

**A Statewide Training of Community Clinicians to Treat Traumatized Youths Involved
with Child Welfare**

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Author Note

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Abstract

Despite considerable investment in efforts to disseminate evidence-based treatments (EBTs), few data are available on how frequently clinicians achieve competence in delivering the treatments or on whether clinical outcomes actually improve. The Louisiana Child Welfare Trauma Project (LCTP) was a five-year demonstration project funded by the Children's Bureau. One of the aims of the LCTP was to train community clinicians statewide in an EBT for posttraumatic stress disorder (PTSD). A training model was designed to reach any willing community practitioner with minimal travel, cost, and time involved for trainees and trainer. Of the 335 clinicians who attended a one-day training in Youth PTSD Treatment (YPT; Scheeringa & Weems, 2014), a manualized treatment for youths with PTSD, 117 began consultation calls. Forty-five (38%) clinicians who began calls achieved Advanced training, completing at least one case using YPT and attending weekly calls. Of the 102 clients discussed during calls, 64 (63%) completed YPT. Pre- and post-treatment measures were available for 17 (27%) of the completers. All 17 clients showed decreases in their PTSD symptoms by youth or caregiver report; with 12 (71%) showing a decrease in symptom count by at least half of the pre-treatment score. This is the first known report of the proportion of community clinicians who voluntarily completed consultation calls to achieve competence following initial training in an EBT. The results suggest that effectiveness of an EBT is possible in community settings but is likely constrained by clinicians being willing and/or able to complete training requirements geared towards achieving competency in and fidelity to the protocol. Because the majority of clinicians did not complete training requirements, this suggests major limitations in the current models of dissemination.

Keywords: child welfare; evidence-based treatment dissemination; PTSD treatment

Children involved in the child welfare system often have been exposed to potentially traumatic events, including physical abuse, sexual abuse, and exposure to domestic violence (Griffin et al., 2011; Kolko et al., 2010). Following traumatic experiences, these youths may develop psychiatric problems such as posttraumatic stress disorder (PTSD) and other disorders including oppositional defiant disorder, separation anxiety disorder, attention-deficit/hyperactivity disorder, and major depressive disorder (De Young, Kenardy, Cobham, & Kimble, 2012; Scheeringa & Zeanah, 2008; Scheeringa, Zeanah, Myers, & Putnam, 2003). Studies have consistently demonstrated significant associations among traumatic and other adverse experiences, the onset of parent-child relationship disturbances (e.g., Lieberman, 2004; Lieberman & Knorr, 2007), and later diagnosis of psychiatric and substance abuse disorders (Green et al., 2010). Children experiencing trauma also may have trouble forming trusting relationships with family members and others caring for them, peers, and siblings.

Given the prevalence of exposure to potentially traumatic events in the child welfare system, recently there have been efforts to develop best practices and improve trauma-informed care services (Conradi, Wherry, & Kisiel, 2011; Murphy, Moore, Redd, & Malm, 2017; Samuels, 2011; Strand & Sprang, 2018). These efforts have generally embraced the Substance Abuse and Mental Health Services Administration's (2015) concept of a trauma-informed system that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma, and integrates knowledge about trauma into policies, procedures and practices.

Although there is no consensus on the essential components of a trauma-informed child welfare system, the National Child Traumatic Stress Network (NCTSN) outlines that a

comprehensive trauma-informed child and family service system includes screening, evidence-based treatment, resource availability, resilience-building, addressing caregiver trauma, continuity of care and collaboration, care for staff, and responding to the unique needs of diverse communities. The NCTSN (2013) has developed training materials for child welfare staff to increase their knowledge of trauma and improve responsiveness to youths who have been traumatized, known as the Child Welfare Trauma Training Toolkit. The Children's Bureau, an agency within the Administration for Children and Families, has funded a series of demonstration projects to improve the capacity of child welfare systems to respond to the needs of traumatized children (Samuels, 2013). Although results are still pending, these efforts may assist jurisdictions in responding to federal legislation that officially recognizes the prevalence and impact of trauma on children involved with the child welfare system and requires systems to screen and refer for appropriate care (Child and Family Services Improvement and Innovation Act, 2011).

In this paper, we describe one of these recent projects, aimed at enhancing the capacity of a child welfare system to address PTSD among the youth they serve with evidence-based treatment (EBT). Estimates of youths with PTSD in the child welfare system range from 19% for children who are placed in foster care (Kolko et al., 2010) to 25% for adults who had resided in foster care as children (Pecora et al., 2005). These are significant proportions notwithstanding the number of children who have symptoms but who do not meet full criteria for PTSD and may also benefit from EBT for PTSD.

Despite the need, child welfare systems often have limited capacity to respond effectively because they are dependent on public funds (e.g., Medicaid or other federal and state programs) to pay for services and many providers are unwilling to accept the

relatively low reimbursement rates offered. In addition, some clinicians avoid working with youth involved in the child welfare system due to the documentation and possible court testimony required. Further, practitioner training and experience in evidence-based treatments to sufficiently address the needs of traumatized youth are lacking (Hanson et al., 2014).

Over the last two decades, there has been a call for clinicians to complete training in and deliver evidence-based treatments (EBTs) for emotional and behavioral problems (McHugh & Barlow, 2010; Novins, Green, Legha, & Aarons, 2013). Over 500 EBTs exist for child and adolescent mental health disorders (Dorsey, Berliner, Lyons, Pullman, & Murray, 2016), and extensive dissemination projects have been conducted with enormous financial support from national and state governments and private funding sources. It is not clear however that dissemination projects have met the goals of improving client outcomes when extending beyond the tightly controlled environs of randomized trials and moving into uncontrolled community-wide disseminations.

Before client outcomes can improve, community clinicians have to adopt the EBTs. In a review of the major initiatives to disseminate and implement EBTs, McHugh and Barlow (2010) noted that few dissemination initiatives recorded information on the two most basic outcomes required to justify the magnitude of funding and effort spent: (1) number of clinicians who failed to reach competency, and (2) client symptom outcomes. Without such basic metrics, examinations cannot begin to explore mediators of successful adoption, such as duration of consultation, the best sustainability models (i.e., “train the trainer”), stakeholder support facilitators, or ways to address the highly variable rates at which clinicians adopt EBTs for treating PTSD (Rosen et al., 2015).

In a review of dissemination efforts Barlow, Bullis, Comer, & Ametaj (2013) concluded that “didactic trainings alone are insufficient” (p. 19), and there now seems to be broad consensus about that. The different training strategies that projects have used to move beyond “didactic trainings alone” have been varied [see Cohen & Mannarino, 2008, for a review of efforts to disseminate trauma-focused cognitive behavioral therapy (TF-CBT) in community settings]. Nearly all of the different training strategies have included ongoing consultations for six to 12 months, while the details of frequency (weekly versus less often), group size, format (in-person versus remote), and expectations of participation in the consultations vary. Different recruitment strategies have ranged from training any willing community clinician (Dorsey et al., 2016) to hiring dedicated project clinicians (Murray, 2017).

Dissemination studies are only beginning to include information on training requirements and completion rates. Dorsey et al. (2016) describe the Washington State Department of Social and Health Services sponsored training for CBT+ (Chorpita, Taylor, Francis, Moffitt, & Austin, 2004; Weisz et al., 2012). This training included a three-day in-person training for which clinicians received 18 to 20 continuing education credits, followed by six months of biweekly consultation calls with 10 to 15 trainees per call. Trainees were expected to attend nine to 12 calls to receive a certificate of completion. The number of clinicians originally invited for the training was not reported but in four cohorts of trainees over three years, there were 400 participants including non-clinicians (e.g., administrators, case workers, or other staff). The total number of clinicians and supervisors completing the pre-training survey was 284 and 180 completed a post-consultation follow-up survey. Call attendance data were available for only 155

participants. The mean number of calls attended was 9.4 (SD 1.9, range 1-12), with 80% of the 155 (n=124) attending nine or more calls. However, neither the percentage of total available clinicians statewide nor the percentage of clinicians who began training and completed training expectations was reported.

Given the need for trauma-informed services for youth involved with child welfare and the gap in the extant literature regarding EBT training completion rates and client outcomes, in this study we report data addressing two research questions. First, what percentages of community clinicians who are invited to free, low-burden trainings aimed at enhancing the service array for the child welfare population will engage to achieve three different levels of competency – a minimum level of attendance at a one-day training only, a basic level that included follow-up phone consultations that did not involve their own cases, or an advanced level of competency that included follow-up phone consultations that involved their own cases for three to six months? There are no known prior estimates in the literature of the percentage of clinicians who voluntarily initiated an EBT training and followed through to achieve training expectations. In the absence of an empirically-derived parameter we aimed for the benchmark suggested by Dorsey et al. (2016) of 80% of clinicians to complete training expectations and achieve the advanced level of competency.

Our second research question was, when community clinicians engage in training to achieve the full level of competency, to what degree do their clients improve? In the largest randomized controlled trial of an EBT for PTSD in youths, 75% of those diagnosed with PTSD prior to treatment who received TF-CBT improved to the extent that they were not diagnosed with PTSD following treatment compared with 49% of those in the non-EBT control group. Further, the entire EBT-treated group showed a 57% reduction in PTSD

symptom severity compared to 39% reduction in PTSD symptoms severity in the non-EBT control group (Cohen, Deblinger, Mannarino, & Steer, 2004). Based on these prior findings, an exploratory aim of the study was for the mean PTSD score on an objective measure for clients receiving EBT for PTSD to reduce by 50% or more from pre- to post-treatment.

Method

Participants

The national Children's Bureau launched an initiative to fund demonstration projects to disseminate evidence-based practices in child welfare systems that focused on trauma and trauma-related problems. Five-year projects were funded in child welfare systems in 19 different states in a series of three cohorts (funded in 2011, 2012, and 2013).

The Louisiana Child Welfare Trauma Project (LCTP) was one of the five-year demonstration projects funded by the Children's Bureau with their first year beginning in 2012 (<http://latrauma.com>). The primary goal of the LCTP was to train Louisiana Department of Children and Family Services (DCFS) caseworkers to use a new universal screen for trauma exposure, trauma-related problems (i.e., PTSD), and other emotional and behavioral problems. In parallel with this training of caseworkers to screen and detect youths in need of clinical services, an additional aim of the LCTP was to enhance the service array in anticipation of greater referrals.

Participants were clinicians who provide mental health services to Medicaid-eligible children and adolescents across the state of Louisiana. Clinicians who could potentially receive training in the EBT for PTSD were identified using the existing Louisiana Medicaid behavioral health providers' online directory. A search was conducted within the directory using the following criteria: 1) licensed clinicians who identified themselves as providing

services to children and adolescents and 2) providers located within a 25-mile radius of DCFS offices in the target region of the state. Providers were also identified by asking local DCFS administrators and staff for a list of licensed clinicians and agencies to whom they regularly refer children for psychotherapy. Clinicians from publically funded behavioral health services clinics, (“Human Services Districts”), were also invited to the training. Some clinicians learned about the training by word-of-mouth. As the project progressed, the training was available to clinicians from regions where training had already been provided to allow clinicians who had missed previous trainings to attend.

Youths seen by clinicians receiving training through the LCTP were determined eligible to receive the EBT typically if they displayed significant symptoms of PTSD, usually meeting the cutoff score on the measure developed for the LCTP. The appropriateness of clients to receive the EBT was discussed during consultation calls (described below). Given that the information about youth participants was limited to what was needed to consult to clinicians in screening for PTSD, detailed demographics were not collected. Just less than half of the youths who were tracked by the clinicians were involved with DCFS. The LCTP did not interfere in decision-making about which clients were referred to specific clinicians for treatment. The trainer tracked the progress of clients discussed during calls but did not track the number of clients who were determined ineligible for treatment, those who dropped out of treatment prior to completion, or whether or not they continued in treatment beyond the completion of the EBT for PTSD. The project was reviewed and approved by the Tulane University Committee on the Use of Human Subjects. The project met an exemption determination and informed consents were not required.

Procedures

The child welfare system in Louisiana is a statewide system that is administered by DCFS. The state is divided into nine geographic regions. The LCTP rolled out implementation of DCFS caseworker training to use the Trauma and Behavioral Health (TBH) screen and simultaneous clinician training to learn the EBT for PTSD one region at a time. A training model was created that could reach any willing solo practitioner with minimal travel, cost, and time involved for trainees and trainer. Trainings were delivered to clinicians in one to two regions at a given time over the course of four years. Pre- and post-TBHs of clients receiving the EBT were collected by clinicians completing case consultation when possible.

Youth PTSD Treatment training. Youth PTSD Treatment (YPT; Scheeringa & Weems, 2014) is an individually delivered, 12-session manualized cognitive-behavioral therapy (CBT) for youth, ages seven to 18 years, with PTSD. YPT was chosen because of its highly structured, manual-based format that facilitates dissemination among novice CBT therapists. YPT includes traditional components of CBT for childhood trauma including psychoeducation, skill building in identification and expression of emotions, relaxation exercises, exploration of negative thoughts, narrative processing of trauma events, graded exposure exercises in and out of the office, safety plans, and involvement of caregivers in every session. The YPT manual is an older-age extension of the Preschool PTSD Treatment (PPT) manual that has shown good efficacy in a previous trial with children, ages three to six years (Scheeringa, Weems, Cohen, Amaya-Jackson, & Guthrie, 2011). The efficacy of YPT for the treatment of PTSD symptoms for older children has been described previously (Humphreys, Weems, & Scheeringa, 2015; Scheeringa & Weems, 2014).

In-person training. Clinicians were initially invited to attend a one-day, in-person

training to be held in their geographical region by mail or email. A total of 10 trainings across the nine regions were held. Interested clinicians completed an application for the training, which included questions about clinicians' credentials and whether or not they were Medicaid providers, and therefore eligible to serve children involved with DCFS. In addition, applicants were asked to agree to complete at least one case using the YPT model and to attend weekly consultation calls for six to nine months to receive case consultation. Participation was voluntary and was not mandated by the clinician's agency management, DCFS, managed care providers or other entities. All training sessions were free of charge to clinicians.

The trainer (and first author) was a psychologist, licensed to practice in the State of Louisiana, with expertise in working with traumatized children involved with child welfare. At the start of training, she had seven years of experience conducting, supervising and consulting on the use of YPT with children of all ages.

The one-day, 6.5-hour training covered assessment and diagnosis of PTSD, including the use of the TBH, and the content of the YPT manual in detail. The YPT manual and handouts were provided to each participant. Video excerpts from actual treatment sessions were used to illustrate treatment components. Interactive exercises allowed for participants to practice treatment techniques. A portion of the training also covered special considerations for providing YPT to youth involved with the child welfare system, including identifying which traumatic events to target in treatment, working with foster parents, and communication with DCFS and the courts. Continuing education credits were provided to eligible clinicians.

Teleconference consultation. Approximately one week following the in-person

training, the trainer emailed participants inviting them to sign up for weekly consultation calls. Generally, groups were formed with one to five clinicians. Groups were kept small in order for each clinician to have the opportunity to receive consultation on a weekly basis. An effort was made to group clinicians from the same agency together with no outside clinicians in order to be able to discuss agency-specific policies that may be impacting the delivery of YPT.

The one-hour calls were generally held on a weekly basis for six to nine months for clinicians in the target region. Occasionally, a clinician completed a case within three months and discontinued consultation following the completion of the case. One group of two clinicians from the same agency attended calls for over 12 months due to difficulty with retaining clients in services.

At the outset, the trainer explained the nature of consultation and the fact that the therapist was ultimately responsible for the care of the client. The trainer used a cognitive-behavioral framework for consultation calls in order to model this approach for participants and this was discussed during the first call to set expectations. The trainer emphasized that consultation would focus on PTSD, individual YPT sessions, and issues related to delivering YPT to children involved with DCFS. Although the calls were structured, there was flexibility to allow for clinicians to ask questions and discuss facilitators and barriers to delivering the treatment. An agenda for each call was set between the trainer and the participants, including allocating an equitable amount of time for each clinician to discuss their case.

Content of calls. Identification of clients who would be appropriate to participate in YPT comprised a significant portion of the discussions during initial calls. Clinicians first

presented background information on the case (e.g., age of youth, trauma exposure, child welfare status, and living situation) and then provided the results of the TBH. The trainer and clinician together determined the appropriateness of beginning YPT with the client. Once an appropriate client was identified, the trainer reviewed the manual content and provided step-by-step instructions for delivering each session of YPT. The trainer made suggestions for tailoring sessions to meet the needs of each individual client while maintaining fidelity to the model. As sessions progressed, clinicians presented the events that occurred during the previous week's session and received feedback from the trainer. The trainer then previewed the upcoming session.

TBH administration. With the exception of the first region participating in the training, clinicians were asked to administer the TBH to screen youths for PTSD and assist in determining eligibility for treatment. The clinicians administered the TBH to children ages seven years and up. They also administered the TBH to caregivers of these youths, as well as to caregivers of youths between the ages of three and six years. Clinicians consulted with the trainer as needed to review administration, scoring, and interpretation of the TBH. Clinicians were also asked to administer the TBH following the completion of treatment when possible to determine clinical progress. Clinicians reported TBH scores to the trainer, pre- and post-treatment when available, who recorded them in an Excel spreadsheet.

Measure

The TBH was created for this project and consists of components taken from four existing instruments in the public domain (available at <http://latrauma.com>). The measure includes items forming four subscales assessing PTSD, internalizing symptoms, ADHD, and

externalizing symptoms. The TBH also contains 11 questions to cover substance abuse, psychosis, autism, and preschool issues, but these items do not figure into the scoring of subscales. A caregiver-report version of the TBH was developed for caregivers of children, ages 0 to 18 years. A youth-report version was developed for children, ages seven to 18 years, with the same items as the caregiver version but pronouns modified appropriately for self-administration.

Only the PTSD subscale was used in the current study. This subscale consists of 15 items from the 17-item Child PTSD Symptom Scale (CPSS; Foa, Johnson, Feeny, & Treadwell, 2001). Two items were not retained from the CPSS, including the item for not being able to remember an important part of the trauma. This item has been shown consistently to be one of the least frequently endorsed items (Saul, Grant & Carter, 2008; Scheeringa et al., 2003) and poses developmental challenges for accurate endorsement in younger children (Scheeringa, 2009). The other item that was not retained was difficulty concentrating because this was asked about in a different section of the TBH and was thought to be confusing if asked about twice. The items map directly onto the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (APA, 1994) PTSD symptoms, and were each rated on a four-point (0-3) Likert scale. The reliability for the PTSD subscale of the TBH is very good ($\alpha=.91$ for caregiver-report and $\alpha=.93$ for youth-report). A score of 11 is recommended as the clinical cutoff when using the full CPSS (Foa et al., 2001). A score of 10 on the PTSD subscale was used as the cutoff in the LCTP because we did not use two of the CPSS items.

Data Analysis

The aim of our first research question was that 80% of clinicians who attended the

training would achieve the Advanced level of training. Because 80% was only a benchmark suggested by other experts in the field (Dorsey et al., 2016) and was not derived empirically from a prior study, we did not feel that significance tests of statistical inference were appropriate, and the results are reported descriptively.

There were three levels of training at which clinicians were rostered on the LCTP website: “One-day trained,” was the designation given to clinicians who attended only the one-day in-person training, including those who signed up for consultation calls but dropped out after one or two calls; “Basic training,” indicated that clinicians had attended at least five group consultation calls over approximately a six-month period as they attempted to identify clients appropriate for the model. These clinicians participated in other YPT case discussions but did not complete their own cases using the model. Once a clinician had implemented the YPT protocol (completing seven to 12 sessions) with at least one youth and had attended weekly calls to receive consultation on his/her case, the clinician was designated as having received “Advanced training” in YPT. The “Advanced” clinicians received certificates of completion from the LCTP.

To determine client progress, pre-treatment and post-treatment PTSD subscale scores for 17 youths who completed YPT were compared, and the percent reduction in their scores was calculated. This percent reduction was compared descriptively to percent reductions that were achieved with TF-CBT in the largest prior study to treat youths with posttraumatic stress (Cohen et al., 2004).

Results

Clinician Retention

Table 1 and Figure 1 display the number of clinicians invited to and the

number/percentage that attended the one-day trainings in each region. Of the 2,036 clinicians statewide who were invited to a training session held in their geographical region, 335 (16%) attended.

Table 1 also displays the number of clinicians who participated in the consultation calls and the number of clinicians who completed the requirements for the different levels of training. Of the 117 participants who began consultation calls, the majority (71%) completed at least five calls. Although 45 (38%) of clinicians completed the Advanced training expectations, this was far lower than our aim of 80%. Thirty-eight clinicians (32%) completed training expectations at the Basic level and 34 clinicians (29%) signed up for consultation calls but discontinued after zero to two calls. Finally, 218 clinicians attended the in-person training but never signed up to attend consultation calls. No information is currently available as to the reason so many clinicians never attended consultation calls.

Client Progress

The aims of the LCTP were not focused on individual child PTSD treatment progress because of concerns about creating resistance among clinicians if they knew they would be required to complete extra paperwork. Data on the efficacy of the YPT delivered are therefore limited. Although pre-treatment TBH measures were administered for each client, clinicians reported difficulty in completing post-treatment measures with clients and the trainer noted difficulty contacting clinicians once the consultation had finished. Nevertheless, the trainer tracked 102 clients discussed during consultation calls. Of these, 64 (63%) successfully completed treatment and clinicians completed pre- and post-measures with 17. Of those for whom pre- and post-treatment data were available, the

mean age was 8 years (range = 4 to 17). Fifteen identified as females and two identified as males. All 17 of the clients showed a reduction in PTSD scores by either caregiver or youth report. According to the youths' reports, the mean PTSD score decreased from 26 to 11.1 (57% reduction). The mean caregiver rating of youths decreased from 26.5 to 11.5 (57% reduction). Both of these results exceeded our aim of a 50% reduction in PTSD severity. Further, 12 (71%) had a reduction in post-treatment PTSD score by at least 50% of the pre-treatment score, with nine (53%) no longer meeting the cutoff for PTSD.

Discussion

To begin to address the significant impact of trauma exposure in the child welfare population in Louisiana, the LCTP set out to disseminate an EBT for PTSD for clinicians using a replicable training model with an intentionally low burden. This is the first known report of the proportion of community clinicians who completed consultation calls to achieve competency following the initial training. Of the 335 clinicians who attended the initial training, only 45 (13%) completed the requirements for Advanced training status. The proportion of clinicians who achieved Advanced training status appears disappointing, but is consistent with other previous anecdotal reports of poor uptake of EBTs (McLean & Foa, 2013; Shafran et al., 2009; Zayfert et al., 2005). Of those who made the commitment beyond the one-day training to attend consultation calls, the proportion of clinicians who achieved Advanced training status was better, 38%, but still far below our initial goal of 80%. It is difficult to interpret this result given that no previous studies have reported EBT training completion rates. While Dorsey et al. (2016) provided a benchmark of 80% clinician completion, their report did not include the number of clinicians originally invited to participate in training and completion data were missing for a number of participants.

Preliminary outcome data that were collected by clinicians who remained active in consultation calls indicated positive outcomes for the clients, with clients' PTSD symptoms being reduced by 57%, greater than our aim of 50%, per caregiver and youth report. This reduction in symptom severity is similar to the results reported by Cohen et al. (2004). These results provide unique evidence that dissemination to community clinicians who are willing and able to implement the EBT outside of a highly controlled randomized trial is possible and effective.

We elected to recruit clinicians directly for the training as opposed to targeting agencies. This approach may have appealed to clinicians in private practice and to those working in clinics alike. A popular model for training clinicians in EBTs for youth who have been exposed to trauma has been the learning collaborative, an intensive, multi-layered method developed by the Institute for HealthCare Improvement, and heavily promoted by the NCTSN (e.g., Ebert, Amaya-Jackson, Markiewicz, Kisiel, & Fairbank, 2012). Learning collaboratives often target agencies and are increasingly assessing and addressing agency readiness to implement a particular treatment model. The learning collaborative model was a common choice among other Children's Bureau cohort grantees, but it has several weaknesses that make it ill suited for a statewide dissemination due to several issues in Louisiana. Learning collaboratives are long in duration and relatively slow to train a workforce to competency. They are time intensive and require a substantial amount of missed work to attend workshop trainings. Barriers to implementing the use of the treatment can be time limitations due to agency productivity requirements, organizational restructuring, and staff turnover. Learning collaboratives are designed to change agency cultures in respect to trauma awareness, and therefore include administrators and

supervisors who are expected to return to their agencies as trauma champions. This goal of agency culture shift is less relevant when considering that 80% of psychotherapy businesses are solo practices (Curan, 2016).

As with other efforts to disseminate EBTs, challenges were identified during the consultation. First, retention of clinicians in the consultation was not optimal and was limited by several factors. It is possible that the reason for lack of clinician participation in the consultations was that they could not identify clients for whom YPT would be appropriate. This was a mystery to LCTP staff as DCFS simultaneously complained about a lack of providers available to refer to. LCTP staff attempted to address this problem by providing lists of clinicians accepting referrals to DCFS staff during follow-up project meetings. In addition, the YPT trainer encouraged clinicians to reach out to DCFS offices personally to request referrals. These efforts were successful in a small number of cases but still, the majority of clients who received YPT were not involved with DCFS. In some cases, clients who began YPT sometimes discontinued due to being moved to a foster home in another region or due to caregivers reporting too many stressors to attend weekly sessions. These issues were addressed repeatedly in consultation calls and clinicians sometimes were able to problem-solve in order to retain clients. For example, clinicians were encouraged to reach out to DCFS workers in order to engage families. Also, sessions were offered every other week or multiple times per week in order to accommodate the family's schedule. In order to expand the pool of EBT-trained providers, we did not require clinicians to see youths involved with DCFS at the time of the training, only that they accepted Medicaid and could potentially be providers for DCFS-referred youths in the future. Thus, the LCTP increased the number of clinicians with Advanced training to

effectively treat children with PTSD involved in child welfare across Louisiana by 45 individuals. Despite the efforts in this project, further intensive work needs to be done to make the child welfare system more trauma-informed and to prioritize stability for children so that they may receive the care they need. This important systems-level work was beyond the scope of our study.

Another issue possibly impacting the retention of clinicians in the training was the time required to complete the consultation calls, especially for those with private practices. Although many agency managers allowed for protected time for clinicians to receive the training, some clinicians in private practice were unable to carve out time to participate in weekly calls. This barrier remained despite efforts to address it, including the trainer being available outside of traditional business hours.

Regarding the implementation of YPT, one limitation of the project was that delivery of YPT was tracked using self-report during consultation calls only. While the trainer carefully inquired about and monitored fidelity to the model with each clinician, there was no direct observation of the clinician's service delivery, nor collection of reports from supervisors or clients in most cases. Further, clinicians reported a fair amount of avoidance on the part of the client and caregiver. In some instances, clinicians also disclosed their own avoidance due to the emotionally intense nature of the traumatic event being addressed. The trainer welcomed these discussions about avoidance and client, caregiver, and therapist reluctance to complete the treatment was addressed from the outset of consultation and throughout the course of the calls. Trouble with shifting from a nondirective to a directive approach was also reported by some clinicians during calls. In these cases, the trainer normalized this challenge and enlisted the assistance of other

members of the call to validate and share strategies.

Our observations are similar to those described by Hanson et al. (2014), who interviewed 19 approved national TF-CBT trainers about their perceptions of challenges to the implementation of TF-CBT. Trainers believed some providers lacked basic training in CBT and had trouble shifting from a nondirective to a more directive approach.

Interviewees also reported that avoidance of directly talking about the trauma was experienced both by clients, caregivers, and at times, clinicians, and that this was a significant barrier to the delivery of TF-CBT with fidelity.

One way to improve fidelity tracking in the future is to include video review of treatment sessions as part of the training. Although this may pose a barrier to clinicians signing up for such training, improved and less expensive technology is making the use of these training methods increasingly possible.

Another limitation is the very low rate of post-treatment TBH collection. Although the trainer tracked client progress through clinician report qualitatively during calls, it is possible that clinicians inadvertently avoided post-treatment data collection with those clients who appeared as if they were not improving. Further, as this project was not designed as a randomized controlled trial, the lack of a control group and the lack of randomization of youths to treatment condition also limit the generalizability of the conclusions that can be drawn from the available client data. For example, for a subset of individuals, PTSD symptoms can improve simply with the passage of time and the lack of a control group made this impossible to assess in our study.

Conclusions and Future Prospects

Our experience highlights the major limitations of community-based dissemination efforts and provides some insights for future directions. Financial incentives may be one way to increase the number of clinicians who receive trainings in and implement EBTs. Some states, e.g., California and North Carolina, within their Medicaid programs offer some programs for higher reimbursement rates for the provision of EBTs but the majority of states and/or private insurance agencies have been slow to adopt this practice. Audits and performance feedback may be other methods to enhance adoption of EBTs as they have shown effectiveness to improve quality of care across other health care sectors (Flottorp, Jamtvedt, Gibis, & McKee, 2010). In the practice of psychotherapy, where many, if not most, clinicians work outside of agencies, and the psychological problems are complex, innovative and new methods will be required to make substantial progress in this area.

In conclusion, findings from the present project indicate that effective training in an EBT for PTSD for children involved in the child welfare system is possible with minimal burden on the trainer, clinician and/or agency. However, this optimism ought to be tempered by the disappointingly low proportions of clinicians who elected to engage in such training. These findings are important in light of the numerous preceding dissemination projects supported with public funds that neglected to gather such basic metrics as proportions of clinicians who achieved competency and whether patients improved or not. Much work is needed to move the field forward and achieve the promise of dissemination of best practices for children and adolescents.

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Table 1

Number of Clinicians Who Completed Different Levels of Training in each of Nine Regions and Statewide (Percentage in Parentheses)

Level of Training	1	2	3	4	5	6	7	8	9	Statewide
Invited to training	70	157	106	86	152	577	500	156	232	2036
Attended one-day training	26	26	28	16	14	51	91	41	42	335/2036(16)
Began consultation calls	24	19	13	0	5	8	28	13	7	117/335 (35)
Completed Advanced training	10	6	6	0	2	2	11	5	3	45/117 (38)
Completed Basic training	4	7	5	0	3	3	8	4	4	38/117(32)
Dropped out after less than two calls	--	--	--	--	--	--	--	--	--	34/117(29)
One-day trained only (never began calls)	--	--	--	--	--	--	--	--	--	218/335(65)

Note. --Data missing

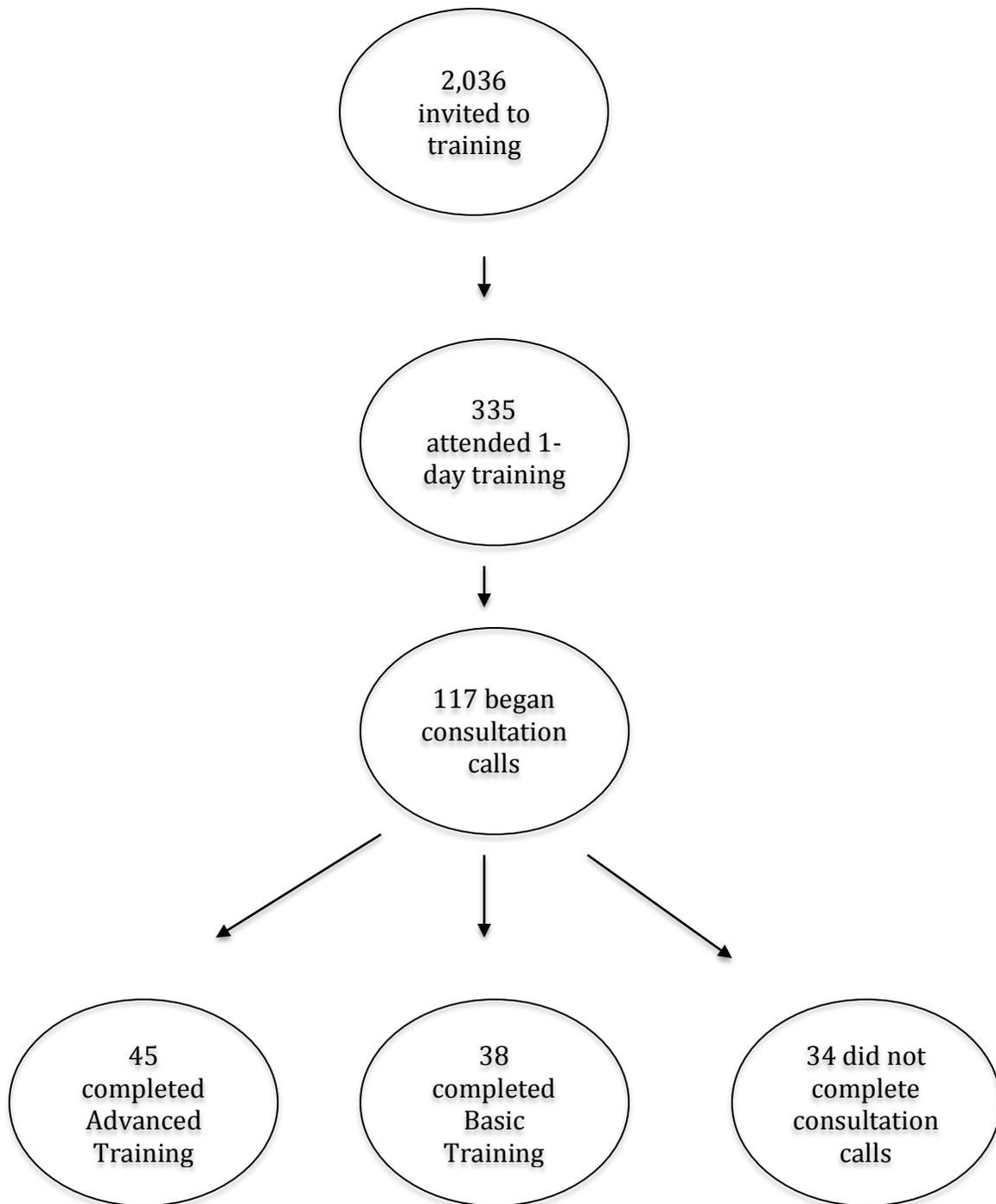


Figure 1. Clinician retention in training. “Advanced Training” = completed one YPT case and attended weekly consultation calls over three to six months; “Basic Training” = attended at least 5 consultation calls over six months.