Partnerships for Success in Washington State: A community-based model to effectively implement evidence-based practices for youth

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Partnerships for Success

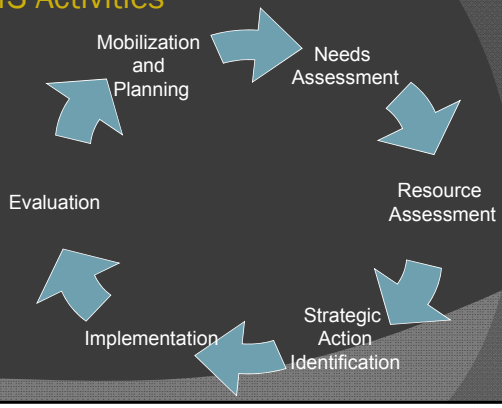
- Developed by David Julian (Ohio State)*
- "A comprehensive approach to building capacity at the county level to prevent and respond effectively to child and adolescent problem behaviors while promoting positive youth development."
- Strategically targets known barriers and challenges towards implementing evidence-based practices
- Guiding Principles:
  - Involving and engaging the entire community
  - Balancing a holistic continuum of approaches
  - Making data-informed decisions

*Julian (2006). A community practice model for community psychologists and some examples of the application of community practice skills from the Partnerships for Success initiative in Ohio. *American Journal of Community Psychology, 35*, 21-27.

The PfS Model

The PfS model revolves around a core of data-informed decisions and is encompassed by a continuous need for community mobilization.

PfS Activities



Washington State Legislative Proviso: *Children's Mental Health Evidence-Based Practices Pilot Project*

- Intent: Support a community to implement new, evidence-based programming
- Support: Dollars allocated to facilitate utilization of Partnerships for Success model AND front-end, start-up expenses associated with EBP adoption

Mobilization and Planning

- Thurston-Mason Counties Community Stakeholders include representatives from:
  - Parents & Foster parents
  - Community Mental Health
  - Juvenile Justice (incl. Courts)
  - DCFS
  - Tribes
  - Children and Youth Services
  - Schools
  - Regional Support Network
  - County Commissioner

Needs Assessment

67 people in Thurston-Mason completed an on-line survey

- Representative of 2-county area
- Mostly direct service providers & parents (64%)
- Other responders were administrators, law enforcement, child psychiatrist, youth, concerned community members

Administrative data revealed a strong case for targeting multi-system involved youth:

- **Over half** of the mental health expenditures in Thurston-Mason Counties are accounted for by 9% of the youth who are involved in multiple systems
- Costs per youth involved in Mental Health and Children's Administration systems: **$19,742**. By contrast:
  - Only mental health system: **$1,773**
  - Only Children's Administration: **$3,032**

Full family partnership	Planning and implementation will be conducted in full partnership with children, youth, and family members from Thurston and Mason Counties.
Accessibility	There will be clear avenues for access to selected practices by children, youth, and families who would benefit from the practices
Community collaboration	Planning and implementation will be conducted with support and participation of local stakeholders and constituents, particularly those impacted by the practice.
Fit to community needs	Planning and implementation will be relevant to the needs of local children and families, compatible with the local environment, and congruent with the local culture.
Shared leadership	Planning and implementation will be conducted in a way that fosters integration and shared leadership of public agencies and providers in the community
Full partnership with and support to provider staff	Planning and implementation will be conducted in full partnership with local provider staff who would be impacted by the practice
Cultural and linguistic competence	Planning and implementation will support the cultures of involved youth, families, and communities. Practices chosen will demonstrate respect for and build on the values, preferences, beliefs, and cultures of involved children, families, and communities.
Data driven decision making	Planning and implementation will be informed by timely data on progress toward goals, implementation fidelity, and child, family, and community outcomes.
Sustainability	Practices chosen for implementation will be sustainable over time and demonstrate a reasonable cost effectiveness ratio.

Resource Assessment

- Particular gaps in availability of services for specific disorders/mental health issues, crisis services, family inclusion, youth voice in the system and rural issues.
- Available services
  - Most of the identified programs were school-based and limited to one or a few school districts.
  - Programs targeting youth with complex mental health needs were generally limited to programs offered through the Juvenile Rehabilitation Administration or through the Child Study and Treatment Center.
  - There were no community-based initiatives for youth involved in multiple systems.

Strategic Action Identification Identified Targeted Impacts

- Family
  - Family functioning (↑)
  - Parent education (↑)
  - Family engagement (↑)
  - Parental conflict (↓)
  - Domestic Violence (↓)
  - Use of foster care (↓)
  - Family-school communication (↑)
- School
  - School Success (↑)
  - School discipline (↓)
- Youth
  - Aggressive/defiant behavior (↓)
  - Substance use/abuse (↓)
  - Placement disruptions (↓)
  - Use of Juv. Justice facilities (↓)
  - Suicide/suicidal gestures (↓)
  - Abuse/Neglect trauma (↓)
- Community
  - Resource access (↑)
  - Community Support (↑)
  - Stigma (↓)

Narrowing-down process

- How well did the program align with community values?
- Programs with too narrow of a reach (e.g., only for 5th and 6th graders) or clear challenges for implementation given project parameters were eliminated.
- Provided community with detailed list of 'matching' EBPs

Choosing an EBP

- Largely done through community consensus process
- Consideration to:
  - Needs and Resource Assessment
  - Community articulated guiding principles
  - Extent to which each program targeted multiple impacts
  - Perceived "fit" within child-serving agencies
- Thurston-Mason community selected **Multisystemic Therapy (MST)** and **Triple P Positive Parenting Program**
- The Tribe selected **Trauma-Focused Cognitive Behavioral Therapy** and **Motivational Interviewing**

Implementation

- Thurston-Mason
  - 1 MST team (4 clinicians, 1 supervisor)
  - 26 Triple P practitioners
    - 11 in lower intensity (Levels 2/3)
    - 15 in higher intensity (Levels 4/5)
- Skokomish Tribe
  - 2 Trauma-Focused CBT practitioners
  - 10 cross-agency staff trained in Motivational Interviewing

Evaluation (MST-only*)

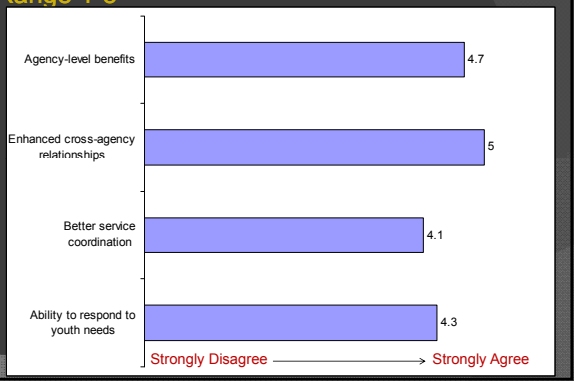
- System-Level (Outcomes: Access, cost savings, cross-agency collaboration, cooperative planning)
  - State Mental Health Division
  - Local Regional Support Network
- Bridge-Level (Outcomes: coordination of services, leveraging funds, cross-agency collaboration, health disparities)
  - Core Team
  - Community Team
  - Provider agency (Behavioral Health Resources; BHR)
- Practice-Level (Outcomes: Decreased out-of-home placements, improved MH outcomes, provider attitudes towards EBPs, adherence, fidelity)
  - MST providers

*Note, we are in the process of collecting outcome data for Triple P and TF-CBT. No data to report at this time

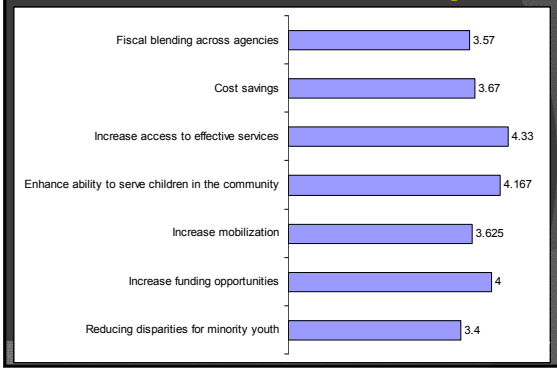
Sources

- Key informant interviews
  - Core Team (N=5)
  - Regional Support Network (N=2)
  - Mental Health Division (N=1)
- Surveys
  - MST Providers (N=5)
- Outcome data for MST
  - Service description
  - Preliminary outcomes

Key Informant Interviews: Core Team (N=5) Range 1-5



Key Informant Interviews: Core Team Range: 1-5



Key Informant Interviews:

- Core Team
  - Strengths in linking with other agencies, learning about evidence-based practices, and establishing a learning community.
- Regional Support Network
  - Project directly aligned with mandate to match services to local population needs and the products from this project can be used to inform future programming efforts.
- State Department of Mental Health
  - Main benefit is the economy of scale. The initial investment yielded multiple projects.
- General Challenges across informants
  - Challenging timeframe and participating on top of existing job.
  - Fitting EBPs into current infrastructure more challenging than originally thought

MST Provider Survey (highlights)

- Community is broadly supporting MST efforts
- The chosen intervention seems to be clinically indicated for the identified population
- Clinicians experience support for doing their job
- Challenges with finding appropriate after-care for MST enrolled youth
- At times it is difficult to implement the program with high-fidelity given the current organizational structure
- Would like more overlap with the community process

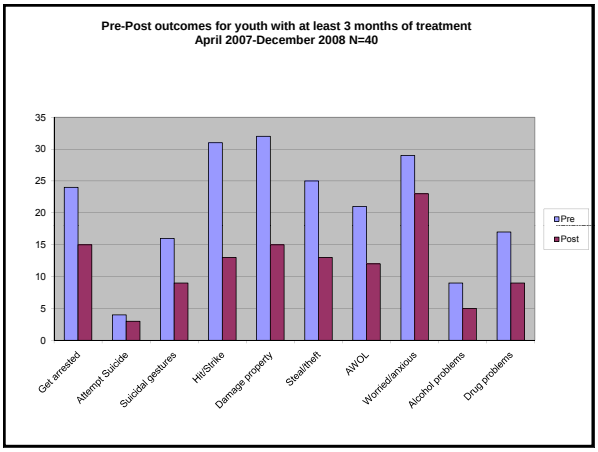
Individual-Level Outcome data for Multisystemic Therapy

- Between April '07 & December '08, 120 youth were served
  - 81% completed treatment
  - 14% discharged due to lack of engagement
  - 4% cases closed because youth placed out of home
  - 4% cases closed because family moved outside of service area

Categories are not mutually exclusive

Youth demographics

- Complete study information on 55 youth
- Referral sources: Self-referral, Juvenile Justice/Courts, School, Department of Social and Health Services, Behavioral Health Resources (community mental health provider), drug treatment centers, inpatient hospitals
- County of residence:
  - Mason: 18%
  - Thurston: 82%
- Average age: 14.09 (range 11-17)
- Gender:
  - Female: 35%
  - Male: 65%
- Ethnicity:
  - 82% Caucasian
- 74.5% Medicaid-eligible
- 65.5% of this sample successfully completed MST treatment



Pre-post differences in key outcomes for MST clients

Outcome Variable	>3mos Tx N cases	>3mos Tx McNemar p-value	Intent to treat N cases	Intent to treat McNemar p-value
Physical Assault	39	.000***	51	.000***
Property Damage	37	.000***	49	.000***
Theft	36	.002**	49	.000***
Drug Problems	39	.021*	52	.003**
Suicide Gestures	40	.016*	52	.021*
Arrests	39	.049*	52	.093[a]
Run-away	38	.035*	51	.008**
Worried/anxious symptoms	40	.210[ns]	55	.052[a]
Alcohol Problems	39	.289[ns]	52	.065[a]
Suicide Attempts	40	1.000[ns]	53	.180[ns]

***p<.001; **p<.01; *p<.05; [a]p<.10; [ns]= not statistically significant

Treatment information –MST services

- For 52 youth in most recent reporting period:
- Average length of treatment: 4.37 months
- Clinician Impression
  - Instrumental Outcomes (youth with >3 months Tx):
    - Family has improved relations: 85%
    - Family has improved support network: 78%
    - Youth is experiencing success at school/work: 78%
    - Youth is involved with prosocial peers/activities: 63%
  - Overarching Goals (all youth):
    - Youth living at home: 87%
    - Youth in school or working: 85%
    - Youth with no new arrests: 67%
- Treatment being implemented with fidelity (TAM=.65; goal ≥ .61)

Summary

- The Partnerships for Success process was successful in mobilizing the community, implementing and evaluating new programming. However, challenges persist with long-term sustainability (esp. MST)
- The Thurston-Mason Counties and the Skokomish Tribe now have 4 new evidence-based programs within 2½ years, addressing diverse population groups and needs
  - Community is generally very enthusiastic about new programs. However, team members had to work at break-neck speed to get programs up and running. This has somewhat limited opportunities for exploration of other community contributions that could promote sustainability
- Community model provided a strategic planning framework that can be used flexibly and broadly for future programming
  - Will position community well for future funding opportunities
- MST being implemented with fidelity and positive outcomes
  - Likely positive economic benefit over time
- Plan to continue to track and evaluate outcomes for other EBPs

Implications & Next Steps

- Community based models such as PfS appear to be one solution to improve community capacity to deliver EBPs
  - Does progressing through the steps of PfS increase community buy-in of the EBP?
- More research is needed to understand the 'key ingredients' of these models and the most parsimonious strategies for delivering them
  - Are there community or agency-specific qualities, capacity or other infrastructure that are necessary for the model to be implemented successfully?
  - What would be the benefits and drawbacks of having a state-wide infrastructure to support such efforts?
- Evaluation across multiple 'action' levels is complex and complicated
  - Given the scope (potentially diffuse at an individual level), what evaluation strategies would best capture the multiple levels of outcomes?

Implications & Next Steps

- Tribe experience
  - Partnerships for Success a culturally sensitive approach towards adoption of evidence-based practices
    - Inherently flexible
    - Community-driven
    - Resources for relevant adaptations
- Leveraging additional dollars
  - In 2006/2007, the counties involved in this process in Ohio leveraged $35,615,179 to sustain programs they identified through the PfS model.



Project FOCUS: Effective Mental Health Practices for Washington's Foster Children

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Project FOCUS Rationale

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Improve functioning of youth in foster care

How?

- Increase referral and access to evidence-based programs
  - Training and consultation with social workers in targeted child welfare offices with youth in foster care on their caseloads
  - Training and consultation with clinicians in the community serving these offices

Clinician Training

- 50-75% of youth in foster care have at least one mental or behavior health problem that warrants treatment
- Often more than 1 disorder or presenting problem

- MATCH (Chorpita & Weisz, 2008)
- Modularized Approach
  - 2-day trainings on each of the following: Behavior Problems, Anxiety, Depression
    - Spaced by about 1-month apart
  - Weekly consultation on using the model with youth in foster care
- Start with a focus on one of the 3, but can pull in modules from other foci to meet needs of the youth

Caseworkers as Brokers: The necessary "cog" in the wheel

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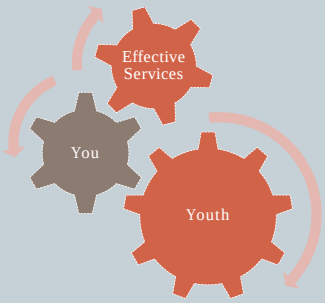


Project FOCUS Research Design

Small randomized trial with 4 offices (began in October, 2008)

- Immediate Implementation
  - 2 offices (urban, 1 rural) receive caseworker and clinician training immediately
- Delayed Implementation
  - 2 offices (1 urban, 1 rural) receive caseworker and clinician training a year later

Project FOCUS Research Design

Participants

- Caseworkers (N = 60)
  - Child welfare services caseworkers
- Clinicians (Goal N = 30)
  - Public Mental Health and Private Practitioners
- Youth in foster care (ages 4-12) (N = 76, to date)
  - Youth and foster parent report
- Outcomes
  - Quantitative: Uptake of training and referrals (CWs, clinicians), mental health outcomes, placement stability (youth)
  - Qualitative: Caseworker satisfaction and usefulness of consultation

Project FOCUS Caseworker Sample

Immediate Implementation Offices (N = 25)

- Rural: 12, Urban:13
- Females:21, Males:4
- Hispanic: 3, Multiracial: 4, Caucasian: 18
- Average age: 37.6 (range 22-65)
- Years of experience: 8.2 (range of 1 – 20)
  - Average of 3 years experience in this agency

Education: Bachelor degree: 15, Some graduate work: 2; Master's degree: 8

Training with Caseworkers

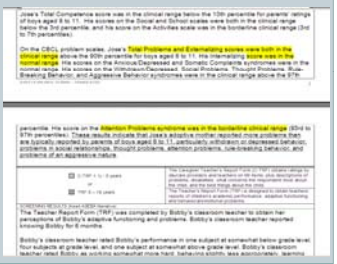
- 6 hours of in-person training
- Biweekly 1-hour phone consultation for 4 months

Topics

- Common mental health needs
  - Grouped by internalizing, externalizing, attention problems, and other (developmental delays, low base rate disorders)
- Using existing data to ID mental health problems
  - Mandatory screening in WA (includes CBCL and other measures)
- Appropriate EBP referrals in the community and how to refer
- Basics on evaluating, or seeking therapy, when an EBP is unavailable

(Example) CHET: CBCL Results

- Look for Problem Scales
- First step: Look at information for:
  - Total Problems (Ext.+Int.)
  - Externalizing
  - Internalizing
  - Clinical range?
  - Borderline?
  - Normal?
- Attention is separate from Ext. and Int. Check it out too!

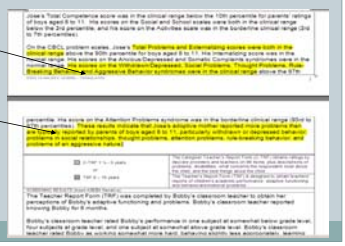


(Example) CHET: CBCL Results

- If Clinical or Borderline Range on Externalizing, or Internalizing, what is driving the score?
- Even when Int. or Ext. Problems are in the normal range, syndromes can be in the clinical range and require treatment

Withdrawn/ depressed

Summary Statement: includes all clinical and borderline syndrome scores



(Example) Externalizing "Acting Out" Behavior Problems

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Problems: Rule breaking, anger outbursts, not obeying, aggression

Principle: Behavior is reinforced ("works") by the environment/people; solution requires changing the response in the environment

Behavioral Therapy

- Caregiver involvement *required*
  - Change/improve their response to, and supervision of, child's behavior
- Therapist may also work with the child
  - Teach problem solving skills and skills for dealing with angry feelings
  - However, therapist-child work isn't most important "ingredient"

Behavior Therapy with the caregiver is the key to kids with behavior problems getting better

(Example) Externalizing "Acting Out" Behavior Problems

13

Specific EBPs in your Area

Young Kids

- Parent-Child Interaction Therapy (PCIT)
- How it works: Caregiver is coached to respond to child by praising positive behavior, ignoring obnoxious behavior and handling problem behavior effectively. Also increases positivity in caregiver-child relationship.

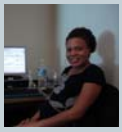
Older Kids

- Functional Family Therapy (FFT)
- How it works: Secures agreement between child and caregiver to solve problems, teaches specifc skills to deal with conflict or communication problems.
- Aggression Replacement Training (ART). Addresses delinquent behavior via Juvenile Court.
- How it works: Teaches the youth new thinking and specific skills, especially for dealing with anger and risky situations. Delivered in group.

Consultation Calls with Caseworkers

Goals:

1. Application of training to cases on their caseload
2. Generalization of cases discussed on consultation calls to non-discussed cases



Structure of Caseworker Consultation Calls

- 60 minute calls (biweekly)
- Asked for CHET data up front when possible
- ID mental health need; using data when available
- Discuss referral options
- Foster parent engagement discussed if relevant
- Call summary/'action plan' emailed to caseworker
- Each call, follow-up on previous cases and discuss new cases

Examples* of Consultation Calls

- Example 1 & 2: Classifying a sibling set/considering possibly appropriate treatments
  - Alleged sexual abuse of 4 y.o., caseworkers thinking she's an internalizer
    - Call #7 of 8
    - Clear that we've made the point: individual treatment only with a young child isn't effective
  - Options for a possible 6 y.o. externalizer
    - Call #7 of 8
    - Area has 3 possible parent management EBPs available

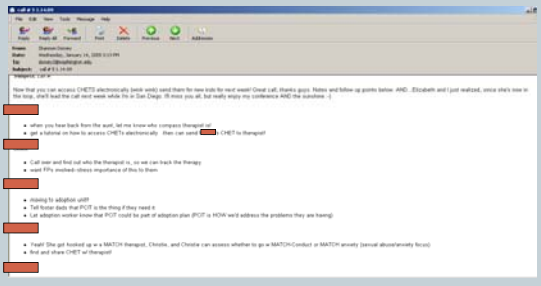
*Caseworker permission for taping provided; only first names of children used.

Examples* of Consultation Calls

- Example 3: Using data to assess need for these kids and engage the kinship parent in treatment
  - Collect data on current mental health functioning to determine need and to engage the kinship parent
  - Caseworker's supervisor on the call (Nan)
- Example 4: Is EBP being provided as expected, with fidelity?
  - 8 year old externalizing kid; supposedly getting MATCH-Conduct, a parent training program like PCIT or Triple P

*Caseworker permission for taping provided; only first names of children used.

Example Action Plan Email



Where we stand, to date

- Provided consultation for over 130 youth
- Enrolled 76 youth in the study (goal: 80)
- Consultation wrapping up this month (March, 2009)
- Follow- up interviews begin in April, 2009
- Caseworkers are saddened that it's ending
  - "I'm going to open another case on myself!"

Feasibility Test (Nov. 07- Feb. 08)

- Caseworker Consultation
  - To our knowledge, had not been done systematically before
- Feasibility Test in 1 office; 2 different conditions
  - 1 unit: caseworker and supervisor consultation
  - 1: unit: supervisor consultation only
  - Interested in the possibility of trickle down and cost effectiveness, if consultation only provided to the supervisor

Feasibility Test Findings

Supervisor consultation wasn't enough, little trickle down
Caseworker consultation was well-received and effective

- Pre-training: 3 of 13 participants listed EBPs in their community (3 EBPs listed total)
- Post-training: 8 of 9 participants listed EBPs in their community (18 listed total)
  - *"...I didn't know that X was not evidence-based. And to hear that Functional Family Therapy is evidence-based so would be preferable ...It gave me food for thought on some of these things that I hadn't really ever thought about."*
  - *"... [The consultant] gave me ideas on...asking specific questions about treatment plans...about what methods they were using—things that I had not been asking."*

Caseworker Feasibility Findings

- In exit interviews, caseworkers reported referring to new programs during Project Focus
  - FFT, PCIT, TF-CBT
- Outside reports from EBP supervisor (i.e., TF-CBT) of receiving calls from caseworkers requesting EBP
  - This had never happened before
  - Kids were flagged and assigned at intake to a clinician trained in the EBP, in case they were appropriate
  - This knowledge--separate from Project FOCUS pilot evaluation

Caseworker Feasibility Findings

- Consultation vs. training, results in application of learning to actual cases, and generalization to non-discussed cases
  - *"The consultation... put the training into the application mode... Because we're talking about services that I don't always know... like Dialectical Behavior Therapy ... was one of the examples: when to use it, what to expect from it, how to know it was being used... "*
  - *"...(Consultation was) useful in being able to apply this broadly to future cases...Sharing one case actually opened up to quite a few others...it's easier to think, 'okay, if this one was acting out, this one's a lot like it... and would benefit from the same service.' So you can take what happened in one case and generalize it to other cases."*

Project FOCUS Feasibility Findings

- Supervisor consultation: new model needed
- Caseworkers: training is necessary, but not sufficient

- For increased referrals, learning, and generalization
- On exit interviews, caseworkers who received training only (one arm of the pilot) were confused (on what were the goals of the training, EBPs, application to practice, etc.)

Project FOCUS: Lessons Learned

- Structure and follow through are important
  - For calls, for the action plan…for getting the information needed to make appropriate referrals
- Caseworker perceptions of therapists are often based on interactions and not necessarily services offered
  - Caseworkers liked therapists that called them back (so EBP therapists need to call back too)
- Referrals often "for therapy"
- Project based on availability of EBPs
- Limited links to mental health, had not considered sharing the CHET results (really rich data) when making referrals to mental health

Project FOCUS: Next Steps

- Complete small trial (July, 2009)
  - Follow up assessments with caseworkers, clinicians, and youth
  - Follow up qualitative interviews with caseworkers
- Work with current supervisors to develop a supervisor consult model
  - Important for sustainability, but challenging
- Wish the economic crisis wasn't aligned with our project?
- Investigate better options for building relationships between child welfare and mental health
  - Steal ideas from Partnerships for Success

Questions? Thank you.

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