Moving from Trauma-Informed to Trauma-Responsive Care Through Training, Referral and Treatment for Youth and Families

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AGENDA

**Childhood Trauma**
- Prevalence among children and youth and impact

**CTTC: mission and goals**
- Trauma-Informed Training, LINK-KID, Training in TF-CBT

**General Outcomes**
- Effects of TF-CBT on child and caregiver outcomes

**Conclusions**
- Practical implications and next steps
Childhood trauma is a major public health issue: 35 million children experience at least one type of trauma by age 8 (Child Trends, 2014; National Survey of Children’s Health, 2013)

1 in 9 children have experienced 3 or more ACEs

61% black, non Hispanic; 51% Hispanic; 40% white, non-Hispanic and 23% Asian, non-Hispanic have experienced at least one ACE
Regional data from our 2012-2016 grant cycle show that children experience a mean of 4.4 traumatic events.

- Most common traumas: domestic violence (54%), traumatic loss (35%), physical abuse (30%), sexual abuse (26%) and community violence (23%).

- Despite the several trauma initiatives in MA (e.g. MCTP; the Defending Childhood Initiative, etc.), the demand to improve access continues to outstrip provider availability.

- Turnover of clinicians is high, with 1/3 leaving their agencies after their EBP training.
IMPACT OF TRAUMA

- Attachment
- Biology
- Affect Regulation
- Dissociation
- Behavioral Control
- Cognition
- Self-Concept
WE KNOW THAT:

Childhood trauma:

- Is a public health crisis - a growing problem in the US and beyond

- Significantly impacts children’s development, functioning and well-being

- Trauma impacts brain structure, development and DNA – impacting future generations
Yet, in spite of this knowledge:

- 47% of children and families don’t receive services
- Children are waiting between 6-12 months to access mental health services
- There is a clear gap in trauma identification, appropriate referral and trauma-informed treatment
THEREFORE: UMMS’ CHILD TRAUMA TRAINING CENTER

Funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) through the National Child Traumatic Stress Network (NCTSN) 2012 - 2016 and 2016 – 2021 awards, out of need for identification of childhood trauma and expanding access to evidence based practices.

National Child Traumatic Stress Network:

- Part of the Substance Abuse & Mental Health Services Administration (SAMHSA) and established by the US Congress in 2000 as part of the Children’s Health Act.
- Over 150 funded and Affiliate NCTSN sites located nationwide in university, hospital, and diverse community-based organizations, with thousands of national or local partners.
- Mission of NCTSN: To raise the standard of care and improve access to services for traumatized children, their families and communities throughout the United States.
- [www.nctsn.org](http://www.nctsn.org)
CTTC’S 3 MAJOR PRIORITIES

1) Widespread trauma-informed & trauma-responsive training across professional groups

2) Creation of a neutral Centralized Referral System, LINK-KID

3) Dissemination of training in Trauma-Focused Cognitive Behavioral Therapy
LINK-KID, A CENTRALIZED REFERRAL SYSTEM

- Creation of a neutral Centralized Referral System that is not linked to any one provider agency, but includes a network of mental health agencies and practitioners who have been trained in evidence-based trauma treatments
- Staffed by 4 clinical resource and referral coordinators
- Incorporation of family engagement strategies
- Database of trained EBT providers
- Toll-free number 1-855-LINK-KID
- Referrals to multiple evidence-based treatments for youth 0 to 25: TF-CBT, ARC, CPP, PCIT and others
HISTORY OF CTTC

- 2006: First Learning Collaborative in TF-CBT via Central MA Communities of Care
- 2009: UMMS Dept. of Psychiatry partnered w/LUK, Inc. → Central MA Child Trauma Center, (NCTSN)
- 2012: UMMS Dept of Psychiatry funded to establish UMMS Child Trauma Training Center, the original
- 2015: Additional funding by the Lookout Foundation to Pilot statewide stepwise roll-out
- 2016: DMH Grant for Trauma Referral Service
- 2016: Refunded by SAMHSA/NCTSN to expand reach, statewide
- Geographic region expanded (2015) to include Boston and Northern, MA regions, and in (2016) to include Southern and far Western, consistent with the DCF structure
- Original target population was youth ages 6 to 18; however, expanded the age range to 0 to 18 for LINK-KID
- 2017: Additional funding by the Lookout Foundation and expanded to include Transition Age Youth up to age 25
MOVING FROM TRAUMA-INFORMED TO TRAUMA-RESPONSIVE

Professionals working with youth have MUCH that they are able to do to build resiliency and protective factors – they just need the right information!

We CAN improve wait times and improve engagement in treatment.
TRAUMA-FOCUSED COGNITIVE BEHAVIORAL THERAPY
TRAUMA-FOCUSED COGNITIVE BEHAVIORAL THERAPY

- Evidence-based treatment for traumatized children, adolescents and parents/caregivers

- Model developed by Judith Cohen, M.D., Anthony Mannarino, Ph.D. & Esther Deblinger, Ph.D. and has been refined during the past 25 years

- A SAMHSA Model Program; One of Kaufman’s “Best Practices”
WHO IS TF-CBT APPROPRIATE FOR?

- Children 3-18 years with known trauma history (CTTC allows up to age 25 in current pilot)
- Any type of trauma (single, multiple, complex, child abuse, DV, traumatic grief, disaster, war, etc.), although originally developed for sexual abuse
- Prominent trauma symptoms (PTSD, depression, anxiety, with or without behavioral problems)
- Parental/caretaker involvement is optimal but not required
- Clinic, school, residential, home, inpatient, refugee or other settings
PRACTICE

- Psychoeducation and Parenting skills
- Relaxation
- Affective modulation
- Cognitive coping
- Trauma narration and processing
- In vivo mastery of trauma reminders
- Conjoint child-parents sessions
- Enhancing future safety and development

Stabilization & skill building
- Trauma narration and processing
- Consolidation and closure
21+ RCT comparing TF-CBT to other conditions conducted all over the world

TF-CBT → greater improvement in PTSD, depression, anxiety, behavior problems compared to comparison or control conditions

Parents participating in TF-CBT also experienced greater improvement compared to parents participating in comparison conditions
AS OF 2019, TF-CBT HAS REACHED THESE COUNTRIES/REGIONS:
As of 2019, TF-CBT has reached these countries/regions:

- Australia
- Belarus
- Bolivia
- Canada
- Cayman Islands
- China
- Columbia
- Croatia
- Czech Republic
- Democratic Republic of Congo
- Denmark
- El Salvador
- Finland
- France
- Germany
- Guam
- Honduras
- Iceland
- Israel
- Italy
- Japan
- Kenya
- Mexico
- New Zealand
- Norway
- Pakistan
- Puerto Rico
- Russia
- Singapore
- Sweden
- Tanzania
- Thailand
- The Netherlands
- The Philippines
- Turkey
- United States
- Zambia
TF-CBT GENERAL OUTCOMES
FROM CTTC 2012 TO 2016 COHORT
METHODS

Training: 3 annual year-long TF-CBT training cohorts, involving 211 clinicians

- Online Training TF-CBT Web: https://tfcbt.musc.edu
- Two-day in person Basic Training
- Advanced Training
- Consultation Calls (monthly)

Project Evaluation: Clinicians enroll 3 or more youth

Data collection: baseline, three months, six months and discharge using REDCap

Measures:

- Demographics
- General Trauma Information Form, checklist
- Child Behavior Checklist
- UCLA PTSD children and parents
- Caregiver Strain Questionnaire
- Social Connectedness
• 308 children and youth who received TF-CBT
• Mean age = 11.3 years (Range = 6-18)
• 58% female
• 62% white; 9% black; 27% Hispanic
• 33% in state custody
TRAUMA EXPOSURE: MEAN TRAUMA TYPES 4.4
### Baseline Behavior Problems

<table>
<thead>
<tr>
<th>Subscale</th>
<th>Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internalizing Score (n = 232)</td>
<td>64.5 (10.7)</td>
</tr>
<tr>
<td>Externalizing Score (n = 232)</td>
<td>63.0 (11.7)</td>
</tr>
<tr>
<td>Total Problems Score (n = 232)</td>
<td>65.5 (10.6)</td>
</tr>
</tbody>
</table>

Clinical cutoff for all scales is = 63
IMPROVEMENTS FROM BASELINE PTSD
UCLA

Re-experiencing  Avoidance  Arousal  Total

3 months  6 months  Discharge
# Change in Child Behavior Problems

<table>
<thead>
<tr>
<th></th>
<th>Mean Reduction</th>
<th>Standard Error</th>
<th>Effect Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internalizing Behaviors</td>
<td>-0.31**</td>
<td>0.11</td>
<td>0.21</td>
</tr>
<tr>
<td>Externalizing Behaviors</td>
<td>-0.45***</td>
<td>0.10</td>
<td>0.29</td>
</tr>
<tr>
<td>Total Problem Behaviors</td>
<td>-0.49***</td>
<td>0.10</td>
<td>0.33</td>
</tr>
</tbody>
</table>

***p<.001; **p<.01
IMPROVEMENTS IN SOCIAL CONNECTEDNESS

Social Connectedness

Children  Caregivers/Parents

3 months  6 months  Discharge
CAREGIVER STRAIN

• Less objective caregiver strain
  (negative events such as financial strain, disrupted family relations, missed work)

• Less subjective internalized caregiver strain
  (inwardly directed feelings such as worry, guilt, and fatigue)

• Less global caregiver strain
  (a combination of objective and subjective internalized strain)

• But not less subjective externalized strain
  (outwardly directed negative feelings such as anger, resentment)

Effect sizes were small to moderate using the Caregiver Strain Questionnaire
IN CONCLUSION, TF-CBT...

- Reduced PTSD symptoms
- Reduced behavioral problems
- Improved children’s social connectedness
- Parents overall stress reduced
PRELIMINARY DATA FROM NEW GRANT CYCLE 2016-2021
## TRAUMA-INFORMED TRAINING

<table>
<thead>
<tr>
<th>FY 4 Q 1</th>
<th>Child-Serving Professionals</th>
<th>Number of Professionals Trained</th>
<th>Youth Impacted by Trauma-Informed Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Educators</td>
<td>190</td>
<td></td>
<td>3,200</td>
</tr>
<tr>
<td>Community Members</td>
<td>480</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outreach Workers, Case Managers, Para-Professionals, Social Workers</td>
<td>875</td>
<td></td>
<td>33,000</td>
</tr>
<tr>
<td>Physicians, Medical Professionals, Medical Students</td>
<td>735</td>
<td></td>
<td>28,600</td>
</tr>
<tr>
<td>Department of Youth Services</td>
<td>81</td>
<td></td>
<td>3,240</td>
</tr>
<tr>
<td>Probation Department</td>
<td>40</td>
<td></td>
<td>1,400</td>
</tr>
<tr>
<td>Caregivers</td>
<td>15</td>
<td></td>
<td>45</td>
</tr>
<tr>
<td>Attorneys/Judges/Policy Makers</td>
<td>290</td>
<td></td>
<td>5,500</td>
</tr>
<tr>
<td>TF-CBT Supervisors</td>
<td>20</td>
<td></td>
<td>60</td>
</tr>
<tr>
<td><strong>Year 3, Quarter 3 Totals</strong></td>
<td><strong>2,706</strong></td>
<td><strong>75,045</strong></td>
<td></td>
</tr>
<tr>
<td><strong>YEAR 3 TO DATE TOTALS:</strong></td>
<td><strong>5,862</strong></td>
<td><strong>126,456</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Year 2 TOTALS:</strong></td>
<td><strong>6,145</strong></td>
<td><strong>63,061</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Year 1 TOTALS:</strong></td>
<td><strong>3,175</strong></td>
<td><strong>17,223</strong></td>
<td></td>
</tr>
<tr>
<td><strong>GRANT TOTALS TO DATE:</strong></td>
<td><strong>16,361</strong></td>
<td><strong>258,151</strong></td>
<td></td>
</tr>
</tbody>
</table>

- Target goal: train 10,000 child-serving professionals and impact 250,000 youth with trauma-informed services
### LINK-KID REFERRALS

<table>
<thead>
<tr>
<th>EBP</th>
<th>Y3 Q3</th>
<th>Y3 Q2</th>
<th>Y3 Q1</th>
<th>Year 1</th>
<th>Year 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TF-CBT</strong></td>
<td>140</td>
<td>111</td>
<td>87</td>
<td>483</td>
<td>437</td>
</tr>
<tr>
<td><strong>ARC</strong></td>
<td>41</td>
<td>36</td>
<td>40</td>
<td>209</td>
<td>150</td>
</tr>
<tr>
<td><strong>ARC GROW</strong></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td><strong>CPP</strong></td>
<td>8</td>
<td>4</td>
<td>4</td>
<td>36</td>
<td>37</td>
</tr>
<tr>
<td><strong>PCIT</strong></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>AF-CBT</strong></td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td><strong>ARC or TF-CBT</strong></td>
<td>18</td>
<td>23</td>
<td>17</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td><strong>Clinicians are trained in both models</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>207</td>
<td>175</td>
<td>153</td>
<td>730</td>
<td>636</td>
</tr>
</tbody>
</table>

- Number of LINK-KID referrals made to each EBP
- **Pending**
In April, 2019, CTTC completed its 2nd TF-CBT Learning Community.

March 25th & 26th CTTC hosted its 3rd TF-CBT Learning Community prioritizing clinicians in Middlesex and Essex Counties.

In total, we trained 108 clinicians from 24 agencies.

CYYC hosted the TF-CBT Supervisor Training on April 8th training about 20 Supervisors.

CTTC will begin TF-CBT Supervisor calls early in the fall.

CTTC will be hosting the TF-CBT Advanced Training in early October 2019.

The TF-CBT Cohort Coordinator and CTTC PD continue to connect regularly with cohort clinicians and supervisors to reduce barriers to model implementation and REDCap implementation.
CONCLUSIONS AND FUTURE STEPS

- **TF-CBT works!**
  - Child, youth, and parent participation in TF-CBT is associated with:
    - reductions in PTSD symptoms, behavioral problems, increase in social connectedness, and decrease in parental stress
  - TF-CBT is effective in reducing maladaptive symptoms of trauma and fostering resilience in youth and their caregivers

- To date:
  - We trained **30,460** professionals in trauma-informed care approximately impacting **430,469** youth
  - We reached **1,543** youth who were provided with TF-CBT
  - **3,298** active referrals have been made to LINK-KID

- Nevertheless, training clinicians and implementing evidence-based treatment in community agencies has many challenges
CONCLUSIONS AND FUTURE STEPS

- With our new grant cycle we are making efforts and several changes to meet these challenges:
  - Providing individual support for each agency
  - Helping clinicians collect and enter data, critically think through TF-CBT work with youth, and review cohort expectations
  - Collaborate with CACs statewide to offer EBPs
  - Training providers in adaptations of TF-CBT for court-involved youth, transition age youth, etc.
  - Piloting TF-CBT PREP
  - Evaluate the effectiveness of TF-CBT across our population of focus
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