Moving Upstream toward Trauma-Responsive Prevention and Intervention in Child Welfare

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The Institute for Child & Family Well-being

• A community-university partnership between Children’s Hospital of Wisconsin and UW-Milwaukee’s Helen Bader School of Social Welfare

• Our mission is to improve the lives of children & families by:
  ➢ Designing and implementing effective programs
  ➢ Conducting cutting-edge research and evaluation
  ➢ Engaging communities and promoting systems change
1. Describe barriers to treatment in the CW system and how we are navigating those barriers through the Trauma and Recovery Project

2. Demonstrate how parent-child interaction therapy (PCIT) can be adapted to “fit” the CW system

3. Introduce the trauma screening, brief intervention and referral to treatment (T-SBIRT) protocol that can increase access to treatment

4. Discuss future directions, including ways that our work aligns with the Family First Prevention Services Act (FFPSA)
Background

• Trauma is widely distributed but not equally distributed

• Children who enter the CW system are particularly at risk
  ➢ 40-50% present with clinically significant MH disturbances
  ➢ Their parents and caregivers often face complex challenges

• Timely access to validated mental health care is lacking
  ➢ Shortage of community providers that accept Medicaid
Barriers to Care in Child Welfare

• CW system is not designed to provide therapeutic services
  ➢ Only 8% of federal child welfare funding goes to Title IV-B for family
    preservation & reunification services
  ➢ Limited staffing and administrative support for clinical services
  ➢ Protocols to coordinate screening, assessment & referral to treatment
    are lacking
More Barriers

• Most evidence-based mental health treatments are not designed for the child welfare system
  ➢ Outpatient models delivered by licensed, trained clinicians
  ➢ Many require long-term engagement (i.e., 6-18 months)
    o Do not match child welfare timelines
    o Expensive
The Trauma and Recovery Project

• 5-year SAMHSA-funded initiative supported by the National Child Traumatic Stress Network
  ➢ Partnership with Wisconsin Department of Children & Families and Wisconsin Office of Children’s Mental Health

• Establishes a Community Treatment Service Center (i.e., Center of Excellence) in southeast Wisconsin
Goal #1

- **Strengthen systems of care needed to support and coordinate evidence-based, trauma-focused services**
  - Increase consumer participation & key stakeholder participation in a Collective Impact process
  - Increase public awareness of the need for mental health services & reduce stigma
Goal #2

• Increase availability of training in evidence-based mental health treatments for trauma-exposed children
  
  ➢ Increase the number of clinicians trained and children served
  
  ➢ Reduce disparities in access and service provision by targeting resources to southeast Wisconsin
Goal #3

- *Increase access to evidence-based screening, assessment, and treatment*
  - Promote the use of validated tools to detect MH needs
  - Strengthen referral processes to increase access to:
    - Trauma-focused cognitive behavioral therapy (TF-CBT)
    - Parent-child interaction therapy (PCIT)
Ultimate Goal:

*Improve child and family well-being*
Results

In the first 18 project months…

• 80 practitioners trained in Milwaukee & Racine, including 16 at the Center of Excellence
  ➢ 30% are clinicians of color

• Over 400 children have received PCIT or TF-CBT at the Center of Excellence
  ➢ 63% from an underserved racial/ethnic minority group
Innovation & Incubation

• To reduce barriers to care, the ICFW Center of Excellence is:
  ➢ Developing and validating briefer treatment modalities
  ➢ Minimizing training and supervision costs
  ➢ Altering staffing decisions and reconfiguring work flow
  ➢ Designing data systems and processes
Spotlight on PCIT

- Well validated treatment for children ages 2-7 with externalizing symptoms
- Typically delivered by a therapist in a clinical setting over an average course of 12-14 weekly sessions.
- Distinguishing features: (a) conjoint treatment for children and caregivers, (b) live parent coaching, (c) use of assessment to tailor treatment, and (d) homework
“Programmatic interventions help people beat the odds. Systematic interventions can help change their odds.”

– Karen Pittman
(Co-Founder – Forum For Youth Investment)
Parent-Child Interaction Therapy (PCIT)

- Evidence-based intervention - Supported by:
  - Kauffman’s Best Practices Project
  - National Child Traumatic Stress Network (NCTSN)
  - Title IV-E Prevention Services Clearinghouse / FFPSA

- Targets children ages 2 – 7 years (…6y 11m 364 days) and their caregiver(s)

- 2 Phases (Manualized) over 12-20 weeks:
  - Relationship Enhancement (CDI)
  - Positive Discipline (PDI)

- Improves the quality of the parent/caregiver-child relationship and changes parent/caregiver-child interaction patterns through direct coaching & overlearning skills
PCIT Target Population

- Primary or secondary disruptive behaviors
- Receptive language @ 2 y/o (able to understand simple commands)
- Motivated parent/caregiver with IQ above 75 (equivalent to high school diploma)
- ECBI (parent report of behavior in PCIT) Intensity Raw Score ≥ 131
- Therapist fluent in family’s primary language is recommended
How PCIT Works

- Coaching and modeling

- Child well-being:
  - Externalizing behavioral functioning
  - Internalizing behavioral functioning
  - Emotion regulation

- Adult well-being:
  - Positive parenting practices
  - Parent/caregiver mental or emotional health
  - Parent/caregiver stress
Traditional PCIT Clinic
Primary goal of CDI = relationship enhancement

Parent/Caregiver shapes positive behavior through differential social attention
  Attend to positive child behavior
    PRIDE skills
  Ignore negative child behavior
    Selective Attention

Caregiver mastery criteria

Daily Special Time

Weekly assessments: ECBI / DPICS
Parent-Directed Interaction (PDI)

- Extremely structured
- Extremely consistent
- Predictable for caregiver and child
- Safe, positive discipline through use of effective commands and a unique time-out procedure
- PDI relies on caregiver attention only:
  - PCIT does not use material rewards or punishments
PCIT & Resilience

Executive functioning skills

Connections to competent and caring adults

Increase Resilience

Strong Caregiver-Child Connections

Executive functioning skills

Decrease Resilience

Adverse Childhood Experiences

Toxic Stress

Exposure to Violence
Research & Evaluation
- Randomized Control Testing (RCT)
- Evaluation of external programs
- Data Analytics

Design & Implementation
- Intervention Adaptation
- Training
- Pilot (RCT)
- Testing
- Consultation

Policy & Advocacy
- Policy Briefs, Legislative Advocacy
- Policy Consultation & Collaboration
- Dissemination: EBTs
- Events, Presentations
- Publications, Social Media

PCIT
PCIT in Child Welfare

- PCIT vs. Traditional Parenting Programs

- Typical Referral:
  - Parents / Foster parents / Kinship caregivers seeking help in managing their child’s behavior problems
  - Need for positive discipline techniques
  - Goals: Relational repair, Placement stability, and/or Reunification

- Considerations for Target Population
PCIT in Child Welfare

- Service Access / Family Engagement
  - In-house clinicians
  - Incorporation of MI tools
  - Parallel Process / Scaffolding
  - Generalization of Skills

- Recognized need: Skills for child welfare staff

- Lengthy service wait lists
PCIT Adaptations

- Group-based PCIT
  - Project Connect - 2-day Parent/Caregiver Training
  - Families Empowered together – 10-week groups

- Brief Intervention
  - 5-7 individual sessions

- In-home PCIT

- Collaboration with other family supports/providers

- Child-Adult Relationship Enhancement (CARE)
Training & Consultation

• Training PCIT Clinicians through TARP

• CARE at Children’s Hospital of Wisconsin Community Services

• Building Brains w/ CARE

• Communities of Practice
Translational Research: PCIT

- PCIT Developed by Sheila Eyberg in 1974
- PCIT first used in the general population in 1997
- PCIT Used for foster parents in 2005
- PCIT Used for families where abuse has occurred in 1999
- UWM Starts Project Connect in 2005
- PCIT Used for families involved in child welfare in 1997
- Children's starts PCIT and Project Connect with families involved in child welfare in 2005
- ICFW offers PCIT Training through TARP in 2013
- ICFW launches web-based PCIT CoP in 2015
- ICFW begins Implementation of CARE for child welfare in 2017
- ICFW offers PCIT Training through TARP in 2018
- Children's begins monthly CoP meetings (in-person) in 2016
- ICFW begins Implementation of CARE for child welfare in 2017
- Brief PCIT piloted at Children's in 2011
Implications

- Modifications / Adaptations
- Dissemination of PCIT & CARE
- Establish additional communities of practice (CoPs)
- Train and collaborate with other clinicians, service providers & family supports
  - Diverse agencies
  - Other caregivers involved with a child
  - Schools/Daycares/Community Programs
- Multi-site research studies
T-SBIRT

• T-SBIRT = Trauma Screening, Brief Intervention, & Referral to Treatment
  • 10 to 30-minute protocol designed to screen for client exposure to stress, trauma and trauma symptoms
  • Includes a follow-up motivational interview
  • And concludes with a referral to a qualified mental health provider or other social support
  • Integrated into healthcare and social service programs
Rationale

• Trauma exposure and symptoms are common among service users, e.g., child welfare involved parents

• Trauma exposure and symptoms affect adult, family, and child functioning and undermine response to services

• T-SBIRT direct addresses trauma exposure and its effects
T-SBIRT: Screening

• Screening
  ➢ Current stressors
  ➢ Trauma Exposure (CES)
  ➢ Trauma Symptoms (PC-PTSD)
T-SBIRT: Brief Intervention

• Brief Intervention: Motivationally-based & Client-centered
  ➢ Review screening results
  ➢ Coping
  ➢ Self-medication
T-SBIRT: Referral

• Referral to Treatment (or services)

• Warm referral
  ➢ Mental/Behavioral Health
  ➢ DV Services
  ➢ Healthcare
T-SBIRT Practices

• Ask permission to discuss stress and trauma

• Use of critical MI skills
  ➢ Information giving
  ➢ Open-ended questions
  ➢ Affirmations and reflections
  ➢ Reflection
  ➢ Summarization

• Reflects trauma response practices
T-SBIRT within Employment Services

• Healthy Worker Healthy Wisconsin
  • 5-year project, funded by the Wisconsin Partnership Program

• Integrate T-SBIRT and trauma-responsive practices into employment services: W2, reentry, etc.

• Community Advocates Public Policy Institute
  • UMOS, Jobs Work, Mindful Staffing, CFSS, YWCA, & Community Warehouse

• Delivered by case managers and jobs specialists
Results

• 132 participants
  • Over 95% acknowledged exposure to significant trauma
  • 51.9% screened positive for PTSD

• 59.1% accepted mental health referral
Implications

• T-SBIRT integrated into child welfare b/c parents exposed to trauma

• Trauma exposure affects parenting behavior

• T-SBIRT provides a strengths-based way to screen for trauma

• Warm referral to adult-focused trauma-resolution services

• Supplement to child-centered treatments such as PCIT
Closing Thoughts

- Successful translation of evidence-based models into routine care is facilitated by:
  - Human-centered and system-centered design
  - Strong community-university partnerships
  - Planning & Perseverance
Closing Thoughts

• Major policy changes are needed to alter the way child welfare services are delivered and funded

• FFPSA represents one promising, albeit measured, step toward reforming child welfare funding priorities
  
  ➢ Allows states to use Title IV-E dollars, without regard to family income, to provide family support services
  
  ➢ In addition to TF-CBT and PCIT, in-home parent skill-based programs such as **home visiting** are reimbursable
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