as easy and efficient as possible to create individualized services. In the beginning, providers submitted service descriptions the Office of Mental Health and Substance Abuse Services for each child. The service descriptions tended to fall into three major categories Therapeutic Staff Support, Mobile Therapy and Behavioral Specialist Consultant and were soon added to the Medical Assistance fee schedule. Guidelines for providing the services were spelled out in the 1994 Medical Assistance Bulletin e titled "Outpatient Psychiatric Services for Children Unde 21 Years of Age

While the creation of these service categories simplified procedures for providers and helped children and familie in significant ways to access individualized services, there have bee unintended outcomes as well. These include:

- the development of "cookie-cutte services that became routine and lacked individualization,
- heavy reliance on these services for e tended periods of time rather than searching out more creative and natural supports another service that might be more effective
- increasing costs due to over-prescrip- and
- lack of attention to measuring outcomes and determining the effectiveness of the services to actually help kids get better.
- lack of focus on creating unique or evi dence-based programs

Therapeutic Staff Support services, familiarly known as TSS, has often been the source of the most concern.

In an effort to increase both the quality and effectiveness of BHRS, the Office of Mental Health and Substance Abuse Services in collaboration with providers across the commonwealth is encouraging different approaches. Rather than relying on traditional Therapeutic Staff Support prescribed for long periods of time with no definite ending point, more providers are beginning to implement evidence-based programs like Multi-Systemic Therapy and Functional Family Therapy or develop creative alte native especially in school settings. Elements of these different approaches that improve on traditional TSS include

- Less stigma against children for being accompanied by a TSS person all day
- Time-limited
- Focus on specific risk factors and/or targeted toward specific populations
- Increased focus on clinical interve training and adherence to a clinical mode
- Family and youth engageme with emphasis on building on strengths
- Focus on outcome o make sure the intervention is working

This edition of the newsletter highlights several programs that are having some success with treatment mode that are in the BHRS family but not the same old, same old. These programs complement other efforts to expand High Fidelity Wraparound and the System of Care approach, also shown to be effective.* In an environment where cost-containment and emphasis on what works increasingly drive decision-making, creative approaches are becoming more and more necessary so that children and families will continue to receive the services they need to be successful.

Harriet S. Bicksler, edito

*You can learn more about High Fidelity Wraparound in Pennsylvania in the December 2009 edition of the newslette and about the System of Care Partne ship in the September 2011 edition: ***http://listserv.dpw.state.pa.us/cassp-newsletters.html***

Evidence-Based Treatment for Adolescent Sex Offenders

By Jaime Houston

An often surprising and sobering statistic is that more than one-quarter of sexual offenses in the U.S. are committed by minors and one-half of adult offenders committed their first sexual offense during their adolescence. The juveniles who commit these sexual offenses pose a complicated challenge for the community and child-protection and the criminal justice systems. Historically, juvenile offenders have been lumped together with adult offenders not in the nature and seve ity of criminal sentencing but also in the mental health treatment they have received. Howeve our increased unde standing of adolescent social, emotional and sexual development has made it clear that treating an adolescent sex offender with the same methods we would use to treat an adult sex offender is ineffective. Using an "adult model" of treatment doe ot account for developme ntal factors and how the family and environment affect childre s behavior. Therefore in orde to effectively treat the problem of juvenile sex offending we need to at the youth within the context of their ecology and treat them with the family in mind.

Despite our increased understanding of the unique treatment needs of adole ce there is a proliferation of special ized programs for treating juvenile se offenders that have little or empirical evidence demonstrating that they are effective. Fortunately there is now widespread support for the use of evidence-based practices when treating adolescent behavior problems in general, and increasing support for the use of evi dence-based interventions to treat juvenile sex offenders specifically.

One such evidence-based interven on is Multisystemic Therapy for Youth with Problem Sexual Behaviors (MST-PSB). MST-PSB has been specifically designed and developed to treat youth (and their families) for problematic sexual behavior and is the only treatment for sexual offenders that is on the National Registry of Evidence-Based Practices. Building upon the research of standard Multi-Systemic Therapy (MST), the MST-PSB model represents a state-of-the-art practice uniquely developed to address the problem of juvenile sex offending within a family therapy context. This model represents a particularly potent advancement in the treatment of juvenile sexual offenses with three randomized clinical tri als of MST-PSB that stand alone in the field with respect to the rigor of their design and the positive treatme comes.

Hempfield Behavioral Health has been providing traditional MST services since 2002 throughout Central Pennsylvania as a part of our overall mission to offer evidence-based programs for youth and their families. Over the past 10 years nearly 1000 families have participated in the service but unfortunately many fami lies had to be turned away due to referral behaviors that included sexual acting out. The presence of sexual acting out behaviors disqualifies most youth from traditional MST and therefore leaves many families without acce s to an evidence-based practice. In 2011 we expanded the Hempfield MST program to include MST-PSB as a BHRS exception program, thereby giving access to more families in need of services. To date, six families have participated in the program and feedback about the program has been positive and encouraging.

So what does this treatment look like ut of the pages of the research journals and into the real world, with a real family?

Susan will be the first to tell you that she was shocked to learn that her son had sex with her young niece. As Susan told us during our intake session, "As a single om I struggled to talk to him about sex, to find out what he had done to his cousin shocked and scared me. He is my little boy but now I don' know who he is or what he is capable of." When a pare learns that their child has committed a sexual offense the family is ofte apart. Susan reported feeling judged by everyone around her and feeling that nothing would ever be normal for the again. Terms such as perpetrator and se offender became a part of her daily language.

Many traditional forms of treatme might have removed he son from the home or committed him to individual treatment with the responsibility for recovery placed solely on him. MST-PSB takes a different approach. As we e plained to Susan, we were going to treat he son within the context of the family with the responsibility for recovery placed on everyone because he is a child and we do not want to assume that her son will always be motivated to recognize his own risk factors or manage his own behaviors. Over the seven months of therapy, Susan and her son learned to fully acknowledge his sexual offense, place full responsibility for the offense on him and not with the victim, and recognize his risk factors and the skills he needed to manage them. He on was able to explain what he had done, why he had done it and what support he needed from his family to be successful. Susan reported that once she understood what he had done she was no longer afraid of him and had confidence in her ability to parent him. He son was able to demonstrate empathy for his vic- had an understanding of sexual fee ings and how to manage them, and learned skills for interacting appropriately with girls. At discharge the family had a comprehensive sustainability plan to fol ow to maintain his success through their family network.

Jaime Houston, Psy.D. is the program director for the Multi-Systemic Therapy program at Hempfield Behavioral Health, based in Dauphin County.

Yesterday Was Good, Today Will Be Better: A School-Based Behavioral Health Continuum of Care

By Tamara Shepard

Beginning in 2007, the Northwest Behavioral Health Partnership Board (NWBHP) embarked on a partnership with five school districts to transform the way Behavioral Health Rehabilitation Services (BHRS) are delivered in school. The findings prompted the NWBHP to pursue a school-based behavioral health continuum of care to better meet the needs of students. NWBHP of Crawford, Mercer and Venango Counties adopted a child and family-centered approach for delive ing BHRS in the public school setting. The vision is to develop and implement an integrated behavioral health team as an in-school resource for students and their familie

With a new paradigm for BHRS, NWBHP contracted with Southwest Behavioral Health Management, Inc. (SBHM) to design, develop, and administer a school-based behavioral health continuum of care. SBHM carefully conducted school and HealthChoices data analysis, extensive research of evidence and research-based best practice and consulted with parents, the participating school districts, the Positive Education Program in Cleveland, Value Behavioral Health of PA and the American Re-Education Association.

Three premises guide the continuum of care:

Treatment approaches incorporate strengths-based interventions based on individual behavioral health and educational needs.
Services adjust as rapidly as the changing needs of the student.
A common language blends the educational environment and behavioral health treatment.

The result is a school-based continuum of care under a shared leadership model between the school, service provider, VBH and SBHM. Using the three-tiered approach of School-Wide Positive Behavioral Interventions and Supports*, each entity shares leadership responsibilities and resources. Each tier encourage family participation in the stude s treatment and educational proce

The first tier represents universal interventions for all students. Tier One also functions as a referral source to more intensive services or a recipient of stude stepping down from more intensive se ices. Tier Two supports students with academic and behavioral health challenge while they remain in the general population. The model uses strengths-based interventions and strategies focused on building resiliency and promoting recovery. The staffing ratio is a range of one behavioral intervention specialist to 2-students. The third tier is an integrated classroom that supports students who are experiencing significant academic and behavioral health challenges. A team of one teacher funded by the school district and two behavioral intervention specialists employed by a mental health provider staff a classroom of 10-12 students.

Since the program began, successes include increased academic achieveme improved school-parent relationships, the development of a behavior management "tool box" for students and faculty, a decrease in office discipline referrals, and more students who enjoy coming to school and are being successful. The fol lowing story is a composite illustrating the kind of successes that are common in the program.

Yesterday Was Good, Today Will Be Better

Lauren, a 4th grader attending an inner city elementary school, opens her eyes and greets the new day with enthusi asm. She thinks to herself, "Yesterday was a good day and today will be even better." N t too long ago Lauren, her mother and little brother were homeless and bouncing between a women's shelter and sleeping on couches in strange living rooms. Now it' just the three of them in their own apartme and she and he brother sleep in their own beds.

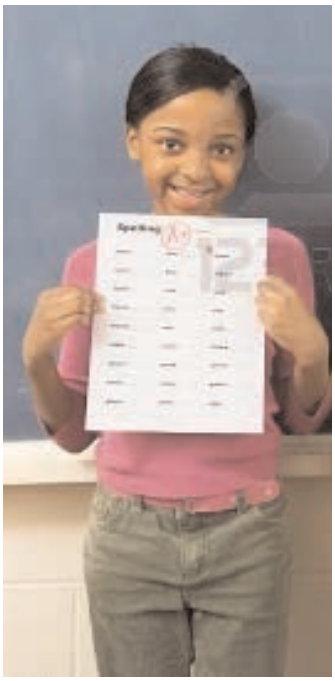
The beds were delivered shortly after they moved into her apartment when a behavioral intervention specialist working in the building wide model at her school learned Lauren and her brother were sleeping on the floor. Sleepily Lauren recalls the blustery December Saturday morning just before Christmas when Ms. Karen and two behavioral specialists knocked on the door. They had arrived with two bed frames and mattresses which were quickly assembled and dressed with crisp new sheets.

As she enters the school building Lauren rushe to reach the re source classroom before the late bell rings. She makes it and is welcomed by the behavioral specialists who staff the building-wide model in her home elementary school. The behavioral specialists greet Lauren with a smile and move quickly to assess her for carry-in issues from home and to dete mine interventions she may require throughout the day. During the 15-minute check-in group, 10 students identify their feelings, one goal for the day, and the time of day when assistance from the behavioral specialist is needed. Today Lauren is selected recorder for the group because she had the highest number of points the day before.

Diligently Lauren records each group member's account as Ms. Jen asks each student to report. Using the volcano technique the students report whether the are good to go or ready to blow and the feeling associated with the blow leve Lauren reports that she's good to go and her goal is to and think before reacting when she becomes anxious. She also says she feels anxious and needs assistance during her spelling test. In addition, she asks the behavioral specialist to check

with her occasionally throughout the day.

As morning check-in group ends, Lauren grabs her point sheet for the day and heads for the door. She loves the morning ritual Mr. Wayne created because it al ways gets her day off to a good start. "OK, everyone line up; it's time to pay the Mr. Wayne says. Lauren puts he biggest and best smile for Mr. Wayne as she goes past him; he returns the smile and wishes her a successful day.



Lauren move through a fairly uneventful day and when she begins to feel anxious she uses the relaxation techniques she learned from the behavioral specialists and group. Occasionally, Lauren catches a glimpse of a behavior specialist through her classroom window or they pass in the hall during restroom breaks. Each time Lauren offers the agreed-upon signal of a smile and nod to indicate she is having a good day and does not need their assistance

Shortly before lunch period Lauren appears in the doorway of the resource classroom asking if she can eat her lunch with Ms. Fran. They walk to the cafeteria together and catch up with Lauren's teacher to inform her that Lauren is eating lunch with Ms. Fran in the resource classroom. As they talk through lunch, Ms. Fran ask how the day is going and helps Laure process her anxiety over the spelling test in the afternoon. Ms. Fran works with Lauren to reduce her anxiety by helping her believe that she is good in spelling. She encourages Lauren, "You are a good speller, and I have seen 100 perce t on all our spe lling tests this year." Ms. Fran continue "I can tell by the clock on the wall that you have 10 minutes before spelling class. Why don' you show me some relaxation techniques you can use during the test?" After she accompanies Lauren to her spelling test, Ms. Fran walks two doors down the hall to check on another stude

As the bell rings at 2:15 for the last class of the day, Lauren once again appears in the resource classroom doorway, this time all smiles! N t only doe s she produce a spelling test with a big A on the but she also earns all her points for the day. Ms. Ann, the group leader for the day, congratulates Lauren and asks he share her success during group. As the 10 students from morning group turn in their point sheets and ge together, Lauren takes her place at the dry erase board to begin afternoon group.

Just as they had done in the morning check-in group, all 10 students identify their feelings, if they feel they achieved their goal for the day, and what helped them or could have helped the achieve their goal. Lauren records the information and proudly shares her success with the spelling test and the relaxation techniques she found useful. Other students in the group congratulate Laure using her relaxation techniques and the A n her test, and they e ncourage he keep up the good work

Ms. Ann begins a skill-building lesson with the group on the Re-Education principle that trust is essential. The students take turns defining trust, what it means and how it feels to have a trusting relationship. They continue the discussion by talking about predictability, and each student identifies people in their lives they can count on for support. As the group concludes, Ms. Ann reminds students to take home their daily communication logs to their parents. Ms. Stephanie Ms. Brooke, and Mr. Eugene offer assistance o the students as they bundle up for dismissal. The behavioral specialists discuss expectations with each student for a safe and successful trip home and a positive evening.

Tamara Shepard, M.S. is the director of school-based services for Southwest Behavioral Health Management, Inc., New Castle, where she is the architect and administrator of the school-based behavioral health continuum of care in Crawford, Mercer and Venango Counties. Contact Tamara at tshepard@swsix.com.

*You can learn more about School-Wide Positive Behavioral Interventions and Supports in Pennsylvania at ***www.papbs.org***

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goal of the program is to improve family communication, adopt positive solutions o family problems, and prevent further involvement with more extensive services.

The FFT program offered at Family Services of NW PA differs from traditional Behavioral Health Rehabilitation Services (BHRS) in its unique ability to show outcomes on the positive and long-lasting behavioral changes FFT has for the entire family. FFT doesn't focus solely on the behaviors of the identified youth, but empowers parents and other family members to play a role in helping the youth remain in his or her home and community. Traditional BHRS programs have more often focused on specifically helping youth function in identified settings while, FFT works with the entire family to better solve problems and prevent further involvement with other services.

Most importantly, FFT is an evidence-based program, and one of only in the nation identified as model programs by the Center for the Study and Prevention of Violence at the University of Colorado at Boulder. According to a 2010-2011 sur ve 91 percent of families completing the program reported a decrease in family conflict. Thanks to the exceptional quality offered by programs at Family Services of NW PA, individuals like Amanda are able o avoid place ment and remain in their wn homes and communities.

Erik Pe rino is a marke ting consultant for Family Services of NW PA, Erie.

Helping Families Develop Problem-Solving Skills

By Griszel Long and Ebony Gardne

Young people are entering the mental health system exhibiting unparalleled emotional, behavioral and social struggle This article show how Functional Family Therapy, unlike traditional outpatient interventions, uses family relationships as the focus of treatment and relie on managing risk and protective factors to pro duce positive change in referred youth and their families. A real life illustration is presented.

Functional Family Therapy (FFT) is a short-term intervention for youth ages 8-18 who are at risk. The number of sessions range from 8 to 2 depending on the severity of problems. The mode s theoretical perspective is reflected in a set of core principles founded on the notion that youth are best helped and understood through their relational family system. The approach to treatment is also grounded in the therapist's ability to form relationships with youth and their families through unyielding, respect-based, nonjudgmental and non-blaming therapeutic alliances. The model further works to delineate change through very specific techniques that are tailored to meet the unique relational characteristics and cultural composition of each family. In this context, efforts to reduce risk factors and increase protective factors in the individual and family are addressed.

Consider Aaron, a 17-year-old adolescent and his mother, who both reported increased anxiety and symptoms of depression when Aaron was referred for truancy problems. Despite this presentation the therapist was careful not rush to but learn to the family. Through conversations in the first phase of treatment, a picture was co-constructed between the members the family and the therapist. The picture involved identifying the family's unique strengths, capabilities, and the functions of important behaviors within their relationship. Aaron and his mother were close and participated in outings and ate meals together. They also placed high value on education. When the incongruence betwee valuing education and truancy was discussed, we found out that Aaron suffered from an intellectual disability as well as di abetes. He had nearly died from complications from the diabetes several months ago, and his mother blamed herself for his near death. She felt that she had missed the signs because she was over-worked and under significant stress. The emergency raised concerns about her ability to properly care for Aaron. Because she was shamed by the fingers pointed at her, she vowed to keep him safe. She became highly involved in Aaron's care, left he job, attended specialized weekly doctor visits and kept him home from school when necessary.

The increased care came at a cost: truancy, increased anxiety for both and depression for mom. Aaron struggled to express his frustration and shut down at the thought of dealing simultaneously with school and his diabetes. He didn' know how to "fix the problem." He wanted relief, ot just for himself but also for his mother. As a result, both felt "undone," but not without understanding one important caveat: they were both worried about each other yet they struggled to communicate and problem-solve. Giving them hope meant guiding both to use communication and problem-solving in order to begin to address their concerns. As the family reached the middle phase of treatment, interventions included flash cards for Aaron and his mother to discuss strong emotions between them. Signs around the home helped Aaron assist his mother with the care of his diabetes. The family was encouraged to spend time together on a consistent basis. Family time should be leisure time so they could feel more balanced in their relationship. To say that Aaron and his mother quickly integrated these skills would be an oversimpli fication. The changes required practice and consistent support and monitoring by the FFT therapist.

During the final phase of treatme the family continued to extend their communication and problem-solving skills to other areas within the relationship. A relapse plan that involved using mom' informal supports help in times of distress or need for respite was put in place. Aaron's natural ability to be honest with his mother and seek her out whe there was a problem was incorporated into the plan. Community advocacy se ices as well as outpatient care to monitor s depression and anxiety were also addressed.

The family was discharged several weeks ago. Aaron continues to attend school regularly and is doing well. His mother is working and reports reduced feelings of anxiety and depression.

The FFT model with its emphasis on a relational family focus, risk and protective factors is ideal for today's strengths-based, trauma-informed conceptualizations. Aaron and his mother, rather than the therapist, defined the problem, determined the intervention and learned how to change the way they looked at the issues through newly-found communication and problem-solving skills.

Griszel Long, M.S.W., L.S.W. is FFT supervisor and Ebony Gardner, M.S.W., L.S.W., a clinician at The Consortium, Philade - phia.

A Family Game Plan: Brief Treatment

By David Loshelder and the Mercy BHRS Team

"Fix my kids!" the mother of two e ergetic young boys, Adam and Joshua, demanded at the initial session with the mobile therapist at Mercy Behavioral Health. Adam was diagnosed with Atte tion-Deficit Hyperactivity Disorder and also had difficulties in his relationship with his mother. One of the goals in his Brief Treatment plan was to improve family relationships by increasing positive communication and interaction.

As the therapist reviewed the treatment plan with Adam's family, she e plained that the skills she would teach them would be incorporated into their everyday lives and they would practice these skills in many ways. The therapist proposed that their next session consist of beginning to practice some skills in a fun way – a game of touch football. The therapist described which behaviors and skill sets they would be working on and explained what these would look like in their practice session (the touch football game) and how this session would he achieve the goals in Adam's treatme plan. She would also teach skills in active listening, negotiating and conflict resolution. All of these skills would help to increase positive communication and interaction in the family as described in the treatment plan.

At the next scheduled session, the therapist was greeted enthusiastically by the boys. She explained the rules and expectations to the boys in a clear, concise manner and then asked them to review what she had presented. The therapist invited the parents to join in the game. Dad agreed even though he was a little skeptical. However, Mom was more hesitant and wasn't convinced that a game of touch football would help achieve the treament plan goals. She sat nearby and watched as her family and the therapist engaged in a spirited game of touch football, with frequent "high fives" and "nice listening," peppered with an occasional time-out for "unnecessary roughness."

During a period of debriefing following the game, the therapist talked about how the game they had just played taught Adam and his family how to communicate clearly, follow directions, comply, acce consequences, and provide and accept feedback. In the following weeks, the therapist introduced various activities and always ended sessions by carefully explaining the method to her madness as a means of teaching skills to both childre and parents. The family also had the opportunity to talk about what worked and

what else would be helpful to them. The therapist introduced behavior tracking forms measure progress (in the form of a football field with first downs for meeting objectives, field goals for bette than expected behavior and touchdowns for exceeding expectations). She assisted the family in structuring a daily schedule that included "playtime," using materials the family had in their home. The therapist was convinced she had achieved at least short term success when she arrived at the house one day and was met by Mom donning her Steelers sweatsuit, holding a newly-purchased football and eagerly awaiting "kick off." At the end of that session, Mom admitted that not onl was she enjoying her children once again, but she had discovered a level of comfortable confidence in parenting.

This type of "treatment" could not be provided in a traditional outpatient setting. The Brief Treatment plan was able to incorporate activities the family could easily do, such as a touch football game, into teaching sessions where the therapist clearly stated the behaviors being targeted and the strategies employed. The likelihood of generalization occurring was far greater with services being provided in the home. The therapist could see firsthand why some techniques would not be practical to implement and the customize plans and tactics. Most importantly, parents and children both looked forward to "therapy," ensuring both attendance and involvement by all parties.

The Mercy Behavioral Health Wraparound Program provides intensive, medically necessary mental health services to children and adolescents ages 2-21 who need services beyond "traditional" outpatient therapy. These services can be delivered to children in their homes, schools and/or communities. The purpose of the Brief Treatment program is to encourage the development of good mental health, maintain intact families, facilitate safe and healthy home environments and avoid the need for more intensive services. Services can also be used as a "ste down" from more intensive service such as family-based, partial hospitalization, residential treatme etc.

The frequency and duration of se ices are based on the needs of the child and family, but may be prescribed for one o six hours a week for a 36-week authori zation period with every effort being made to accommodate a family's schedul ing needs. The mobile therapist provides individual/family therapy, develops behavior plans and introduces behavioral interventions and strategie such as the touch football game, while assisting in their implementation. The therapist also consults with a child's school and/or other professionals.

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A Proactive Approach to Juvenile Fire Setting

By Kayleigh Gallagher

Billy is a 12-year-old boy who is diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) and trying to deal with the recent divorce of his parents. His mother kept finding lighters and matche around the house. She also noticed that Billy was watching a lot of videos on the internet about making home-made bombs. She dismissed Billy's curiosity because he is a very intelligent boy who understands that fire and bombs are dangerous. While she was grocery shopping one day, she came home to find Billy had lit a deck of cards on fire in his room. She told Billy to playing with fire, e pecially in the house. Over the next fe weeks, she noticed that Billy continually lit her candles and stared at the flame. But again, his mother played off his behavior as typical. One day while she was doing the dishes, she looked out her kitchen window and noticed that her shed had gone up in flames. Billy was outside the shed trying to extinguish the fire. She yelled for Billy to get away from the fire and called 911. She feared for the safety of her child, her home, his friends, and even his school. She worried that Billy' behaviors would get him caught up in the legal system or even worse, be fatal for him or others.

Billy is not alone. Juveniles account for more than 50 percent of arson arrests. One third of those children are under the age of 15, and nearly 4 percent are under the age of 10 (Putnam & Kirkpatrick, 005.) Billy' s mother inquired about what she could do to be proactive in preventing Billy from becoming a statistic. Originally, she was told that Billy may have to go to a residential treatment facility, but then she heard of a more convenient option that could keep Billy at home.

At the Children's Service Cente we offer a Juvenile Fire Setter Program (JFS) which is dedicated to teaching and providing specialized therapy to youth who currently use fire as a maladaptive coping skill. JFS provides individualized fire safety education to increase awareness of the severity of fire-setting behaviors, models safe fire behaviors for the youth and family, and helps parents practice fire safety. Our goal is to keep children home, treating their needs in a community-based setting rather than out of home placement. As of this writing, the JFS program has a zero recidivism rate based on approximately 20 cases who participated in the program.

When a child begins the Juvenile Fire Setter program, he is assigned a mobile therapist and a Juvenile Fire Setter Counselor who meet with him on a weekly basis. Both collaborate with the family and any other agencies involved with the child to provide a continuum of care during the program. The mobile therapist provides cognitive behavioral therapy to the youth and family which specifically identifies and isolates the fire setting behaviors. This is developed through an indi vidualized treatment plan for the child and a safety plan for the family. The mobile therapist also provides assessments of the child, coordinates resources, and provides clinical consultation to other service systems and team members. The Juvenile Fire Setter Counselor provides periodic assessments of the home environment to monitor safety, provides fire science training to families, reinforces skill building activities, provides feedback on interventions and observations, delivers individualized fire safety education, collects data, and engages in relapse prevention. All staff members receive continuous training and outreach through David K o Ph.D., ABPP at the University of Pittsburgh School of Medicine.

After working with the Juvenile Fire Setter Program at the Children Service Center, Billy no longer plays with fire. He speaks openly about his feelings towards the divorce of his parents and its effect on him. He tells his mother about his fee ings, when he needs time to himself, and when he would like to be around his peers. Billy is involved in extracurricular activitie and puts his energy into playing football. He still follows his safety plan to keep himself out of dangerous situations. Billy would like to serve his country whe he gets older.

Any child who appears to be mesmerized by fire or explosives, hoards lighte and/or matche , or use s fire to cope is recommended for the Juvenile Fire Sette Program. Our goal is to educate and counsel children in fire safety before they ge into an irreversible dilemma.

Kayleigh Gallagher, M.A., is director of Juvenile Fire-Setting Program at Children' Service Center, Wilkes-Barre. For more information, contact Kayleigh at 570-825-6425 or KGallagher@e-csc.org .

Reference:

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