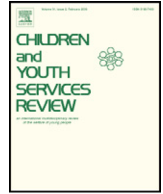
Children and Youth Services Review 35 (2013) 1023–1029

Contents lists available at SciVerse ScienceDirect

Children and Youth Services Review

journal homepage: www.elsevier.com/locate/childyouth



Statewide dissemination of trauma-focused cognitive-behavioral therapy (TF-CBT)☆

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A R T I C L E   I N F O

Article history:
Received 28 November 2012
Received in revised form 25 March 2013
Accepted 27 March 2013
Available online 3 April 2013

Keywords:
Dissemination
Implementation
Trauma
Evidence-based practices
Training

A B S T R A C T

Despite evidence linking childhood trauma to subsequent social, emotional, psychological, and cognitive problems, many children who have experienced trauma do not receive mental health treatment that has been proven to be effective. Large-scale dissemination of evidence-based practices (EBPs) is one possible solution to enhance the current negative state of mental health treatment for these children. This article describes a dissemination effort of an EBP (i.e., Trauma-Focused Cognitive-Behavioral Therapy [TF-CBT]) for childhood symptoms of post-traumatic stress disorder throughout Arkansas. The effort targeted mental health professionals within child advocacy centers and community mental health centers across the state. The article describes the process of dissemination and implementation. Lessons learned and recommendations for future dissemination efforts are highlighted.

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1. Introduction

Nationally, the percentage of youth exposed to some form of trauma is high, ranging from 8% to 53%, depending on the type of trauma and population studied (e.g., Copeland, Keeler, Angold, and Costello, 2007; Finkelhor, Ormrod, Turner, and Hamby, 2005; U.S. Department of Health and Human Services, 2011). Despite high rates of subsequent related post-traumatic stress disorder (PTSD), and other symptomatologies, many children who have experienced trauma either do not receive treatment or receive treatment that has not proven to be effective (Burns et al., 2004; Cohen, Mannarino, and Rogal, 2001; Kolko, Cohen, Mannarino, Baumann, and Knudsen, 2009; Ringeisen, Casanueva, Urato, and Stambaugh, 2009). Without adequate and appropriate treatment, trauma symptoms may linger or exacerbate over time, developing into other mental health problems such as internalizing or externalizing disorders (Hamblen, 1999; Hernandez, Lodico, and DiClemente, 1993; Hoven et al., 2005; Siegel and Williams, 2003). In addition, lack of treatment has the potential to increase secondary adversities such as health problems, home and foster home placement disruptions, school difficulties, social maladjustment, and substance abuse (Felitti et al., 1998; Goodman, 2002; Hamblen, 1999; Myers et al., 2002; National Institute for Mental Health, 2001).

Large-scale dissemination of evidence-based practices (EBPs) is one possible solution to enhance the current negative state of mental health treatment for children who have experienced trauma. Kitson, Harvey, and McCormack (1998) suggest that successful dissemination of EBPs involves interplay of three core elements: Context, Evidence, and Facilitation. Context is the combination of culture, leadership, and measurement in which the dissemination effort is to take place. Successful dissemination efforts will occur in contexts that are open to and support continuing education and effective practices, are organized, and provide feedback. Evidence is the combination of research, clinical expertise, and patient choice of/for the practice being disseminated. For example, successful dissemination efforts will use practices that have significant research support (i.e., EBPs), have high levels of consensus and consistency of view of effectiveness, and are viewed as beneficial and helpful by patients. Facilitation is the process of implementing evidence into practice and is the combination of characteristics, role, and style of the facilitator(s). Successful dissemination efforts occur when facilitation is respected, credible, empathic, authentic, collaborative, supportive, consistent, and flexible.

In the spring of 2009, the Arkansas Legislature approved funding to improve screening, monitoring, and continuity of care for children who experienced trauma in Arkansas to address the psychological impact of their trauma. The funding was disseminated through the Arkansas Commission on Child Abuse, Rape, and Domestic Violence which provided the infrastructure for the program and helped facilitate a

☆ This research was supported by a grant from the 2009 Arkansas Revenue Stabilization Act.

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0190-7409/$ – see front matter © 2013 Elsevier Ltd. All rights reserved.
http://dx.doi.org/10.1016/j.childyouth.2013.03.012

multidisciplinary collaboration between the University of Arkansas for Medical Sciences Psychiatric Research Institute and the Department of Pediatrics. With the infrastructure and collaboration in place, the Arkansas Building Effective Services for Trauma (AR BEST) program was created. The mission of AR BEST is to improve outcomes for traumatized children and their families in Arkansas through excellence in clinical care, training, advocacy, and research/evaluation across systems. The remainder of the paper describes the process of disseminating an EBP for PTSD symptoms in children (i.e., Trauma-Focused Cognitive-Behavioral Therapy [TF-CBT]) throughout Arkansas within a conceptual framework (i.e., Kitson et al., 1998).

1.1. Context

AR BEST staff reviewed state-of-the-art trauma-informed practices and compared these to the state of care in Arkansas. Staff noted a need for improvement among Arkansas' providers charged with ensuring the safety and health of children (e.g., mental health, child welfare, juvenile justice, health, education, and first responders). Specifically, efforts were needed to create a trauma-informed system of care. A trauma-informed system of care can be broadly defined as:

1) Awareness of and knowledge about the impact of traumatic stress across systems;
2) Awareness of and access to effective trauma assessment and interventions strategies that exist within and across different systems;
3) Trauma-focused education and skill-building to providers and administrators within and across key child-serving systems in order to change practice; and
4) Promoting strong collaborations across systems and disciplines (National Center for Child Traumatic Stress, 2009).

In Arkansas, efforts were needed to provide a unifying and/or systematic language or approach to assessing and treating children who have experienced trauma. Few community mental health providers (MHPs) were trained in trauma-informed EBPs and thus providers had few options for referrals in these practices. The practices for training advocates (i.e., individuals who provide support and referrals for child victims and their families) in child advocacy centers (CACs) varied across the state; furthermore, child welfare, foster parents, juvenile justice, and other systems staff had little knowledge about trauma-informed care (i.e., the impact of trauma on children) and lacked options for referrals to community mental health providers trained in trauma-informed evidenced-based treatments. Finally, little training was being conducted in trauma-informed care with the foster parent, educational, juvenile justice, and first responder systems. AR BEST staff decided that disseminating TF-CBT was the first step in changing trauma practices. With MHPs trained in TF-CBT, referrals could be made to these providers from child welfare, juvenile justice, and other systems, therefore, increasing communication between systems and helping to gain buy-in from leadership within these systems. Once training in TF-CBT began, these other systems received training in trauma-informed care, further enhancing communication and providing a unified and systematic language for assessing and treating children who have experienced trauma.

1.2. Evidence

TF-CBT, co-developed by Judith Cohen, M.D., Anthony Mannarino, Ph.D., and Esther Deblinger, Ph.D., is an EBP for childhood symptoms of PTSD with well-established efficacy. It is a treatment consistent with the principles of cognitive-behavioral, exposure, and parenting therapies that are widely accepted by MHPs. TF-CBT is a manualized and flexible therapeutic intervention. The therapeutic components include psychoeducation about the trauma; parenting skills; development of relaxation and other coping skills; feelings identification; understanding the link between thoughts, feelings and behaviors; developing a narrative of the traumatic event which has been experienced by the child/adolescent and processing of associated thoughts, feelings and behaviors; gradual exposure to the traumatic event with the youth learning how to manage being exposed to such event(s); conjoint parent–child work; and enhancing safety/prevention skills. In recent reviews of research on treatment for children with PTSD symptoms (i.e., Chadwick Center for Children, Families, 2004; Chadwick Center for Children and Families and Child and Adolescent Services Research Center, 2009; Saunders, Berliner, and Hanson, 2004; Silverman et al., 2008), TF-CBT was the only treatment given the highest rating (i.e., evidence-based practice) in all of the reviews. Due to TF-CBT's promising outcomes in children with a history of trauma, large-scale dissemination is under way. In 2009, 19 states were already in the process of or had completed large-scale TF-CBT dissemination projects. The methods and processes of dissemination for the majority of these projects are briefly described in Sigel, Benton, Lynch, and Kramer (in press).

1.3. Facilitation

Due to substantial evidence of efficacy and effectiveness and through on-going large-scale dissemination projects, several dissemination strategies have been developed to facilitate TF-CBT dissemination with fidelity and within an implementation research framework (i.e., Kitson et al., 1998). Cohen and Mannarino (2008) have discussed three dissemination methods that have been used (web-based learning, live training plus ongoing consultation, and learning collaborative) as well as the advantages and disadvantages of each model. Web-based learning involves completing TF-CBT*Web* (accessible at www.musc.edu/tfcbt), developed by investigators at the Medical University of South Carolina Crime Victims Center in collaboration with TF-CBT developers. The website includes parent and child sections for each component of the model, video examples of all of the key treatment components, printable scripts to use, handouts for parents and children, instructions on how to handle clinically challenging situations, guidelines on cultural issues, and resources and links. This method's advantages are overcoming barriers such as cost, distance, and inconvenience of having to travel to live trainings and ability to train multiple MHPs at one time. Disadvantages are lack of interaction with a live trainer and no access to on-going consultation.

The two other models of TF-CBT dissemination require more intensive training and follow-up efforts. The live training plus ongoing consultation model involves in-person training in TF-CBT followed by ongoing phone or in-person consultation. The training and consultation are provided by the treatment developers or other approved trainers who monitor trainees to ensure the treatment is being used with fidelity. The advantage of this model is that practitioners receive support when they start seeing clients, which may enhance fidelity and sustainability once training is completed. The disadvantages to this method are cost and limits to the number of MHPs that can be trained. By comparison, the learning collaborative model is designed to change the larger culture in which TF-CBT is implemented with the goal of achieving buy-in across systems and enhancing long-term sustainability. TF-CBT training typically involves separate tracks for MHPs, supervisors, and senior leaders (i.e., administrators and directors) (Ebert, Amaya-Jackson, Markiewicz, and Burroughs, 2008). Each track has several in-person trainings with follow-up by phone or in person consultation over the course of a year targeting different parts of the TF-CBT model, implementation strategies, and/or dissemination issues. The contents of the in-person trainings and consultations are based on where the therapist, supervisor, and/or senior leader are in the TF-CBT model, implementation, and/or dissemination process. The trainings and consultation are also provided by the treatment developers or other approved trainers. With this model, supervisors and senior leaders are involved in the calls, which may provide additional support to MHPs learning the model from within the agency as well as change or maintain the culture required for a particular model. The inclusion of senior leaders may enhance sustainability once training has ceased. Senior leaders

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