Journal of Clinical Pediatrics and Neonatology

Barth et al., J Clin Pediatr Neonatol 2021; 1(1):1-3.

Commentary

Partnering for Success- A prototype for integrating evidence-based practices between referring professionals and mental health professionals

Richard P Barth[1*], Jessie Watrous[2]

[1]Professor and Chair, Executive Committee of the Grand Challenges for Social Work, University of Maryland School of Social Work, 525 W Redwood St, Baltimore, MD 21201, United States

[2]Director of Evidence-Based Programs, University of Maryland School of Social Work, 525 W Redwood St, Baltimore, MD 21201, United States

*Author for correspondence:
Email: rbarth@ssw.umaryland.edu

Received date: November 22, 2020
Accepted date: January 06, 2021

Citation: Barth RP, Watrous J. Partnering for Success- A prototype for integrating evidence-based practices between referring professionals and mental health professionals. J Clin Pediatr Neonatol. 2021; 1(1):1-3.

Abstract

Children who experience abuse and neglect often have behavioral health sequalae which are poorly addressed because services are not evidence-based and partnerships with behavioral health providers lack precise coordination. Partnering for Success provides interprofessional training on EBPs, communication, and data sharing and has now been expanded to address the unique needs of children in treatment foster care.

Children who are involved with child welfare service (CWS) agencies are among the most disadvantaged in our society. They have high rates of adverse childhood experiences that go well beyond norms (and more often than not grow up in families that experience a plentitude of challenges—namely, poverty, substance abuse, and housing instability). The result is an exceptionally high rate of behavioral health concerns that may precede, concur with, and endure well beyond the abuse [1].

Therefore, many children and youth involved with CWS are referred to mental health services (MHS) although the benefit has not been shown to be impressive [2]. Substantial evidence suggests that MHS efforts are frequently uncoordinated and clinical outcomes are inconsistent. At the same time, coordination of care has not developed a reputation for improving outcomes, ostensibly because the treatments that are delivered at the end of the coordination process may not be evidence-based [3]. Enhancing the coordination with mental health services is a potential mechanism for improving outcomes when combined with the use of evidence-based practices. Further mental health (MH) services are very often not well-matched to client needs [4]. Matching of evidence-based practices (EBPs) to children's needs requires organizational supports to be in place. The CWS and MHS workforces will remain ill prepared to participate in optimized matching while supervision, quality assurance, and fiscal constraints including lack of resources, remain barriers.

Mental health providers frequently lack the resources and financial incentives to expend limited resources on evidence-based practice training. Mental health providers face an additional challenge insofar as the social and emotional difficulties of the child welfare population are diverse and it is highly aspirational for any community to have a workforce with training in specific, manualized, evidence-based treatments that match up to the complex needs of youth in the CWS [5]. Lastly, there is growing recognition of the benefits of using online treatment decision report tools to clarify the relationship between symptoms and treatment components in order to achieve better outcomes [6,7].

Primary care providers—largely pediatricians, family physicians, and nurse practitioners—working with CWS-involved children and caregivers also have a need to understand optimal service planning. Primary care providers typically provide medication and parenting consultation to children involved with CWS and, therefore, must also know whether an evidence-informed treatment program is in operation. Recognizing the components of effective partnerships will enhance their ability to provide the mental health-improving care that they seek. A multi-phase approach is required to develop the partnerships to improve mental health outcomes. This includes cross-systems coordination and planning efforts.

The Partnering for Success (PfS) model [8] promotes greater collaboration between the CW and MH providers by building capacity within each system at multiple organizational levels. Frontline CW providers learn to accurately screen for common child MH issues, link child and families to locally provided evidence-based treatments (EBTs), support engagement in the treatment and monitor progress toward treatment targets. Concurrently, local MH treatment professional are prepared to use Cognitive Behavioral Therapy plus Trauma-Focused treatment components (CBT+). These common elements approach focusing on typical MH issues for CWS-involved children: anxiety, depression, conduct problems, and traumatic stress. Training for both front-line CW and MH professionals includes training, followed by consultation. Further, the model also engages and prepares both CWS and MHS leadership to ensure implementation success.

PfS has been implemented in multiple sites and achieved positive results across these sites indicate that the model is generally feasible and training efforts result in significant knowledge gain for child welfare workers and mental health practitioners [9]. More importantly, over the course of the PfS demonstration project, 2,285 clients were served using the clinical model and, across all treatment targets, significant improvements in children's symptoms were observed. Symptom data were collected by community-based mental health therapists as part of standard CBT+ treatment adherence procedures. Multilevel linear growth modelling was used to evaluate symptom change over time. Significant improvements were observed across all four treatment targets, with a slight curvilinear relationship found for anxiety, depression, and behavior problems. This promising initial evidence suggests CBT+ is a viable training option for treatment of child welfare-involved children and youth with a range of mental health concerns.

The demonstration project prepared CW professionals to use the practices described with all children the child welfare system engages-- regardless of whether placed in foster care or receiving early intervention or preventative services. It prepared MH providers to similarly provide CBT+ to these CW involved youth. Frequently the MH providers applied the treatment to youth who were not referred by the child welfare system as well, making an evidence-based MH treatment more broadly available to families and youth in the community. CBT+ trained MH treatment providers are able to deliver the treatment to families for whom the service is subsidized through Medicaid and private insurance. In Baltimore County, Maryland, PfS has now trained 12 cohorts of mental health and child welfare professionals, totaling nearly 500 professionals working in eight agencies. This has led to more uniform and consistent service delivery that is now better understood and delivered by the entire treatment team.

Partnering for Success Extension

The initial success of PFS generated considerable interest in extending the model in two ways. The first was to better assist treatment foster care (TFC) providers in better meeting the mental health needs of youth placed in treatment foster care—a valued setting for children and youth with advanced behavioral health needs. As had been done for child welfare agencies, the PFS-TFC developer provided technical assistance to treatment foster care agency leadership to ascertain their needs to improve communication and coordination between TFC agency personnel, CWS agency personnel, and mental health providers. Conversations with TFC agency administrators, researchers, and thought leaders from around the country helped to clarify the needs [10]. These interviews indicated that treatment knowledge, and the ability to collaborate with allied professionals each drawing on their expertise, were key. These findings further reinforced the importance of some cross-professional training so that each can broadly understand the expertise available.

Partnering for Success/Cognitive Behavioral Therapy+ (PfS/CBT+) for Treatment Foster Care (TFC) Parents

After ascertaining the unique challenges embedded in TFC, a curriculum and coaching model was developed to support TFC social workers and treatment foster care parents. The PfS-TFC development followed the original PfS model by continuously testing quality assurance measures and revising as needed to ensure quality model implementation. The preliminary evaluation of Partnering for Success for Treatment Foster Care with two cohorts of treatment foster care parents and social workers suggests sizable gains in the knowledge and skills around the key PFS-TFC competencies. TFC Parents additionally reported a high level of satisfaction with the training.

We recognize the significant need to fit PFS within CW service training programs. This has been difficult to accomplish [11] but the interest among agencies remains significant [4,9]. This recognition led to the second PfS extension and the development of a web-based training on the best partnership practices for care coordination in family –serving systems, so child welfare, juvenile justice, or mental health, rather than the child welfare system only. Over the course of eight interactive, self-paced modules, care coordinators learn the fundamentals of evidence-based programs, best practice for partnership between care coordinators and EBP providers and develop competency in four core care coordination practices. The training topics provide necessary knowledge and opportunity to develop skills to maximize the benefits of EBPs for children, youth, and families. It uses vignettes, reflection, videos, and interactive tools to bring concepts to life and promote application to everyday practice. Participants can access additional resources and online tools in real time in order to strengthen their knowledge and understanding.

All PFS training, consultation and technical assistance is available through The Institute for Innovation and Implementation, University of Maryland, School of Social Work, https://theinstitute.umaryland.edu/.

Conclusions

We recognize that the effectiveness of an EBT is constrained by clinicians' being willing and able to complete training requirements geared toward achieving competency in and fidelity to the protocol. Partnering for Success relied heavily on group consultation calls which increases the likelihood that the skills observed and practiced in training continued to be implemented [12]. These tele-consultation sessions—that included required documentation and tracking of progress using the EPB Toolkit (an electronic health record specific to children's behavioral health)--and a capstone project that described a case—were used to assist therapists in making sound decisions about how to effectively match treatment targets and clinical interventions. We recommend their broader use in training of primary care, child welfare, and behavioral health professionals.

Other features of this successful effort were that treatment protocols were flexible and based on observed clinical need (and

ceased when the observed clinical need was managed). They were delivered within an initiative that supported mental health professionals to collaborate closely with child welfare professionals. Our requirement of progress monitoring seems especially central to a successful effort that includes collaboration between child welfare, mental health, juvenile court, and resource families. Such progress monitoring provides valuable information about the focus of treatment and improvement trajectories.

The challenges faced by child welfare professionals caring for children who also need behavioral health treatment are common to primary care professionals during their frequent procedure of referring to specialty care providers. The strategies employed in this successful program are also needed by pediatric care providers. These include critical elements of: (1) agreement and cross-training on basic principles of cognitive-behavioral, and trauma informed, treatment; (2) ensuring that treatment strategies match problem behaviors; (3) providing skills and a sense of efficacy for negotiating effective treatment plans; employing a shared electronic health record that is focused on treatment goals and improvements in a way that enables clear communication and strong partnership.

Acknowledgements

Partnering for Success is a program of the National Center for Evidence-Based Practice in Child Welfare (NCEBPCW) which is supported through grant 90CT7001-01-02 from the U.S. Department of Health and Human Services, Administration for Children Youth and Families, Children's Bureau. Funding support was also provided by the Children's Bureau through the State of Maryland's Title IV-E Waiver Demonstration project. The National Center for Evidence-Based Practice in Child Welfare (NCEBPCW) is operated by The Institute for Innovation and Implementation, University of Maryland, School of Social Work (UMSSW). The contents of this paper/presentation are solely the responsibility of the NCEBPCW and do not necessarily represent the official views of the Children's Bureau of the US Department of Health and Human Services.

References

1. Burns BJ, Phillips SD, Wagner HR, Barth RP, Kolko DJ, Campbell Y, et al. Mental health need and access to mental health services by youths involved with child welfare: A national survey. J Am Acad Child Adolesc Psychiatr. 2004;43(8):960-70.
2. McCrae JS, Barth RP, Guo S. Changes in maltreated children's emotional-behavioral problems following typically provided mental health services. American Journal of Orthopsychiatry. 2010;80(3):350-61.
3. Bickman L, Andrade AR, Lambert EW. Dose response in child and adolescent mental health services. Mental Health Services Research. 2002;4(2):57-70.
4. Berliner L, Fitzgerald MM, Dorsey S, Chaffin M, Ondersma SJ, Wilson C. Report of the APSAC Task Force on Evidence-Based Service Planning Guidelines for Child Welfare. Child Maltreatment. 2015;20(1):6-16.
5. Chorpita BF, Bernstein A, Daleiden EL. Empirically Guided Coordination of Multiple Evidence-Based Treatments: An Illustration of Relevance Mapping in Children's Mental Health Services. Journal of Consulting and Clinical Psychology. 2011;79(4):470-80.
6. Nakamura BJ, Chorpita BF, Hirsch M, Daleiden E, Slavin L, Amundson MJ, et al. Large-Scale Implementation of Evidence-Based Treatments for Children 10 Years Later: Hawaii's Evidence-Based Services Initiative in Children's Mental Health. Clinical Psychology-Science and Practice. 2011;18(1):24-35.
7. Weisz JR, Chorpita BF, Palinkas LA, Schoenwald SK, Miranda J, Bearman SK, et al. Testing Standard and Modular Designs for Psychotherapy Treating Depression, Anxiety, and Conduct Problems in Youth. Archives of General Psychiatry. 2012;69(3):274-82.
8. Barnett ER, Jankowski MK, Trepman AZ. State-Wide Implementation and Clinical Outcomes Associated With Evidence-Based Psychotherapies for Traumatized Youth. Psychological Trauma: Theory, Research, Practice, and Policy. 2019;11(7):775-83.
9. Kerns SE, Phillips JD, Berliner L, Barth R. Symptom and outcome monitoring for child welfare involved children and youth receiving modularized cognitive-behavioral treatment. Journal of Child and Family Policy. Under Review.
10. Lee BR, Phillips DR, Steward RK, Kerns SEU. Equipping TFC Parents as Treatment Providers: Findings from Expert Interviews. Journal of Child and Family Studies. In press.
11. Barth RP. The move to evidence-based practice: How well does it fit child welfare services? Journal of Public Child Welfare. 2007;2(2):145-71.
12. Miron D, Scheeringa MS. A statewide training of community clinicians to treat traumatized youths involved with child welfare. Psychol Serv. 2019;16(1):153-61.