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

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Outline

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)

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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

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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)

    - ❑ Do not match child welfare timelines
    - ❑ Expensive

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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

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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

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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

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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

o Well validated treatment for children ages 2-7 with externalizing symptoms

o Typically delivered by a therapist in a clinical setting over an average course of 12-14 weekly sessions.

o Distinguishing features: **(a)** conjoint treatment for children and caregivers, **(b)** live parent coaching, **(c)** use of assessment to tailor treatment, and **(d)** homework

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"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)

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

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

o 2 Phases (Manualized) over 12-20 weeks:
  - oRelationship Enhancement (CDI)
  - oPositive Discipline (PDI)

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

PCIT Target Population

o Primary or secondary disruptive behaviors

o Receptive language @ 2 y/o (able to understand simple commands)

o Motivated parent/caregiver with IQ above 75 (equivalent to high school diploma)

o ECBI (parent report of behavior in PCIT) Intensity Raw Score ≥ 131

o Therapist fluent in family's primary language is recommended

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How PCIT Works

o Coaching and modeling

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

o Adult well-being:
  o Positive parenting practices
  o Parent/caregiver mental or emotional health
  o Parent/caregiver stress

Traditional PCIT Clinic

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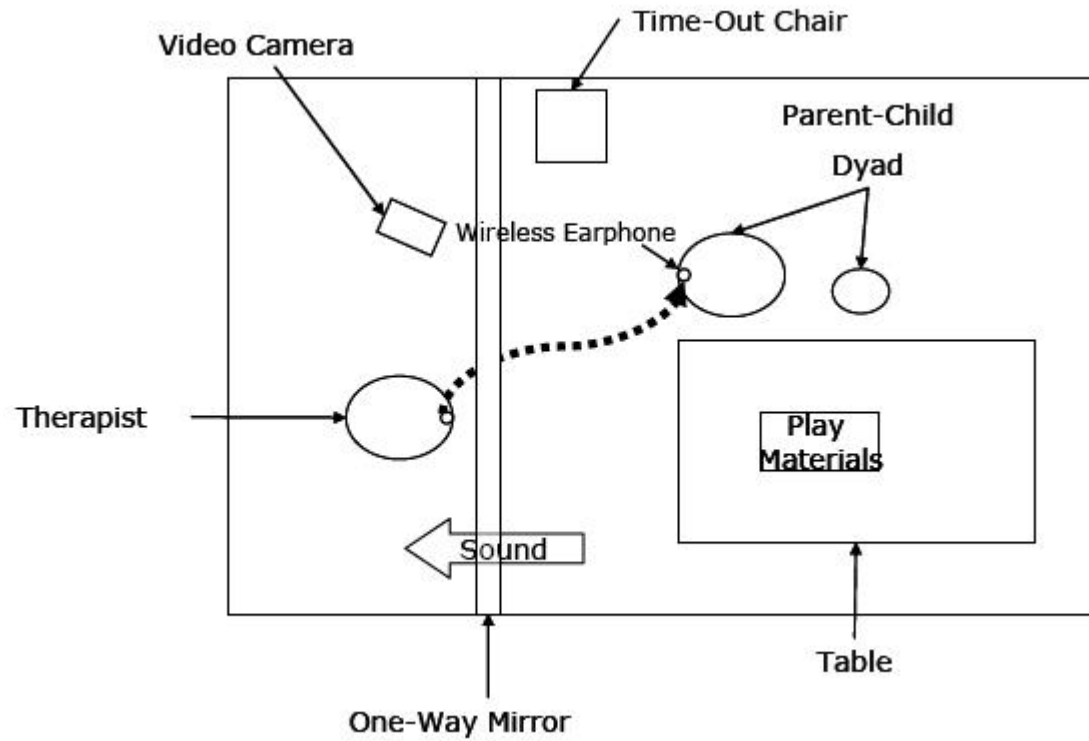
# Child-Directed Interaction (CDI)

o Primary goal of CDI = relationship enhancement

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

o Caregiver mastery criteria

o Daily Special Time

o Weekly assessments: ECBI / DPICS

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Parent-Directed Interaction (PDI)

o Extremely structured

o Extremely consistent

o Predictable for caregiver and child

o Safe, positive discipline through use of effective commands and a unique time-out procedure

o PDI relies on caregiver attention only:

o PCIT does not use material rewards or punishments
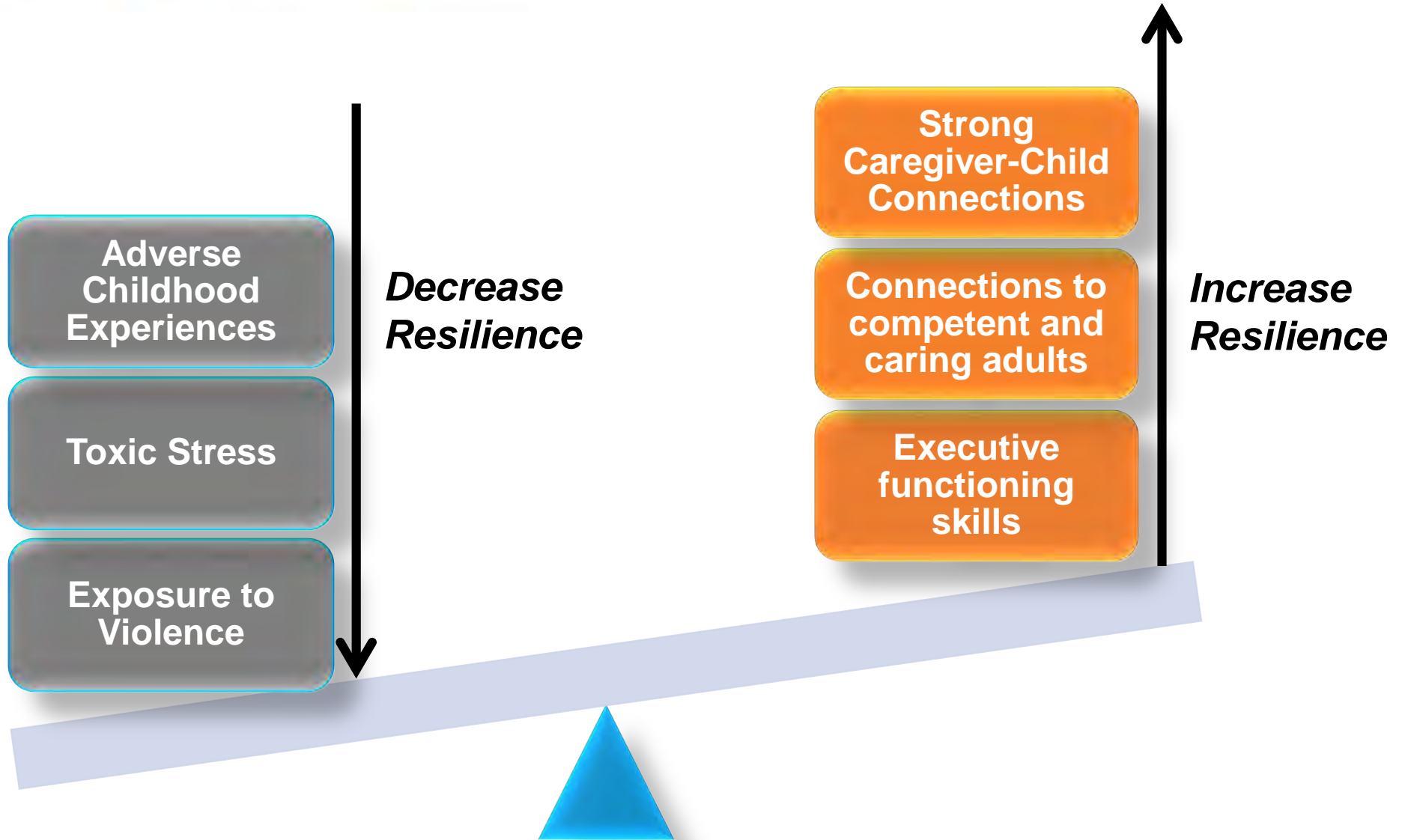
PCIT in Child Welfare

o PCIT vs. Traditional Parenting Programs

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

o Considerations for Target Population

PCIT in Child Welfare

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

o Recognized need: Skills for child welfare staff

o Lengthy service wait lists

PCIT Adaptations

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

o Brief Intervention
  o 5-7 individual sessions

o In-home PCIT

o Collaboration with other family supports/providers

o 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
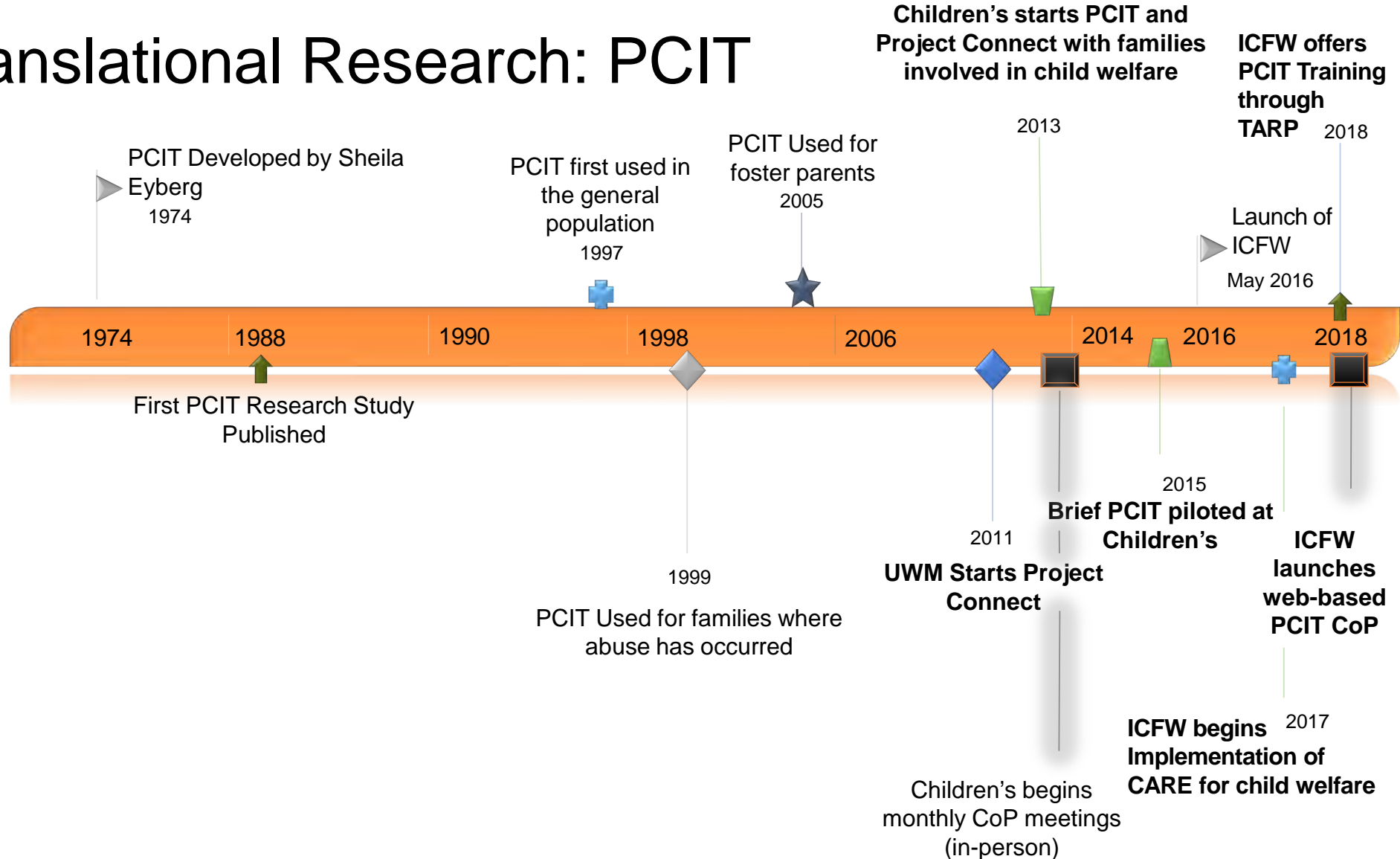
Implications

o Modifications / Adaptations

o Dissemination of PCIT & CARE

o Establish additional communities of practice (CoPs)

o Train and collaborate with other clinicians, service providers & family supports
  - o Diverse agencies
  - o Other caregivers involved with a child
  - o Schools/Daycares/Community Programs

o 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)

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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

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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

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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

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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

Acknowledgments

- **TARP Partners**

  - University of Wisconsin-Milwaukee

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  - Office of Children's Mental Health

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