Using Implementation Science to Advance Child Well-Being

Advances in Screening for Trauma and Behavioral Health Needs in Child Welfare Settings

28th Annual Research and Policy Conference on Child, Adolescent and Young Adult Behavioral Health
March 24th, 2015, Tampa, FL

Suzanne Kerns
University of Washington

Kay Jankowski
Dartmouth College

Lisa Conradi
Chadwick Center for Children and Families

Funded by the US Department of Health and Human Services, Administration for Children and Families, Children’s Bureau, Grants #90C01103 (WA), #9OC01099-01 (NH), & 90C01101 (CA)
Why is the Children’s Bureau funding the “Trauma Grants”?

- Child mental and behavioral problems are related to poorer placement outcomes
- However, Child and Family Services Reviews by the Children’s Bureau found that:
  - Most state child welfare agencies do not systematically conduct high-quality mental health screens
  - States that do screen rarely use the information to connect children to services
  - Most states lack adequate mental health services for children in state care
- Mental and behavioral needs are often a result of trauma, especially in the child welfare system
“Trauma Grantees”

- 5 sites funded in 2011
- 9 sites funded in 2012
- 6 sites funded in 2013
Achieving Better Adoption Outcomes

Factors Leading to Successful Installation, Implementation and Sustainability

1. Validated Screening
2. Clinical Assessment
3. Well-Being Outcome Measures
4. Case Planning for Safety, Permanency, and Well-being
5. Evidence-based Intervention(s)

Outcomes: Safety, Permanency, Well-Being, Psych Med Use

Progress Monitoring
social-emotional functioning
Major Goals of the Funding Opportunity Announcement

- Improve outcomes by creating a flexible service array that provides early access to effective mental and behavioral health services that match client’s needs;
- Support the implementation of a comprehensive and integrated approach to evidence-based screening and assessment of mental and behavioral health needs, and the use of functional outcome-oriented case planning;
- Support service array reconfiguration approaches that are aligned and responsive to the screening and functional assessment data, while de-scaling services that are not effective or do not meet the assessed needs;
- Identify factors and strategies associated with successful installation, implementation, and sustainability of service system changes;
- Evaluate the effect of implemented system changes on safety, permanency, well-being, and adoption outcomes.
Project Process

- **Phase I: Assessment and Planning**
  - Building collaborations, re-assess chosen screening and assessment approaches, identify effective and ineffective practices, assess the fit between the system and the implementation activities, assess the readiness of the system
  - Develop Phase II plan (Years 2-5)

- **Phase II: Implementation and evaluation**
  - Implementation, evaluation, and fine-tuning of the Phase II plan
Emerging issues across sites

- Screening
- Communication Across Systems
- Data Sharing
- Training and Workforce Development (cross-cutting)
California Screening, Assessment, and Treatment (CASAT) Initiative
DCYF CPSWs & JPPOs routinely screen for mental health well-being

Functional assessment of youth conducted at regular intervals

Screening & assessment results used in case planning & decision-making

Screening

Case Planning

Mental health outcomes are monitored & result in flexible, individualized interventions

Outcome Monitoring

Increased access to evidence-based treatments for trauma

Service Array Changes

PARTNERS FOR CHANGE PROJECT
Dartmouth Trauma Interventions Research Center (DTIRC)

Collaborative Trauma-Informed Child Welfare System

Collaborative Trauma-Informed Child Welfare System

Dartmouth Trauma Interventions Research Center

NH Division for Children, Youth, & Families

Mental Health Provider Community
Screening and Assessment

- Screening?
- Assessment?
- Evaluation?
  - These terms are often used interchangeably, but what are they? When it is appropriate to use one vs. the other?
Screening and Assessment in CW and MH Systems

**Screening**
- Administered to Everyone in Group
- Brief
- Easy to Complete
- Gives ‘Yes’ or ‘No’ Information
- Focused on a Specific Topic

**Assessment**
- In-Depth
- Requires Training
- Administered to Targeted People
- Gives Unique Client Picture
- Informs Treatment
- Completed Over 1-3 Visits

**Psychological Evaluation**
- Even More In-Depth
- Completed by Psychologists (typically)
- Gives Very Specific Information
Where Does Screening Fit into the Process?

Screening  Assessment  Treatment
CASAT Process for Selection and Implementation for Screening Tools

Step 1: Conduct a Review of the Literature
- Are mental health needs and trauma-related needs distinct?
- How are assessment and screening different?

Step 2: Identify Key Criteria for Tool Selection
- Number of items
- Length of administration
- Cost
- Child age range targeted with the instrument
- Method of administration
- Respondent
- Translations and available languages
- Empirical support
- Empirical support for the tool (with diverse populations, for translated tools)
- Domains addressed
- Approach to trauma screening
### Step 3: Review Existing Tools based on Key Criteria

### Step 4: Gather Input from Content Experts

### Step 5: Determine Preliminary Approach

- Strengths and Difficulties Questionnaire
- SCARED-Short

<table>
<thead>
<tr>
<th>Measure and Subscale</th>
<th>Normal Range</th>
<th>Somewhat Concerning Range</th>
<th>Concerning Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strength and Difficulties Questionnaire (SDQ) Total Difficulties Score</td>
<td>&lt; 16</td>
<td>16 - 19</td>
<td>20 - 40</td>
</tr>
<tr>
<td>Screen for Child Anxiety Related Disorder (SCARED) Brief Assessment of PTS Symptoms</td>
<td>&lt; 4</td>
<td>4 - 5</td>
<td>6 - 8</td>
</tr>
</tbody>
</table>
Step 6: Pilot Proposed Mental Health Screening Approach

- Interviewing small samples of workers regarding their experiences using the screening tools and the acceptability and appropriateness of the tools
- Identifying barriers to implementation and administrator attitudes towards feasibility of the screening approach
- Determining if the trauma screening tool appropriately identifies additional children or youth that were not identified with the general mental health screening tool, and
- Evaluating the incremental validity of the screening approach over existing methods of referring families to mental health services (e.g., SDM).
Preliminary Findings – Tulare County Pilot Study

- Data was gathered on the percentage of kids who are identified as needing an assessment using the Strengths and Difficulties Questionnaire (SDQ) and the SCARED-Short.

<table>
<thead>
<tr>
<th>Tool</th>
<th>% with Any Concern</th>
<th>% without Any Concern</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>SDQ</td>
<td>36.5</td>
<td>63.5</td>
<td>734</td>
</tr>
<tr>
<td>SCARED</td>
<td>21.8</td>
<td>78.2</td>
<td>725</td>
</tr>
<tr>
<td>Any Concern (both tools)</td>
<td>43.9</td>
<td>56.1</td>
<td>725</td>
</tr>
</tbody>
</table>

- These results are consistent with the National Survey of Child and Adolescent Well-Being.
- Our preliminary assumption based on these results is that it is advantageous to use both a general mental health and trauma-specific screener.
Challenges to Implementation Efforts

- Counties are discussing the necessity of including trauma screens (vs. more broad general mental health screens)
- The process of implementing screening assists in the State’s greater goal of improving collaboration between the child welfare and mental health systems only if the information is shared and a feedback loop is generated.
- Counties are tending to use tools they have heard about, not necessarily the tools that have the best psychometric properties.
CASAT Screening – Training and Workforce Development

- If possible, leverage existing initiatives and requirements.
  - Better integration with the State and requirements of the Katie A lawsuit
  - Potential integration with SDM
- Start with true champions who are excited about the change, see its value, and are willing to be innovative and pilot test various practices.
- Provide broad training on trauma and its impact as a baseline
- Utilize a “Small test of change” approach to test various screening tools
- Train broadly immediately prior to implementation
- Emphasize the importance of “going slow to go fast.” Be thoughtful at the beginning.
- Make sure to address concerns related to STS and hearing about additional traumas
Now that you have used the Trauma Tool, how are you feeling about continuing to use it?

- Reticent (1)
- Okay (2)
- Comfortable (3)
- Good (4)
- Confident (5)
Communication and Collaboration across Systems

SPECIAL CONSIDERATIONS OF COMMUNICATION BETWEEN MENTAL HEALTH PROVIDERS AND CHILD WELFARE PROFESSIONALS
Interagency collaboration is a critical component to ensure children and families in the child welfare system receive the advantages associated with evidence based practices

-Palinkas, Fuentes, Finno, Garcia, Holloway & Chamberlain, 2014

But what does interagency collaboration look like????

• Bronstein (2000) model of effective collaboration (part 1):
  ○ Interdependence
  ○ Newly created professional activities
  ○ Flexibility
  ○ Collective ownership of goals
  ○ Reflection on Process
Some examples from the literature

- Quality of inter-professional collaboration can impact the efficacy of any potential services (Garland, et al., 2013)
- Collaboration is viewed a positive and rewarding (Darlington, Feeney, & Rixon, 2004)
- Satisfaction is particularly high when “respect, role clarity, and unity of purpose” are apparent (Lewandowski & GlenMaye, 2002)
Washington State: Cross-system communication strategies for child welfare and mental health

- Baseline survey – current landscape and needs
- Initial training efforts:
  - Child welfare
  - Mental health
Results from Baseline Assessment

- **Sample:**
  - 127 Child Welfare professionals
  - 148 Mental Health providers

- **Statewide Approach**
  - 16 focus groups (with exit survey) for CW
  - Anonymous web-based survey for MH

- **Perspectives on the pathway from identification → referral → intake → engagement in treatment → ongoing treatment.**

- **Perspectives on service issues**

Communication and collaboration mentioned across most domains

**At referral:**
- **Needs:**
  - Tools or consultation to identify agencies providing EBT
  - Wishing MH providers knew more about foster care
  - Sometimes feels like ‘an ordeal’ to make an appointment
- **Facilitators:**
  - Sending copies of information when referring
Communication and Collaboration

**At intake**
- Significant challenge: Differing opinions about need for services
- Solutions
  - Learning ‘key phrases’ (e.g. highlighting placement stability is threatened due to child’s MH needs)
  - Attending the intake appointment

**Engagement in therapy**
- Impact of reliance on interns?

**Ongoing treatment**
- Desire open lines of communication
- Mismatched expectations and needs (e.g., reports)
- Questions about information sharing
- Issue of not enough time – acknowledging it takes “extra effort to build relationships with practitioners”
• Mental health liaisons
• Expand use of technology

○ Technological barriers impact practice. When asked about communicating with MH providers via email:

“I can do everything in my life so easily over the Internet at home, but when it comes to my job, [the communication] is just so painfully slow.”
And, let’s hear from the MH providers

- Over 1/3 of comments related to communication and collaboration!
- Similar concerns about information sharing
- Hard balancing needs (foster parents, biological parents, CASAs, caseworkers)
- Less frequently provide recommendations about living situation, permanency and visitation
- Like: Team meetings (especially shared planning), flexible services, frequent communication
MH provider wish list

- Training that explains the foster care system
- Skills to better collaborate
- Training on trauma and its effects
- Specific EBPs
- Training on how to match EBP to specific needs of youth in care
Training Approach – Child Welfare

- Child Welfare Professionals
  - Two trainings
    - 3-hour training for all new in-coming social workers
    - 6-hour ‘skills focused’ training for existing workers
  - Understanding basics of children’s mental health and traumatic stress
  - Overview of effective treatment approaches (including the role of psychopharmacologic treatments)
  - Understanding and interpreting standardized assessment results
  - Strategies for enhancing communication & collaboration with MH providers
Knowledge gain highest in (2+ point improvement on 10-point scale):

- Using and interpreting trauma screens
- Describing symptoms of trauma
- Coordinating with service providers
- Overall knowledge of children’s mental health
- Incorporating assessment results in case plans

From a recent in-service training: “The evidence-based information should be mandatory for line SW, especially new SW.”

“I like the small group exercise-followed by whole group sharing and feedback by instructors.”
Training Approach

- Mental Health Providers
  - Currently under development
  - Three parts:
    - 1) Basics of the child welfare system (focus on foster care)
    - 2) Skills for working with children and youth in foster care
    - 3) Perspectives of bio parents, foster parents, and alumni of care
      “everything I wish my therapist knew”
Some Considerations

• BILLING FOR COLLABORATIVE TIME
• ROLES AND CONCERNS ABOUT SCOPE CREEP
• REGIONAL DIFFERENCES (URBAN, RURAL, LINGUISTIC, AVAILABILITY OF SERVICES)
Creation of Data Systems and Data Sharing to Optimize Utility of Screening Results
Overall Goals for our Project

- To install universal trauma and behavioral health screening for all open cases in child protection and juvenile justice at baseline and every 90 days for the life of a case.
- Optimize utility of MH and trauma related screening information for casework practice (incorporating it into case plans, informing MH and other referrals, progress monitoring).
- Utilize a web-based electronic data system to collect and manage data at the child and system level.
Primary Needs and Considerations for Development of a Data System

- Serve 3 functions: 1) user friendly interface for children and families to complete screening instruments; 2) efficient storage and access of data; and 3) interface for creation of useful reports for workers and management of their caseload needs for screening (e.g., alerts for when re-screening is needed, ability for supervisors to oversee compliance with screening requirements from their staff)
Needs and Considerations Cont’d

- HIPPA compliant, addresses needs for data security and confidentiality
- Sustainability factors (cost, maintenance, flexibility to accommodate new needs as they may arise, e.g. adding new measures)
Our Plan

- After completing research and talking with colleagues, we decided on Qualtrics, which is a company that creates web-based software for surveying; popular among universities and businesses, some hospitals
- Got buy-in from NH DCYF, began development of Data Share and Business Associate Agreements (Dartmouth, Qualtrics and State of NH)
"The paper and ink content is within acceptable norms, but the contract itself appears to have too many clauses."
Process of Development and Installation

- About 9 months to plan, create, test and troubleshoot product (Qualtrics and Dartmouth team)
- Two parts to the web-based system: 1) interface where children and caretakers complete the surveys; and 2) dashboard for staff to manage their data, obtain scored reports with interpretation of results, graph repeated measures over time (e.g., baseline and subsequent time points) to allow progress monitoring
<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>ClientID</td>
<td>1234</td>
</tr>
<tr>
<td>DOB</td>
<td>2001-01-01</td>
</tr>
<tr>
<td>Last Survey Completed by</td>
<td>Becky Parton</td>
</tr>
<tr>
<td>Does the child have a mental health provider?</td>
<td>Yes</td>
</tr>
<tr>
<td>What is the name of the child's mental health center?</td>
<td>Riverbend Jane Smith</td>
</tr>
<tr>
<td>Have results from screening been shared with the child's mental health provider?</td>
<td>Yes</td>
</tr>
<tr>
<td>Is the client attending therapy regularly</td>
<td>Yes</td>
</tr>
<tr>
<td>Type of therapy</td>
<td>Family Therapy, Trauma-focused Cognitive Behavioral Therapy</td>
</tr>
<tr>
<td>Known medications for emotional health</td>
<td>No response</td>
</tr>
</tbody>
</table>
| Reported Traumatic Exposures                                            | Witness to violence
   Accident (vehicle crash, animal attack, burn, near drowning)
   Threats / Stalking
MHST (ages 3 - 6)

MHST (ages 7 - 10)

2015-02-10 09:59:23
2015-01-23 14:43:18

MHST (ages 11 - 20)

Scoring Category | Most Recent (2015-02-10 09:59:23)

sdq total: | Borderline (15)

sdq emotional: | Clinical Level (5)

sdq conduct: | Normal (2)

sdq hyperactivity: | Normal (5)

sdq peer: | Borderline (3)

sdq prosocial: | Clinical Level (2)

ptsd total: | Normal (10)

ptsd reexperiencing: | SubTotal (5)

ptsd avoidance: | SubTotal (3)

ptsd hyperarousal: | SubTotal (2)

ptsd part2: | SubTotal (3)

[View Score History]
Progress to Date

- 300+ screens have been completed in Qualtrics across 7 District Offices (250 unique children)
- We incorporate training on Qualtrics into our basic training on conducting MH and trauma screening; provide consultation as needed both content and technical
- Training consists of the basic implementation how to’s and interpreting results
- Completion of at least 2 screeners are required per worker
Implementation Challenges

- Major practice shift for this workforce – not used to having clients complete web based instruments; also not used to making data driven decisions about MH and trauma related needs
- IT challenges for State workers (antiquated computers, old software, lack of internet access)
- Provision of technical support – we are not IT people! How much do we do vs. how much do we ask the State of NH IT Dept to do, contract out, etc.
- Data security issues, sharing of data across systems
Thank you!

- Suzanne Kerns sekerns@uw.edu
- Lisa Conradi lconradi@rchsd.org
- Kay Jankowski Mary.K.Jankowski@Dartmouth.edu