A TALE OF TWO STATES:

OUTCOMES FROM TWO STATE-WIDE DEMONSTRATION PROJECTS TO EXPAND EVIDENCE-BASED PSYCHOTHERAPIES FOR TRAUMATIZED YOUTH

Erin R. Barnett¹, Devi M. Murphy², Mary K. Jankowski¹, Michael S. Scheeringa²

Discussant: Suzanne Kerns³

¹Geisel School of Medicine at Dartmouth  ²Tulane University  ³University of Denver
Today’s Objectives

• Discuss successes and failures of evidence-based psychotherapies (EBPs) reaching community settings

• Compare and contrast clinician drop out and adherence to consultation expectations across two states implementing 3 different EBPs and varying in training/clinician expectations

• Compare and contrast clinical outcomes related to these EBPs

• Critically examine implications for administrators, policy-makers, trainers, and clinicians
Trauma and Youth

• The US child welfare system substantiates roughly 700,000 cases of child abuse and neglect each year (US DHHS, 2015)

• Early adverse experiences and trauma can have devastating effects on the developing child and leave children vulnerable to mental health disorders such as PTSD, and many more (Shonkoff & Garner, 2012; De Bellis et al. 2014)
Evidence-Based Psychotherapies (EBPs) for Youth Trauma/PTSD

• Numerous EBPs exist

• Cognitive Behavioral Therapies have similar, and robust effect sizes (Dorsey, et al. 2017)

• 3 treatments utilized in our two states
  • Trauma-Focused Cognitive Behavioral Therapy (TF-CBT): 17 RCTs
  • Child Parent Psychotherapy (CPP): 5 RCTs
  • Youth PTSD Treatment (YPT): 1 RCT, but outgrowth of TF-CBT

• Each model has unique strengths and weaknesses with regard to implementation (e.g., training requirements)
Controlled Studies vs. the Real World

• Meta-analysis of 52 studies of **EBPs vs. usual care in youth**
  • Superiority of EBPs was widespread and consistent (Weisz et al., 2013)

• However, **less than half of patients actually receive EBPs, and EBPs are delivered suboptimally** (Shafran et al, 2009).

• **Overall, EBPs have not reached community settings** (McHugh & Barlow, 2010)

• **Overall penetration rate of EBPs for children 1-3%** (Bruns et al 2016)
Implementation Science

**IMPLEMENTATION IS HARD!**

- Growing literature base to support successful strategies
  - Fixsen et al., 2009: 7 components of implementation (e.g. Careful staff selection, ongoing expert consultation)
  - Hoagwood et al., 2014: 5 effective system strategies (e.g., health information technology, parent activation, quality indicators)

- Learning Communities/Collaboratives are popular, but...
  - Nascent in its research base (2 controlled trials) (Gustafson et al. 2013; Nadeem et al. 2016)
  - Expensive, and, agency directors #1 concern with EBPs is cost (Chor, 2014)
Why This Project?

- The Administration for Children, Youth and Families, Children’s Bureau
  
  “Initiative to Improve Access to Needs-Driven, Evidence-Based/Evidence-Informed Mental and Behavioral Health Services in Child Welfare”

- Total of 19 states received funding

- Project dates October 1st, 2012 – September 30th, 2017
5 Goals of the “Parent” Projects

1. **Screening**
   - Universal; evidence-based/informed tools for behavioral and mental health needs.

2. **Functional Assessment**
   - Repeat screen over time to track improvements.

3. **Data-Driven Case Planning**
   - Match client needs with effective services based on empirical data.

4. **Progress Monitoring**
   - Monitor at the child and systems level. Quantitative and qualitative.

5. **Service Array Reconfiguration**
   - Allow access to evidence-based/informed treatments that fit client needs.
Questions?
The Louisiana Child Welfare Trauma Project

Devi Miron Murphy, Ph.D. & Michael S. Scheeringa, MD
Tulane Dept. of Psychiatry & Behavioral Sciences
March 5, 2018
Louisiana Child Welfare Trauma Project

• A federally funded grant

• A public-private partnership

[Logos of Children’s Bureau, Tulane University School of Medicine, and the Policy & Research Group]
DCFS
Partner
Rhenda Hodnett
Laura St. Amand
Karene Lynch
and others

Tulane University
LCTP Lead
Mike Scheeringa
Devi Murphy
Thao Anh Mai

Policy & Research Group
Independent Evaluator
Lynne Jenner
Alethia Gregory
and others
Louisiana Target Population

Every child under some type of DCFS supervision:

• Foster care (FC) – Children removed from biological caregivers. DCFS is the legal guardian.
• Family services (FS) – Children remaining with biological caregivers. DCFS not the legal guardian.
• 0-18 years
• Entire state
State-wide Roll-out

• 2013 Planning year
• 2014: Pilot Region
• 2015: 4 more Regions
• 2016: 3 more Regions
• 2017: 9th and final Region
• Quasi-experimental design to compare regions with the project to regions without the project.
Results: How many children in the child welfare system in Louisiana have PTSD?

- Before LCTP (prior to 2014), we didn’t know.

- We now have >10,000 TBH screens on unique cases, plus >3,000 TBH screens repeated after 6 months.
TBH Results: Entire State

All Regions as of 04/03/17

Psychological conditions

- 3-6 yrs old
- 7-12 yrs old
- 13-18 yrs old

% at or above clinical cutoff

Caregiver
Child
Joint
Caregiver
Child
Joint
Caregiver
Child
Joint
Caregiver
Child
Joint
Caregiver
Child
Joint
Caregiver
Child
Joint
Caregiver
Child
Joint

PTSD
INT
ADHD
EXT
How Did We Approach the Service Array?

- Louisiana had relatively limited experience with evidence-based practices
  - Multisystemic therapy and functional family therapy could be reimbursed at higher rates under Medicaid
  - Trainings had been provided in the past for TF-CBT, Child-Parent Psychotherapy, and Parent-Child Interaction Therapy.
  - There were no rosters or state-wide tracking publicly available.
- We did not want to train caseworkers to screen for mental health problems without providing some better clinical resources to refer to.
- So, we decided to simultaneously train providers in CBT for PTSD state-wide.
Training and Consultation Model

- Model was created that could reach any willing solo practitioner with minimal travel, cost, and time involved for both trainees and trainers.
- Youth PTSD Treatment (YPT; Scheeringa et al., 2011).
  - Cognitive-behavioral therapy for youths, age 3-18 years, with PTSD
  - 12 sessions; more structured with step-by-step session plans compared to TF-CBT
  - Caregivers involved in every session
  - Components include psychoeducation about PTSD, behavioral management, relaxation exercises, exposures, safety planning, relapse prevention
Training and Consultation Model, cont.

- 1-day trainings held in each region at the same time that we trained DCFS caseworkers
- Providers could receive 6-9 months of free weekly telephone consultation
- Training and consultation were entirely voluntary (not mandated by Medicaid, DCFS, agencies etc.)
Levels of Training

• “Advanced” – completed weekly consultation calls for 3-6 months and completed at least 1 case using YPT
• “Basic” – completed at least 5 calls over 6 months as they actively attempted to identify client
• “One-day trained” – attended one-day training only
• Rosters available at our website [http://latrauma.tulane.edu/resources-for-caseworkers.html](http://latrauma.tulane.edu/resources-for-caseworkers.html)
Resources for DCFS Caseworkers

The Trauma and Behavioral Health Screen

**TBH Quick Reference Guide**  **TBH Caregiver Version**  **TBH Caregiver Version - Spanish**

**TBH Online Data Entry System**  **TBH Child Version**  **TBH Child Version - Spanish**

**TBH Training on Moodle:** If you are a new worker or missed our training, please complete the course on Moodle to get credit. Course name: "Training for the Trauma and Behavioral Health Screen".

**Finding a Provider**
- Alexandria Region
- Baton Rouge Region
- Covington Region
- Lafayette Region
- Lake Charles Region
- Monroe Region
- New Orleans Region

**Quality of Care Reporting**
- File a grievance with Aetna Better Health
- File a grievance with Amerigroup RealSolutions
- File a grievance with AmeriHealth Caritas
- File a grievance with Louisiana Healthcare Connections
- File a grievance with UnitedHealthcare
# Implementation Outcomes

<table>
<thead>
<tr>
<th>Metric</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td># people invited to trainings</td>
<td>2,036</td>
</tr>
<tr>
<td># / % people attended trainings*</td>
<td>335 (16%)</td>
</tr>
<tr>
<td># / % people began project consultation groups</td>
<td>117 (35%)</td>
</tr>
<tr>
<td># / % clinicians who met expectations for project consultation (of those who began groups)**</td>
<td>45 (38%; Advanced) 38 (32%; Basic)</td>
</tr>
</tbody>
</table>
Content of Calls

- Identification of appropriate clients
- Step-by-step guidance for each of 12 sessions
- Involving caregivers in treatment
- Addressing anxiety, avoidance and oppositional behavior in sessions
- Addressing issues specific to DCFS-involved clients
- Addressing therapist reluctance
Training: Successes

- Of those who began consultation calls, retention was 84-100% in some regions
- Eagerness of clinicians to maintain fidelity to the model
- Discussions about complexity of cases
- Clinicians’ positive comments about effectiveness of treatment, evidenced by data in some cases
- Clinicians continue to follow up after completing first case
Training: Challenge and Barriers

• Lack of retention of clinicians (0%) in one region
• Not all clinicians completed cases due to:
  • Clients dropping out for various reasons (e.g., changing foster home, too many stressors, culture of 1x month attendance at clinic)
  • Lack of interest in continuing consultation
  • Time constraints, especially solo practitioners
  • Some fidelity issues – tracked by clinician-report only
  • Lack of referrals, esp. from DCFS
• Need to address the DCFS-clinician communication gap for referrals
## Clinical Outcomes

<table>
<thead>
<tr>
<th># clients tracked by clinicians</th>
<th>102</th>
</tr>
</thead>
<tbody>
<tr>
<td># / % clients reported by clinicians as successfully completed (of those tracked)</td>
<td>64 (63%)</td>
</tr>
<tr>
<td># clients who had pre-mid or pre-post scores available (of those tracked)</td>
<td>17 (27%)</td>
</tr>
<tr>
<td># / % clients with reductions on PTSD measure (of those with scores available)*</td>
<td>15 (88%)</td>
</tr>
</tbody>
</table>
Pre-post treatment TBH results

Pre- and Post-Treatment Mean PTSD Scores (n=17)
Acknowledgements

• Louisiana Department of Children and Family Services
• Louisiana Child Welfare Trauma Trauma Project

Tulane
Michael Scheeringa
Devi Miron Murphy
Caroline Lind
Dani Johnson
Geri Waycie
Thao Anh Mai

DCFS
Laura St. Amand
Karene Lynch
Lynn Farris
Rhenda Hodnett
and others

PRG
Alethia Gregory
Lynne Jenner
and others
Questions?
New Hampshire: Partners for Change

NH Division of Children, Youth, and Families
- Eileen Mullen
- Catherine Meister

Dartmouth Trauma Interventions Research Center
- Kay Jankowski (PI)
- Erin Barnett
- Cassie Yackley
- Rebecca Parton

Center for Program Design and Evaluation at Dartmouth
- Karen Schifferdecker
- Rebecca Butcher
- Laura Pickrell
New Hampshire

Agency/Clinician Recruitment:

• Invited “all” community clinicians serving child welfare population in NH in phased approach

• Offered 8 2-day trainings plus weekly 9 or 12-month consultation groups in TF-CBT or CPP (4 trainings each)
  • 20-60 clinicians per training
  • 20 consultation groups total over 3 year period
  • 3-8 clinicians per consult group
New Hampshire

Preparation/Vetting:

• Required pre-approval and commitment to expectations from administrators, supervisors, and clinicians
  • Administrators, supervisors: confirm agency serves child welfare, allow clinicians the time off for training/consultation, support ongoing internal peer support following year of expert consultation
  • Clinicians: agree to 2 days of training and 80% attendance in consultation groups, agree to begin 2 clients with treatment model within first 2 months
New Hampshire

Training and Consultation:
• 8 2-day trainings (4 in each model) staggered over 3 years, 2 psychologist trainers at each training
• 20 consultation groups led by 4 psychologists
  • 3-8 trainees per group, grouped by agency
• 9 months (TF-CBT) or 12 months (CPP) of weekly consultation
• Consultants facilitated case-based group calls
• Clinicians asked to track basic information on cases and turn in at end of consultation period
## Implementation Outcomes

<table>
<thead>
<tr>
<th></th>
<th>TF-CBT</th>
<th>CPP</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td># people invited to trainings</td>
<td>154</td>
<td>138</td>
<td>292</td>
</tr>
<tr>
<td># / % people attended trainings*</td>
<td>131</td>
<td>112</td>
<td>243</td>
</tr>
<tr>
<td># / % people began project consultation groups</td>
<td>110</td>
<td>56</td>
<td>168</td>
</tr>
<tr>
<td># / % clinicians who met expectations for project consultation (of those who began groups)**</td>
<td>52 (47%)</td>
<td>18 (32%)</td>
<td>70 (42%)</td>
</tr>
</tbody>
</table>
## Clinical Outcomes

<table>
<thead>
<tr>
<th></th>
<th>TF-CBT</th>
<th>CPP</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td># clients tracked by clinicians</td>
<td>237</td>
<td>126</td>
<td>363</td>
</tr>
<tr>
<td># / % clients reported by clinicians as successfully completed (of those tracked)</td>
<td>22 (9%)</td>
<td>10 (8%)</td>
<td>32 (9%)</td>
</tr>
<tr>
<td># / % clients reported by clinicians as ongoing in treatment (of those tracked)</td>
<td>102 (43%)</td>
<td>58 (46%)</td>
<td>160 (44%)</td>
</tr>
<tr>
<td># clients who had pre-mid or pre-post scores available (of those tracked)</td>
<td>55 (23%)</td>
<td>28 (22%)</td>
<td>83 (23%)</td>
</tr>
<tr>
<td># / % clients with reductions on PTSD measure (of those with scores available)*</td>
<td>34 (62%)</td>
<td>16 (57%)</td>
<td>50 (60%)</td>
</tr>
</tbody>
</table>
Successes

• Due to a solid “base” of clinicians already trained in TF-CBT and CPP through prior projects, agency administrators were eager to build upon this capacity and were already familiar with the model and training/consultation strategies
• Efficient use of training and consultation materials across prior projects and the 8 trainings
• Major buy-in from “champion” agencies and clinicians, who held the torch and successfully on-boarded other clinicians
• Of those clinicians and clients who stuck with treatment, they got better
Barriers

- Major clinician drop-out
  - Many due to regular agency turnover
  - Others too overwhelmed or not a good fit for EBPs or trauma EBPs
- DCYF – Mental health collaboration (referral, communication systems)
- Client population in constant chaos
## Comparison: TF-CBT Implementation Outcomes

<table>
<thead>
<tr>
<th>Outcome</th>
<th>LA</th>
<th>NH</th>
</tr>
</thead>
<tbody>
<tr>
<td># people invited to trainings</td>
<td>2,036</td>
<td>154</td>
</tr>
<tr>
<td># / % people attended trainings*</td>
<td>335 (16%)</td>
<td>131</td>
</tr>
<tr>
<td># / % people began project consultation groups</td>
<td>117 (35%)</td>
<td>110</td>
</tr>
<tr>
<td># / % clinicians who met expectations for project consultation (of those who began groups)**</td>
<td>45 (38%; Advanced) 38 (32%; Basic)</td>
<td>52 (47%)</td>
</tr>
</tbody>
</table>
Comparison: Clinical Outcomes (TF-CBT)

<table>
<thead>
<tr>
<th></th>
<th>LA</th>
<th>NH</th>
</tr>
</thead>
<tbody>
<tr>
<td># clients tracked by clinicians</td>
<td>102</td>
<td>237</td>
</tr>
<tr>
<td># / % clients reported by clinicians as successfully completed (of those tracked)</td>
<td>64 (63%)</td>
<td>22 (9%)</td>
</tr>
<tr>
<td># / % clients reported by clinicians as ongoing in treatment (of those tracked)</td>
<td>102 (43%)</td>
<td></td>
</tr>
<tr>
<td># clients who had pre-mid or pre-post scores available (of those tracked)</td>
<td>17 (27%)</td>
<td>55 (23%)</td>
</tr>
<tr>
<td># / % clients with reductions on PTSD measure (of those with scores available)*</td>
<td>15 (88%)</td>
<td>34 (62%)</td>
</tr>
</tbody>
</table>
Questions
Expert Discussant: Suzanne Kerns

Potential points of discussion

- Readiness assessments and preparation of clinicians/agencies
- Unique barriers when working with child trauma/PTSD, child welfare population, etc.
- Pros and cons of using resource-intensive implementation strategies
- Potential need for novel approaches to implementation, modes of treatment for this population (web-based, self help or task sharing)
Questions

Erin.R.Barnett@dartmouth.edu
DMiron@tulane.edu
Suzanne.Kerns@du.edu