

**Delaware Division of Prevention and Behavioral Health Services:  
Response to the HJR 7 Resolution Mental Health Task Force, Chaired by Lt. Governor Matt Denn  
Enhancing Kent/Sussex Service Capacity through Three Specific Approaches**

**Prepared by Charles Webb, Ph.D.  
Director of Evidence Based Practices, DPBHS**

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This proposal from the Division of Prevention and Behavioral Health Services (DPBHS) is a response to specific requests from members of the HJR 7 Task Force. It is a suggested specific approach to enhance Kent and Sussex service capacity and quality.

**Background and Current Situation:**

DPBHS has been building capacity for the treatment of child Posttraumatic Stress Disorder (PTSD) in Kent and Sussex counties for five years by offering biannual trainings in an evidence-based practice called Trauma-Focused Cognitive Behavioral Treatment (TF-CBT). TF-CBT is a 12-16 session intervention developed to help children exposed to sexual abuse and other traumas, such as exposure to violence or sudden loss of a relative. Original studies have found TF-CBT more effective than other treatment alternatives and DPBHS has replicated those studies, finding significant reductions in PTSD symptoms through a local evaluation. Since the inception of the TF-CBT training program, 47 clinicians in southern Delaware have participated in didactic training and 27 have achieved TF-CBT certification through ongoing consultation with a local expert.

Increasing the number of providers that can treat PTSD in southern Delaware is only a first step to building a system of care for trauma-exposed youth. Like most evidence-based treatments for child traumatic stress, TF-CBT is intended for children diagnosed with PTSD and not for mild-to-moderate or acute cases in which the child's symptoms fall below the diagnostic threshold. It is not the preferred approach for prevention or early intervention.

Another limitation of our program is that therapists, once trained, are often hard to locate or access. When we consult with child professionals, community advocates and families, we are frequently told that our trained therapists are difficult to access, and that referred victims are slowly or never engaged by local clinics. One approach that has helped to expedite referral and engagement in the past has been to create a position that is responsible for triaging families of trauma-exposed youth with providers that are well trained and available to help. Two years ago, DPBHS instituted such a position to assist victims in the wake of a public, traumatic event in Sussex County. Our division eventually redeployed the crisis worker once the critical demand for crisis assistance had ebbed. In recent months, the Child Advocacy Center has asked DPBHS to reinstate this position and help triage mental health support for its clientele.

A final challenge to our training effort is that we have simply do not have enough mental health clinicians to cover the geographically large catchment areas of our southernmost counties. Despite the

existence of many institutions of higher learning in our state, too many of the social work and psychology graduate students that emerge from these institutions go on to take jobs outside of Delaware. As a consequence, we suffer a steady drain of valuable additions to our workforce, and much needed expertise in evidence-based practices that have shown to improve outcomes. We believe that by directly involving universities and university students in the implementation and evaluation of new programs in Delaware, we can not only strengthen the integrity and effect of those programs, but encourage young clinicians to become invested in and potentially committed to our local communities.

**Proposal:**

This proposal addresses three challenges in the Kent/Sussex treatment system of care for children with mental health problems due to trauma: first, the need for prevention and early-intervention services; second, the need for a resource that can help families of trauma-exposed youth navigate the labyrinth of mental health services in southern Delaware; and third to foster relationships with a local university to strengthen its investment in rural Delaware.

More specifically we propose to build greater service capacity in southern Delaware by training a large number of mental health clinicians to use a brief intervention model designed for children with recent trauma exposure. It is called the Child and Family Traumatic Stress Intervention. Second, DPBHS proposes to locate a seasonal/casual position or contracted worker in Kent County to help connect families of sexually abused children and families of children with mental health challenges with trained therapists in the community. Third, to engage the Department of Psychology at the University of Delaware in the evaluation and dissemination of the Child and Family Traumatic Stress Intervention.

**Approach 1. Implement of Child and Family Traumatic Stress Intervention in Kent and Sussex:**

DPBHS wants to better engage families into early intervention, assessment and (if needed) treatment for child traumatic stress due to sexual abuse or other traumatic experiences. Thus, we intend to train clinicians in Kent and Sussex on a brief intervention called the Child and Family Traumatic Stress Intervention (CFTSI). We want to disseminate to the broad community of mental health workers and especially to target those clinicians that work with acute and moderate cases of child traumatic stress (i.e., cases that would not be well served by TF-CBT).

CFTSI is a 4-6 session intervention, designed for children that have traumatic stress but do not qualify for PTSD due to their symptom count or the recency of the triggering event. CFTSI uses standardized assessments to evaluate for emerging symptoms and open lines of communication about the child's sense of well-being and need for support.

CFTSI has been the subject of a recent efficacy study involving children that have been abused, injured, threatened or frightened by violence. According to that study, CFTSI was more effective at preventing emergent symptoms of PTSD than service as usual.

DPBHS will implement CFTSI in Kent and Sussex counties in 2 phases. In phase 1, the intervention will be implemented on a limited scale and evaluated. In phase 2, it will be trained to a larger audience. Phase 1 will be accomplished in collaboration with CFTSI's originators at University of Pennsylvania (UPenn) and a field evaluation team at the University of Delaware (*see below: Approach #3*). This collaborative team will train a test group of 20-30 clinicians in the state's children's crisis service and local schools. Faculty from UPenn will lead the test training, monthly consultation and expert review of recorded sessions. Once, the test implementation is complete, faculty from UPenn will return to lead a second training of 200+ mental health clinicians. This second training will combine a standard overview of the brief intervention model with a report by the local evaluation team based on numerical data and case examples from Kent and Sussex counties.

### **Approach 2. Hire or contract a position to provide clinical liaison for children exposed to trauma**

As previously reported, our division's effort in Southern Delaware has done much to increase the number of clinicians trained to treat child PTSD, but not enough to improve access to trained clinicians. Thus, we propose to hire or contract a position in Kent/Sussex that will maintain a caseload of families that are actively seeking mental health services for trauma-exposed youth.

The position in Kent/Sussex will be full-time. The worker will serve as a clinical liaison between referred families (e.g., referred by the Child Advocacy Centers) and community providers that are trained to provide prevention, early intervention and treatment services to children affected by trauma.

This worker will fulfill her primary responsibilities as a clinical liaison by maintaining a steady caseload of at least 20 families, at any given time, seeking services for an alleged victim. Each family will receive standardized screening for PTSD and other relevant disorders (e.g., depression, behavioral problems), a summary of the child's evaluation and help locating a community clinician that provides CFTSI (acute or sub-threshold cases), trauma-specific treatment (e.g., TF-CBT for diagnosable cases) or other services as needed. Families receiving this service will not be discharged until the child has met with an appropriate service provider, verbally requested discharge from the program, or failed to return calls to the service worker for a period of 3 months.

### **Approach 3. Engage university faculty and students in the evaluation and dissemination of CFTSI**

In order to gauge the measurable worth of CFTSI as a product for broad dissemination and invest university staff and students in a large mental health initiative in Kent and Sussex counties, the Department of Psychology at the University of Delaware will be contracted to conduct an evaluation of CFTSI's test training and to use the results of that evaluation to build a case for scalable implementation.

As part of early preparation for the test training, faculty and a half-time graduate student will develop a protocol for measuring the execution and local effectiveness of the CFTSI model. This protocol will be partially based on interviews with the prospective agencies and trainees about the kinds of information that are particularly relevant for clinicians and administrators that will be responsible for future support and maintenance of the intervention.

Essential components of the protocol will include de-identified descriptions of test cases and interviews at intake, post-treatment and 3 months post-intake in order to track the remission of symptoms and anticipated improvements in school and community functioning. Graduate students involved in this project will not only participate in the accrual and reporting of data, but as clinical interns so that they develop an embedded understanding of the clinics and staff where they are working.

Preliminary results of the evaluation will eventually be returned to the source clinics for comment and feedback. A final report will be generated for general distribution and incorporated into subsequent CFTSI trainings (the larger dissemination training in Kent/Sussex) as evidence of the program’s local relevance and effect.

**Timeline**

The implementation of this 3-tier approach is estimated to take one year, and will be accomplished in 2 6-month phases.

	<b>CFTSI implementation</b>	<b>Hire clinical liaison</b>	<b>CFTSI evaluation</b>
<b>Phase 1 (0-6 months)</b>	<ul style="list-style-type: none"> <li>• Train first clinicians</li> <li>• Begin first cases</li> <li>• Begin consultations</li> <li>• Begin tape review</li> </ul>	<ul style="list-style-type: none"> <li>• Standardize procedures for screening and case management</li> <li>• Hire and train</li> <li>• Initiate clinical liaison work</li> </ul>	<ul style="list-style-type: none"> <li>• Develop evaluative protocol</li> <li>• Begin interview process</li> <li>• Accrue data</li> </ul>
<b>Phase 2 (7-12 months)</b>	<ul style="list-style-type: none"> <li>• Maintain consultation and tape review</li> <li>• Regional CFTSI training</li> </ul>	<ul style="list-style-type: none"> <li>• Maintain 20 family caseload</li> </ul>	<ul style="list-style-type: none"> <li>• Complete dataset</li> <li>• Generate final report</li> </ul>

**Budget justification**

The total cost for fulfilling the objectives listed in this proposal is \$109,365. To fund this proposal, DPBHS will require additional resources beyond its current budget. The cost for a seasonal casual for 1 year is approximately \$44,000. The contract for University of Pennsylvania will cost \$13,400 and cover the two trainings plus consultation and expert tape review for the first training group. Facility costs for the second training will be about \$7,000. The \$44,000 UD contract will cover faculty and student costs for developing the CFTSI evaluation protocol; data-gathering, cleaning and analysis; and final report generation. Finally, \$1,365 will be needed to pay for digital recorders that the test training group will use to record and submit CFTSI sessions for expert review.

**Projected Annual Budget for DPBHS Proposal**

<b>Grand total</b>	<b>\$109,365</b>
<b>Personnel</b>	<b>\$44,000</b>
<ul style="list-style-type: none"> <li>Casual seasonal hire for 1 year</li> </ul>	\$44,000
<b>Contractual costs (subtotal)</b>	<b>\$64,000</b>
<ul style="list-style-type: none"> <li><b>University of Pennsylvania (subtotal)</b> <ul style="list-style-type: none"> <li>- Test training (2 days) \$ 6,000</li> <li>- Regional training (1 day) \$ 1,000</li> <li>- Monthly consultations (12) \$ 2,400</li> <li>- Expert review of taped CFTSI sessions (40 hours) \$ 4,000</li> </ul> </li> <li><b>University of Delaware (subtotal)</b> <ul style="list-style-type: none"> <li>- Graduate intern (20 hours per week for 1 year) \$34,000</li> <li>- Faculty supervision (1 hour weekly for 1 year) \$10,000</li> </ul> </li> <li><b>Training facility for regional training</b> \$ 7,000</li> </ul>	
<b>Supplies</b>	<b>\$1,365</b>
<ul style="list-style-type: none"> <li>Digital recording devices (30)</li> </ul>	\$1,365