

# Louisiana Child Welfare Trauma Project (LCTP): Background, Implementation, and Results

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A white paper about a five-year, federally-funded demonstration project to implement evidence-based screening for trauma-related problems in the Louisiana child welfare system.

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## **Executive Summary**

### **WHY WE DID THIS PROJECT**

By attending more to the trauma-related psychiatric problems of children in child welfare systems, this may facilitate their adaptive functioning and facilitate more stable foster care placements and adoptions, and help strengthen biological families. The national Children's Bureau, an agency under the Administration of Children, Youth, & Families released a request for proposals in 2011 to address these issues. The Louisiana Child Welfare Trauma Project (LCTP) was one of nine grantees across the nation to be awarded one of these demonstration projects.

### **HOW WE DID THIS PROJECT**

Tulane University School of Medicine, Department of Psychiatry and Behavioral Sciences, was the lead institution for the LCTP in close partnership with the Louisiana Department of Children and Family Services (DCFS). The LCTP developed a new screen for traumatic experiences and trauma-related problems, called the Trauma and Behavioral Health Screen (TBH). From 2013-2017, DCFS caseworkers across the entire state were trained to use the TBH screen. Universal screening with this instrument is now part of DCFS policy. In addition, Tulane staff trained 335 licensed clinicians across the state in an evidence-based model of cognitive behavioral therapy (CBT) to treat posttraumatic stress disorder (PTSD). The LCTP team also reached out to thousands of stakeholders to involve them in various aspects of the project and inform them of this project.

### **WHAT WE ACCOMPLISHED**

Over four years, we conducted 42 initial training sessions that included staff from every DCFS office in the state, plus 138 monthly follow-up site visits at these offices, to train over 600 DCFS caseworkers. These caseworkers subsequently collected at least one TBH screen on 10,216 children and adolescents. Following the new DCFS policy, caseworkers were trained to collect the initial TBH screens within 30 days of new cases being opened, and they were successful within that time frame 50% of the time. The results of the TBH screens showed that PTSD is the most common condition in this population, with 24% scoring above the validated cutoff. In addition, 18% of youths scored above the cutoff for Internalizing, 17% for Externalizing, and 14% for ADHD.

Furthermore, caseworkers were trained to collect repeat TBH screens every six months as long as cases remained open. At least two TBH screens separated in time were collected on a total of 3,385 youths. The screens that were repeated after 6-month intervals after a case was opened showed that of those who scored above the PTSD cutoff on their initial TBH screen, 72.5% improved (due either to time or treatment) and scored below the cutoff six months later, but 27.5% did not improve (based on caregiver reports).

For the training of licensed clinicians to learn CBT for PTSD, we conducted 10 one-day trainings, with at least one training in every region of the state, and trained 335 participants. Of those who attended the one-day training, 38 clinicians participated in weekly telephone consultations to achieve Basic Training status, and an additional 45 clinicians participated in consultations with their own cases to achieve Advanced Training status.

By meeting with DCFS caseworkers personally early in this project, the LCTP team learned that the most problematic issue in regards to the mental health of their clients is finding appropriate access to mental health specialists. The LCTP therefore undertook a mystery shopper project to document for the first

time the true level of access to mental health care for children in the child welfare system of Louisiana. We called all individuals who were listed as licensed providers for youth in the Medicaid provider directories. Out of 2,643 listings publicized by Medicaid insurance networks, only 25.5% of those (n=675) represented unique individuals who were willing and able to accept patients. We estimate that this is approximately seven times lower than national recommendations for access to mental health care.

## **WHAT WE RECOMMEND**

Most importantly, DCFS caseworkers need additional and repeated training on a variety of mental health issues to help them learn how best to use these screen results in order to connect to the right types of providers. In turn, this will allow youths to get the treatment they really need from specialized clinicians, instead of receiving less suitable treatment by any willing provider.

The results of screening with the TBH need continued dissemination to stakeholders to make them aware of the prevalence of trauma and PTSD and the resources available for evidence-based care.

More linkage is needed between TBH screen data and actual use of clinical services to determine if youths are receiving appropriate treatment and if those treatments are effective. As the LCTP neared completion, the first-ever data sharing agreement between Medicaid claims-use data and DCFS was being finalized, but the Medicaid data were not available at the time of this report.

In terms of clinical services, once the LCTP weekly consultation calls ended, there was no longer any monitoring of treatment fidelity. Making sure that clinicians actually use the training that they received in going forward will only be possible with a systematic, state-wide system of tracking treatment fidelity. Training is only useful if clinicians take the training back to their offices and consistently and faithfully implement the new techniques, and research at other sites has been clear that this rarely happens without continued oversight.

While the LCTP showed the feasibility of training clinicians on CBT for PTSD, it represents only a good start. There are other evidence-based treatments for other disorders that need implementation for this population.

DCFS cannot accomplish all of these tasks alone. Successful execution of these tasks will require cooperation between legislators, insurance networks, Medicaid administrators, the Office of Behavioral Health, community clinicians, and other key stakeholders.

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## The Problem

The primary missions of child welfare systems in the United States are to protect children and strengthen families. In the day-to-day work of child welfare caseworkers, the majority of their time is spent on child abuse investigations, supervising the parenting of at-risk families, and longer-term protections of children through foster care placements and adoptions. The national Children's Bureau, an agency under the Administration of Children, Youth, & Families, is the major federal agency that oversees child welfare systems in the United States. **The Children's Bureau has recognized that the primary missions of child welfare would be strengthened by a greater emphasis to address the emotional and behavioral problems of children in their systems** (Samuels, 2011). By attending more to the emotional and behavioral problems of children, this may facilitate their functions of providing stable foster care placements and adoptions, and strengthening biological families.

In order to begin to address the questions posed above, the Children's Bureau, under the leadership of Commissioner Bryan Samuels, funded demonstration projects in three consecutive years. The first cohort of five grantees (representing entire states or counties in Colorado, Connecticut, Massachusetts, Montana, and North Carolina) began work in 2011. The second cohort of nine grantees (California, District of Columbia, Louisiana, Michigan, New Hampshire, New York, Ohio, Oklahoma, and Washington) began work in 2012. The third cohort of six grantees (Kansas, Kentucky, New Hampshire, Rhode Island, Tennessee, and Vermont) began work in 2013. Each cohort had slightly different aims but there was much overlap among the cohort aims, including the implementation of mental health screens with a focus on trauma-related problems.

The Children's Bureau created different funding opportunity announcements (FOA) for each of these cohorts, but all of them focused on trauma. In fact, the informal names for the 2011 and 2012 grantees were the "Trauma 1" and "Trauma 2" cohorts.

Child welfare systems are proficient at training their caseworkers on skillsets needed for safety and protection of youths, but expanding their mission to more extensively address the emotional and behavioral problems of youths requires adding new tools and skillsets. Caseworkers already perform a tremendously valuable service to society while often being understaffed and underfunded. Within this context, we have structured this report on the project around five main questions about the best practices for screening and treatment for mental disorders.

(1) One question is **how much emphasis to give to screening for trauma exposure and trauma-related problems**. Nearly 100% of children in foster care have been exposed to life-threatening traumatic experiences, and the negative impacts of trauma, such as the development of posttraumatic stress disorder (PTSD), are well-recognized. But there is a natural avoidance on the part of both caseworkers and youths to address trauma because trauma-related problems can be difficult to talk about.

(2) A second question is really a set of logistical questions about **how best to screen**. When most caseworkers are already pressed for time, how long should the screen be? What should it cover? How to balance the need for comprehensiveness against the need for brevity? Should caregivers, youths, or caseworkers complete the screens? How frequently should a screen be re-administered?

(3) A third question is how best to **train** child welfare caseworkers on how to administer the screen and use the data in their case planning.

(4) A fourth question is how to **translate these screen results into clinical treatment**. Clinical providers are a separate industry apart from child welfare. Therefore, how do you get caseworkers and clinicians to talk with each other? Are there enough clinical providers willing to treat this population? Are there providers in rural areas? Are there providers who know how to treat trauma-related problems with evidence-based practices?

(5) A fifth question is how to **disseminate** the massive amount of data aggregated from screens to the workers within the DCFS agency, to all of the stakeholders, including agency leaders, legislators who fund these programs, clinicians, judges, attorneys, school administrators, and foster parents.

The child welfare population represents a special situation where there is a tremendous opportunity for a broad spectrum of community members and institutions to do good. State and county government agencies possess legal authority to intervene in cases of maltreatment, and there are many concerned stakeholders who are eager and willing to help. Finding the best answers to these questions has important implications for some of our most vulnerable citizens.

### **Background of the Project**

Each grantee was required to work within the structure of a **cooperative endeavor agreement** with the Children’s Bureau, which has both benefits and constraints. Lead organizations could be child welfare agencies, academic institutions, or other non-profit organizations, but each grantee was required to include a child welfare agency either as the lead agency or as a close partner. Each project was also required to include an independent evaluator to monitor the success of the activities.

Tulane University School of Medicine was the lead organization for the LCTP. The application was conceived and created in close partnership with the Louisiana Department of Children and Family Services (DCFS). The Policy & Research Group (PRG) was the independent evaluation team.

For the first nine months of the five-year projects, grantees were required to use that time to revisit their original plans and engage in collaborative discussions with the federal program officer to review and refine their plans. These revised plans required approval from the program officer before the actual work of implementation could begin. While this nine-month planning period resulted in substantial changes in plans for some grantees, this planning period did not substantially alter the plans of the LCTP. Grantees were also required to attend annual meetings of all the grantees in their cohort to discuss common objectives and review progress.

The nine-month planning phase for the LCTP started September 29, 2012. The actual implementation of the project occurred September 17, 2013 to September 29, 2017.

### **QUESTION #1: HOW MUCH EMPHASIS TO PLACE ON TRAUMA?**

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*When the nine grantees of our cohort met for the first time in Arlington, VA, in November 2012 during the planning phase of the projects, it was evident that most of the grantees were not planning to screen for exposure to traumatic events despite the main purpose of these projects being to screen for trauma-related emotional and behavioral problems. Several grantees had a concern that the act of asking youths or their caregivers about the traumatic events that they had experienced would be too distressing to the respondents.*

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**W** *hy focus on trauma in the first place?* The rationale for focusing on trauma is based on an extensive body of research. Children in child welfare systems are often placed into foster care because they have been exposed to traumatic events. Yet, PTSD has historically been, and continues to be, under-recognized in children and adolescents.

The **under-recognition of trauma and trauma-related problems** has been formally documented, even in agencies that purport to be sensitive to trauma (Miele & O'Brien, 2010; van Zyl, Oosthuizen, & Seedat, 2008) (**see sidebar this page, Miele & O'Brien, 2010**).

The under-recognition of trauma exposure and trauma-related problems is particularly unfortunate because there are very effective evidence-based treatments available (Cohen, Mannarino, Murray, & Igelman, 2006). Outcome studies have shown that evidence-based CBT treatment leads to improvements in PTSD, depression, anxiety, externalizing problems, shame, social competence, and sexual problems (Kowalik, Weller, Venter, & Drachman, 2011), which may lead to fewer placements and better adoption rates.

Screening for PTSD is the most efficient and evidence-based method to detect individuals with trauma-related problems. There has been controversy and confusion in the past as to what emotional and behavioral problems develop after trauma. Some have been skeptical that PTSD develops after trauma, and believed that depression, anxiety, or other problems can arise following trauma in the absence of PTSD. McMillen and colleagues (2002) dispelled that notion in a study that addressed the methodological shortcomings of prior studies (McMillen, North, Mosley, & Smith, 2002). Following life-threatening trauma, PTSD is the core psychological problem and any comorbid disorders that arise nearly always arise concurrently with significant PTSD symptoms (**see sidebar next page, McMillen et al., 2002**).

### **Does Asking About Traumatic Events and Trauma-Related Problems Cause Distress?**

It is understandable to think that respondents in the child welfare population might become distressed when asked to complete a screen about their past traumatic experiences. The types of traumatic events that are experienced by this population are mostly interpersonal in nature—physical abuse, sexual abuse, and witnessing domestic violence. These experiences often involve embarrassment, guilt, and shame. These are the types of topics that would be more easily divulged in the context of a trusted, ongoing relationship with a child welfare caseworker. That type of relationship however is not always feasible when screening is to be completed with newly opened cases where the youths and caseworkers may barely know each other.

Yet, there are multiple reasons to believe that asking youths and their caregivers about their traumatic experiences in a screening setting is not excessively distressing, and the benefits of asking about traumatic events outweigh any harms.

## Miele & O'Brien, 2010

PTSD is often missed.

A study was conducted at two mental health programs for children and adolescents in Pennsylvania (Miele & O'Brien, 2010). The researchers reviewed the charts of the patients at the beginning of the study and found that the rates of PTSD diagnosis were 2% at one program and 5% at the second program. This represented the recognition of PTSD when clinicians used their usual methods of practice. They then re-evaluated the same patients with a standardized diagnostic interview for PTSD. This time they found that the rates of diagnosis of PTSD were actually 48% and 45% at the two programs. **Trained and licensed clinicians were missing the diagnosis of PTSD about 90% of the time.** Even more disappointing, is that the researchers found hardly any change when they re-visited one of the programs ten years later. Despite the results of the study and increasing awareness of trauma and PTSD over those ten years, the program was still not using a standardized diagnostic interview and the rate of diagnosis was only 11%.

The exact same result was found in a study in South Africa by Van Zyl et al., 2008.

First, a screen, by definition, is not asking for the details of the events that might trigger feelings of embarrassment, shame, or other distress. A screen requires only that respondents tick yes or no if they experienced a particular traumatic event. Depending on the details of the screen, respondents may be asked to report the ages at which the events happened and how many times each type of event happened. But there is no known screen that asks for respondents to describe any details of traumatic events.

Second, a study was conducted by David Finkelhor and colleagues that directly addressed the question of whether respondents were distressed by these types of questions (Finkelhor, Vanderminden, Turner, Hamby, & Shattuck, 2014). **They found that asking youths about traumatic events and PTSD symptoms rarely caused marked distress (see sidebar next page, Finkelhor et al., 2014).**

Third, for the LCTP, we opted to include a screen of traumatic events and we monitored our own efforts to determine empirically if youths were becoming distressed by completing the screens. During the rollout of the screen in the first region (the Covington region), we made monthly visits to the offices to meet with the caseworkers, and we asked them if they were encountering any experiences of youths or caregivers becoming distressed due to completing the screen. During a time frame when over 1,800 screens were completed, we heard of only three instances when youths became distressed. It was not entirely clear in those three instances whether the youths were distressed by the screen or by other extraneous circumstances. Nevertheless, if we count those three instances, in the context of over 1,800 screens, less than 0.2% of youth respondents became distressed by trauma-related questions—an even lower rate of distress than found in the Finkelhor et al. study.

### How Much Emphasis to Place on Trauma Exposure

Another issue that was noted during the November 2012 grantee meeting in Arlington was that many grantees believed that respondents' answers about trauma-related problems (i.e., their emotional and behavioral problems that followed traumatic events) would be reliable without having to ask anything about experiencing traumatic events. The instructions at the beginning of most questionnaires for PTSD symptoms state that the symptoms that follow on the sheet of paper are problems that youths sometimes have "following upsetting events" or "following traumatic events." No details or examples are usually provided of what counts as an upsetting or traumatic event. Respondents are not asked to tick yes or no as to whether they experienced any specific types of events. The validity of this type of screen to reliably measure PTSD symptoms

## McMillen et al., 2002

PTSD is the core psychological problem following trauma.

Following a disastrous flood in St. Louis in 1993, McMillen and colleagues studied 162 adults. The researchers found that no individual developed non-PTSD disorders in the absence of PTSD. In other words, **all non-PTSD problems that developed after the trauma developed only in the presence of PTSD symptoms**, thereby supporting the notion that PTSD is the core psychological injury following trauma.

Dr. Scheeringa, the LCTP project director, replicated this finding in two other populations in a study published in 2008. Dr. Scheeringa's team assessed a group of 3-6 year old children who survived the Hurricane Katrina disaster along with their mothers. In the children, no individual developed non-PTSD disorders in the absence of PTSD, exactly duplicating the McMillen et al. findings. In the caregivers of these children, only two out of 70 mothers developed a non-PTSD problem in the absence of PTSD symptoms (Scheeringa & Zeanah, 2008).



rests on the assumption that respondents understand what is meant by upsetting or traumatic events.

**There are multiple reasons to believe that respondents do not understand what is meant by upsetting or traumatic events with only that little amount of explanation.** The definition of traumatic events in the Diagnostic and Statistical Manual, Fifth Edition (DSM-5) (APA 2013) for PTSD is clear that the events need to be life-threatening. It seems straightforward that when respondents are answering questions about PTSD symptoms, they are reporting emotional and behavioral symptoms that followed from life-threatening events, not from lower-level types of stressors.

An example of why it is important to be clear that respondents are reporting about symptoms that followed truly life-threatening events comes from a study conducted in England (Joseph, 2000). Stephen Joseph, PhD was concerned about the effects resulting from the stress of divorce on children, so he surveyed adolescents and concluded that 34% of them qualified for divorce-related PTSD. In fact, PTSD supposedly emerged at a higher rate from divorce than from truly life-threatening experiences! It is extremely unlikely that 34% of youths develop PTSD simply because their parents divorced.

Another example comes from a description of a case from a treatment study for PTSD (Scheeringa, personal communication). A 15-year-old female was being evaluated for possible inclusion in a treatment study for PTSD. She had witnessed her sister's attempted suicide of slashing her wrists. This adolescent did not consider her sister's attempted suicide a traumatic event, and she refused to endorse it as a traumatic event in the interview with the investigator. She did however believe that her own breakup with her boyfriend several weeks earlier was traumatic. The research assistant, not being sure of what to do, proceeded with the interview for PTSD symptoms, and the adolescent endorsed enough symptoms to qualify for full-blown PTSD due to her romantic breakup, even though she did not truly have PTSD.

Unlike nearly all other emotional and behavioral problems, trauma-related problems explicitly involve one or more events that caused the problems. This means that there are two key components in the assessment of trauma-related problems: (1) the traumatic events, and (2) the trauma-related symptoms that followed the events. It would appear straightforward that any screen for trauma-related problems must collect information about both of these components.

## Finkelhor et al., 2014

Asking about traumatic events and PTSD symptoms rarely causes marked distress.

Finkelhor and colleagues interviewed over 2,000 youths, aged 10-17 years. Investigators asked respondents directly about exposure to traumatic events and about trauma-related symptoms. Next, they asked the youths if the questions in the survey upset them and, knowing now the nature of the survey, would they have still agreed to do it. Only 4.5% reported feeling any upset, and **only 0.3% said they would not participate again.** This survey ought to give confidence that asking these types of questions do not make the vast majority of youths upset.

## QUESTION #2: WHAT ARE THE BEST METHODS FOR SCREENING?

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*There were eight other grantees from different states who addressed exactly the same tasks as the LCTP. Each grantee was free to choose their own screening instruments. Each grantee decided to use a unique set of screening instruments. Four grantees developed one set of instruments for younger children and a different set of instruments for older youths. The other five grantees used one set of instruments for all age groups. No single instrument was used by 100% of grantees. Clearly, there is little consensus on the best set of screening instruments for trauma-related problems.*

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**T**his question is really a set of questions about how best to screen. How long should the screen be? What should it cover? How to balance the need for comprehensiveness against the need for brevity? Should caregivers, youths, or caseworkers complete the screens? How frequently should a screen be re-administered?

To address these questions we systematically created a list of features that we wanted in a screen to be used for this project.

### **How to Create a Trauma-Related Screen**

Our goal was to have a universal screen that could be implemented by DCFS caseworkers to measure a broad range of emotional and behavioral problems. We wanted the screen to be a single instrument for all age groups for simplicity, with instructions on which sections to fill out for different age groups. The screen would be administered to all new cases, and repeated every 6 months.

The following is our list of **7 desired characteristics of a screen instrument**:

**(1) Cover traumatic events comprehensively** and ask about all possible types of traumatic events (not just maltreatment). **The first component is to recognize that individuals have been exposed to traumatic events.** Avoidance is part and parcel of the PTSD syndrome. The anxiety, shame, and guilt make it difficult for individuals to spontaneously acknowledge their traumatic experiences, so standardized probing is required (Cohen & Scheeringa, 2009; Scheeringa, 2011). A screen for traumatic events must ask a menu of all possible types of traumatic experiences. Furthermore, in a community-representative sample of youth, it was shown that 38% of children who experienced one trauma had experienced multiple traumas (Copeland, Keeler, Angold, & Costello, 2007). This indicates that it is insufficient to screen for only a few types of trauma, such as physical and sexual abuse, and a screen needs to cover all possible types of traumatic experiences.

In addition, in order to screen for the complete range of possible PTSD symptoms in each individual, the symptoms must be asked in the context of all traumatic experiences, not just one experience. A shortcoming of most existing PTSD measures is that they ask about PTSD in relation to only one index trauma. Therefore, we wanted our screen to ask about 12 possible types of traumatic events and then ask about PTSD symptoms in relation to all events.

**(2) Cover PTSD items** fairly well (at least 10 specific PTSD symptoms), as PTSD is the core psychological injury for traumatized children in child welfare.

**(3) Cover co-morbid items** (depression, anxiety, oppositional defiant, and ADHD) with at least several items per syndrome in order to create a range of scoring that can show change over time.

Measurement of syndrome-specific problems was desired because our task as outlined in the Funding Opportunity Announcement (FOA) included practices to support re-configuration of the service array. One of the potential areas of service to reconfigure is clinical treatment with evidence-based practices (EBP). EBPs are targeted to specific syndromes with some exceptions. That is why a broad measure of functioning, such as the Child and Adolescent Needs and Strengths (CANS) is an inappropriate measure for supporting service array reconfiguration. The CANS measures functional impairment in broad domains of role functioning (home, school, and peers, etc.) which do not lend themselves to understanding underlying syndromic problems that could be targeted with EBPs. The CANS is useful for describing general severity of impairment in a population and supporting structured decision-making of which youth need any sort of treatment, but not for specific types of treatment.

**(4) Brief.** Contain < 40 items total and/or accomplished in 5-10 minutes to minimize the burden on workers and clients and aim for 100% completion and data entry. There are ample data from published literature, personal communications from other projects, and our own experience that longer measures will be completed less often, entered into databases less often, result in substantial missing data, and require computerized scoring, and are more difficult to interpret. Information from our focus groups with DCFS caseworkers, and experience from other states (Berliner, personal communication), it was clear that instruments of 100 items would simply not be completed in a consistent manner. In order to maximize data completion, we believed an ideal length would be around 30 to 40 items.

**(5) Self-administered,** as opposed to interview style (with exceptions for clients with reading limitations). In large-scale survey projects such as this, self-administered instruments are the most economical use of time and resources, tend to ensure greater completion of measures, and avoid bias introduced by idiosyncratic interview techniques of caseworkers.

**(6) Apply to infants through adolescents.** We opted to have one screen that was applicable across all age groups as opposed to multiple screens that were designed for specific age groups. We opted for one screen for simplicity because DCFS caseworkers already had one of the highest caseloads in the nation and we wanted to minimize the burden of conducting this new screen.

**(7) Free in the public domain.** There are so many instruments that are free and have excellent psychometric properties that it made little sense to pay for the use of other instruments. Removing a cost barrier for underfunded child welfare systems would make sustainability that much easier.

Drawing from the literature and expertise within our team, we reviewed 20 potential measures, which are listed in Table 1. Each measure was evaluated on the seven characteristics that we desired in a screen. No single instrument possessed all seven characteristics.

Thus, it was decided to try to create a new measure that would have all seven of the desired characteristics. The new screen consists of components taken from four existing instruments: **Traumatic events screen.** Taken from the Child PTSD Checklist (CPC) (Scheeringa, 2010), this asks about 12 types of traumatic events, plus a 13<sup>th</sup> item to pick the most distressing event. For each endorsed event, it asks for the earliest age it happened, the latest age it happened, and approximately how many times it happened.

**Child PTSD Symptom Scale** (Foa, Johnson, Feeny, & Treadwell, 2001). The CPSS is a questionnaire that maps onto the 17 DSM-IV PTSD symptoms rated on a 4-point (0-3) Likert scale. This measure has shown excellent sensitivity to change, internal consistency, and test-retest reliability. A cut point of 11 or greater was shown to have 95% sensitivity and 96% specificity for correctly classifying high and low severity cases of PTSD.

**Table 1. Rating of Key Elements that are Desired in a Screening Measure for 20 Instruments.**

Instrument	Trauma Events	Covers PTSD	Co-morbid	<25 items	Self-admin.	Free
Behavioral Health Screening Form (BH-1)	No	No	No*	Yes	No	Yes
Brief Impairment Scale (BIS) (Bird)	No	No	No	Yes	No	Yes
Brief Problem Checklist (Chorpita et al.)	No	No	No*	Yes	Yes	Yes
CANS – long form (Lyons)	Yes	No	No*	No	No	Yes
CANS – mental health form (Lyons)	No	No	No*	No	No	Yes
CANS – trauma version (Lyons)	Yes	Yes	No*	No	No	Yes
Child Behavior Checklist (CBCL) (Achenbach)	No	No	Yes	No	Yes	No
Child PTSD Checklist (CPC) (Scheeringa)	Yes	Yes	No	Yes	Yes	Yes
Child PTSD Symptom Scale (CPSS) (Foa)	Yes	Yes	No	Yes	Yes	Yes
Child Trauma Questionnaire (Bernstein and Fink)	No	No	No	No	Yes	No
Pediatric Emotional Distress Scale, 2-10 yrs. (Saylor)	No	Yes	No*	Yes	Yes	Yes
Pediatric Symptom Checklist-17 (Jellinek & Murphy)	No	No	Yes	Yes	Yes	Yes
Pediatric Symptom Checklist-35 (Jellinek & Murphy)	No	No	Yes	No	Yes	Yes
Strengths and Difficulties Questionnaire (Goodman)	No	No	Yes	Yes	Yes	No
Social Skills Rating System (SSRS) (Gresham & Elliot)	No	No	No	No	No	No
Trauma Symptom Checklist for Young Children (Briere)	No	Yes	Yes	No	Yes	No
Trauma Symptom Checklist for Children (Briere)	No	Yes	Yes	No	Yes	No
Traumatic Events Screening Inventory (Ford & Rogers) (TESI-CRF-R; Ghosh-Ippen)	Yes	No	No	Yes	No	Yes
UCLA PTSD Index (Pynoos et al.)	Yes	Yes	No	Yes	Yes	No
Young Child PTSD Checklist, 1-6 years (Scheeringa)	Yes	Yes	No	Yes	Yes	Yes

Notes: Trauma Events = comprehensively asks about all possible types of traumatic events. Covers PTSD = captures at least 12 specific PTSD symptoms. Co-morbid = captures common comorbid syndromes (depression, anxiety, oppositional defiant, ADHD) with at least several items per syndrome; **No\*** = comorbid syndromes are inadequately covered with 1 item each. <25 items = checklist has 25 items or fewer. Self-admin. = respondents can fill it out themselves; a **No** means it requires interview assessment. Free = in the public domain and free; a **No** means it must be purchased.

***Pediatric Symptom Checklist-17, modified*** (PSC-17). The PSC-17 is a 17-item, parent-report questionnaire, with each item scored on 0,1,2 Likert scale. The PSC is the most commonly recommended measure for general psychosocial screening for school-aged children (Semansky, Koyanagi, & Vandivort-Warren, 2003). Subscales can be calculated for attention (5 items), internalizing (5 items), and externalizing (7 items). The attention score maps onto ADHD; the internalizing score maps onto depression and anxiety; and the externalizing score maps primarily onto ODD. When

compared to diagnoses from a structured diagnostic interview, the attention scale (cutoff  $\geq 5$ ) showed 88% sensitivity and 72% specificity for an ADHD diagnosis. The internalizing scale (cutoff  $\geq 4$ ) showed 86% sensitivity and 61% specificity for a depression diagnosis, and 65% sensitivity and 62% specificity for an anxiety diagnosis. The externalizing scale (cutoff  $\geq 5$ ) showed 85% sensitivity and 68% specificity for a diagnosis of ODD, conduct disorder, or adjustment disorder with disturbances of conduct. Because sensitivity for anxiety disorders was the lowest for all the syndromes (65%), and anxiety is the most common syndrome in youth (Costello & Angold, 1995), and there are effective interventions available for anxiety disorders, we wanted to improve the sensitivity for anxiety disorders. The low sensitivity of the PSC-17 for anxiety appears to be because there are only 2 items in the PSC-17 that map onto anxiety disorders. We therefore added three anxiety symptoms from the **Screen for Child Anxiety Related Emotional Disorders** (SCARED) in order to create a broader range of scoring for anxiety (Birmaher et al., 1999). “I worry about things working out for me,” and “I worry about being as good as other kids” loaded highest on the generalized anxiety disorder factor (Muris, Merckelbach, Schmidt, & Mayer, 1999). “I am afraid to be alone at home” was used to represent separation anxiety disorder as one of the few items that didn’t confound worry about parents in a foster care population.

The new screen also included 11 items from an instrument that DCFS was currently using, called the Behavioral Health Screen – I. These 11 items covered important issues that were not covered by the items from the CPC, CPSS, PSC-17, and SCARED, such as attachment, autism, psychosis, and drug use.

A parent version was created for caregivers. A child versions was created for youths 7 years of age or older.

**Table 2. Cut-off Scores that Indicate Clinical Concern and Cause for Referral to Clinicians.**

		<b>Items</b>	<b>Cut-off</b>
<b>PTSD score</b>	(15 items)	#11-25	10 or higher
<b>Internalizing score</b>	(8 items)*	#26-30 + #43-45	8 or higher
<b>ADHD score</b>	(5 items)	#31-35	7 or higher
<b>Externalizing score</b>	(7 items)	#36-42	7 or higher

PTSD scoring guidelines from Foa EB, Johnson KM, Feeny NC, Treadwell KRH (2001). The Child PTSD Symptom Scale: A preliminary examination of its psychometric properties. *J. Clin. Child Psychol.* 30: 376-384.

PSC scoring guidelines from Borowsky, I. W., S. Mozayeny and M. Ireland (2003). *Brief psychosocial screening at health supervision and acute care visits.* *Pediatrics* 112(1 Pt 1): 129-33.

\*The PSC contains 5 items for internalizing and the cutoff is  $\geq 5$ . We added 3 items for anxiety from the SCARED because the PSC items were weighted heavily towards depression. The cutoff therefore was raised to  $\geq 8$ .

### QUESTION #3: WHAT IS THE BEST WAY TO TRAIN CASEWORKERS?

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*The dominant training model in the trauma field over the past decade for training a workforce spread over a geographic region has been the Learning Collaborative model (Markiewicz et al., 2006). In the Learning Collaborative model, subsets of the workforce to be trained are selected to attend an intensive training program that involves approximately three in-person training sessions over a 9-12 month period. Typically 2-5 members are selected from each geographic site who are a mix of front-line staff and administrators. The training sessions are typically held in hotel meeting rooms. The participants must take off from work and stay at the hotel for the multiple days of training sessions. Interactive training methods are encouraged to allow participants to interact with other teams (creating subgroups to split off and meet; pairing participants with similar or diverse skills; create crossword puzzles; and competitive quiz games). This interactive strategy minimizes didactics and has participants do most of the work. Innovative teaching methods are encouraged to cater to adult learning styles (e.g., storyboard posters and games that require cooperation) and enables participants to share and learn from their collective experiences. Between training sessions, participants are expected to implement assigned tasks at their home offices, and also act as early adopters to persuade others in the organization to adopt the new practices.*

*There are many reasons why this approach was wrong for our particular system. The LCTP created a completely different model for training that more closely resembles a business model of training all employees on a common set of skills.*

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**C**ontrasting the needs of the Louisiana DCFS with the limitations of the popular Learning Collaborative model is a constructive process to illustrate how we conceived a different model to train caseworkers in the LCTP. Many, if not most, of the other grantees adopted a Learning Collaborative model to train child welfare caseworkers. Given the dominance of this model in the trauma field, we felt pressure from a variety of directions to adopt this model. However, to engage all caseworkers in the field, we adopted a more sustainable model that would be closer to how fast-moving businesses with high worker turnover would train their employees.

#### **Reach Every Caseworker**

With nearly 1,000 caseworkers that needed to be trained, we needed a model in which our trainers could **reach every caseworker in-person and follow-up with them repeatedly** to ensure that accurate training had been installed and correct practices were being used. In contrast, Learning Collaborative models are structured to train a subset of the workforce who are expected to be early adopter “champions” and carry the information back to their offices.

#### **Cost**

It was less expensive for 4-5 project staff to **travel** to 46 offices than it would have been for the travel, hotels, and lost days of productivity for dozens of DCFS staff to travel to hotel sites. The majority

of the 46 DCFS offices were in rural areas. We accommodated these offices by having our trainers travel to those offices rather than asking those workers to travel to central training sites. In addition, Tulane's assistants were available by phone or email for one-on-one assistance, and we encouraged caseworkers to contact them if problems arose.

### **Duration of Training**

The **duration of training** was a strong consideration. When considering how to train a workforce that is already one of the most overburdened in the nation, we wanted a training model that limited the amount of time it pulled them away from their jobs. Our model involved a 1.5 hour initial training, followed by four 1-hour site visits, all conducted within their home offices.

### **Sustainable**

Perhaps most importantly, we wanted to develop a training model that was **sustainable**. Our model was able to create training videos, slides, and talking points that can be used in the DCFS new worker training indefinitely at no additional cost to the agency.

### **Immediate Hands-On Experience**

Given that screening does not require highly technical skills, our philosophy was that the **real learning comes from hands-on experiences**. We wanted to conduct four follow-up site visits, each separated by one month, to give caseworkers time to use the screens. The follow-up site visits were opportunities to discuss their experiences and address new concerns as they arose. A Learning Collaborative model does not allow that much repetition and follow-up.

During the four monthly follow-up site visits that follow the initial trainings at every office, we have discussions with the caseworkers about how to use the TBH for case planning. These topics included:

- Who here has done a screen so far?
- Were there any difficulties entering the screen into the database?
- Were there any barriers to completing screens?
- Have any screens come back with high scores for PTSD?
- Sharing results with caregivers.
- Introducing the screen to biological parents in Family Services (in-home) cases is different than introducing it to foster parents.
- Was the child already diagnosed or in treatment prior to taking the TBH?
- How will the results of the screen affect your case planning?
- Has the therapist been informed of the results?
- How do you plan to talk to the therapist about incorporating this new information into their treatment plan for the child?
- Do you feel like the clinician will be responsive to input from the screen and will they act on it?
- Have any new referrals been created based on the TBH score?
- Are caseworkers requesting trauma-informed treatment after seeing the results? Even if your child is in treatment with a provider who has not done our CBT training, you can still ask if they are trained in another trauma-informed treatment method. The more we ask clinicians for this kind of treatment, the more likely they will be to seek out trauma-focused training in the future.
- At every site visit, LCTP staff provided paper copies of TBH screens printed on brightly colored paper (blue for caregiver version, and yellow for youth version). This also helped them to remember that were two versions.
- Tulane gave monthly TBH logs to parish managers, which showed a list of open cases, their respective caseworkers, and if and when a TBH had been completed for the child.

- Tulane calculated TBH completion rates for regional administrators and area directors each month. Tulane handed these calculations on paper logs to the managers in each office during our site visits, hoping that managers would use these for private discussions later with their line staff.

For staging of the project, we implemented the components in a stepwise design to eventually involve all of the approximately 1,000 DCFS caseworkers. All components were piloted in one of nine state regions in the first year of implementation. We chose the Covington region because of its proximity to our partners and the large number of cases. In the second and third years of implementation, we implemented the project in four additional regions—Baton Rouge and Lafayette in the south, and Alexandria and Monroe in the north. The remaining four regions (Orleans, Thibodaux, and Lake Charles in the south, and Shreveport in the north) were trained in the fourth year.

### **How Well Did the Training Work?**

There are multiple ways to answer this question. The LCTP was able to successfully roll out the TBH to all nine regions of Louisiana in the four years allotted for the implementation, requiring that trained DCFS caseworkers complete TBHs for all clients at the appropriate time.

To formalize this in policy, DCFS revised the DCFS Child Welfare Policy Manual to reflect the required administration of the TBH to all applicable clients throughout the state (Policy 3-220 – Behavioral Health Screening and Assessment of Children). The formalization in policy was an important step as caseworkers are cognizant of DCFS policies. When the LCTP trainers traveled to the dozens of DCFS offices to conduct trainings on the TBH, caseworkers frequently asked if this new screening procedure was in policy.

DCFS incorporated questions about TBH completion in their periodic Continuous Quality Improvement reviews, and training was provided for the CQI reviewers. A question was added to the CQI assessment and case planning document regarding the referral to treatment based on the results of the TBH.

Our independent evaluation team, PRG, created the *DCFS Caseworker Questionnaire* and systematically surveyed DCFS caseworkers. When asked if they were able to use the TBH Screen to develop an appropriate case plan, 107 caseworkers answered with a mean score of 7.13 in 2017 (0 = cannot do at all, 10 = highly certain can do). In 2015 and 2016, the mean scores were 6.58 (73 caseworkers) and 6.81 (59 caseworkers), respectively—showing an increase in self-efficacy reports over time.

Furthermore, the TBH training is now embedded in new worker training at DCFS as well as training for foster parents. Laura St. Amand, who participated in all of the LCTP trainings, has been designated as the DCFS trainer. This will provide excellent continuity as LCTP hands off the TBH screen training to DCFS.

At least one TBH screen was gathered on 10,216 unique individuals. Table 3 shows the percentage of screens completed for newly opened cases that remained open for at least 30 days. Our rationale for including only cases that had been open at least 30 days was that many cases closed before 30 days and it would not be appropriate to include those in the calculations. Note that the total of 8,146 is lower than 10,216 because 1,985 individuals had cases that were opened for less than 30 days or had cases that were opened prior to the TBH training. The Covington region achieved the highest rate, 69%, while the Thibodaux region had the lowest rate, 24%.

At least two TBH screens separated in time were collected on a total of 3,385 youths. When using a more stringent criteria of counting TBH screens that were collected in the standardized policy timetable of collecting the initial TBH after being opened and then repeated after six months if the case



remained open, this was accomplished in 1,459 cases. Table 3 shows that the Lafayette region achieved the highest rate of completing six-month interval screens, 30%, while the Lake Charles region had the lowest rate, 0%. It should be noted that only six months had passed in the Lake Charles region when data completion ended, which was not enough time for repeat screens to be completed.

**Table 3. Initial and Repeat TBH Screen Completion Rate of Open DCFS Cases by Region as of 9/25/17**

Region	Date Started	TBH Screen Completion Rate for		Repeat TBH Screen	
		Newly Opened Cases*		Completion Rate**	
		%	Number Completed	%	Number Completed
<b>Covington</b>	2014 May 13	69%	3,076	29%	842
<b>Baton Rouge</b>	2015 Jan. 5	47%	1,134	4%	40
<b>Lafayette</b>	2015 May 7	61%	1,671	30%	380
<b>Alexandria</b>	2015 Sept. 23	34%	583	22%	79
<b>Monroe</b>	2016 Jan. 13	57%	714	15%	78
<b>Orleans</b>	2016 June 13	35%	310	6%	22
<b>Thibodaux</b>	2016 July 12	24%	180	3%	11
<b>Shreveport</b>	2016 Nov. 2	41%	369	3%	7
<b>Lake Charles</b>	2017 March 15	34%	109	0%	0
<b>Total</b>		50%	8,146	29%	1,459

Note: \*The TBH Screen Completion Rate was calculated by finding the number of clients that were newly opened after the project moved into that region (column labeled Date Started), and had been opened at least 30 days to give caseworkers appropriate time to complete the TBH. This TBH Screen Completion Rate indicated whether these open cases had at least one screen completed.

\*\*For the Repeat Screen Completion Rate, cases that remained open for less than six months were excluded from the calculations. If a case was open for less than six months duration, caseworkers would not have been required to obtain a repeat screen.

In PRG's *DCFS Caseworker Questionnaire Report*, caseworkers were asked how frequently they made referrals if the TBH screen score indicated the need for an assessment or treatment. One hundred seven caseworkers answered with a mean score of 8.3 (0 = none of the time and 10 = all of the time). Furthermore, 107 caseworkers stated with a 7.6 mean score they can identify the appropriate treatment based on TBH Screen scores, assuming all treatments are available. While these survey results suggest that referrals to treatment are made most of the time for youths who score above cutoffs, these data are limited in being **perceptions** rather than measurements of actual practices. In addition, even when referrals to treatment are made, these data do not indicate if the clinicians who receive the referrals are trained in evidence-based practices for the youths' particular problems.

#### **The TBH Data**

The way that we report results of the initial TBH screens for newly opened cases is illustrated in Figure 1. The TBH returns 4 subscales – posttraumatic stress disorder (PTSD), Internalizing (INT), attention-deficit/hyperactivity disorder (ADHD), and Externalizing (EXT). The results are reported by caregiver report, child report, and the joint report.

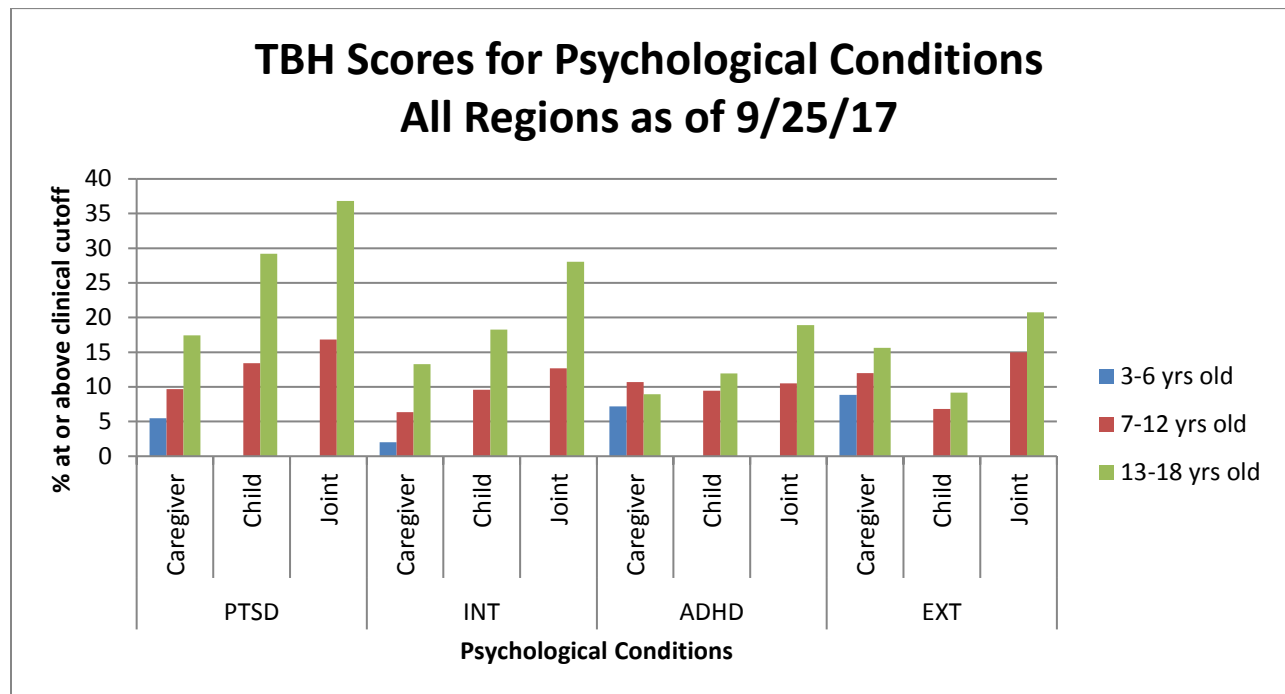
By **caregiver report** for PTSD, 6% of 3-6 year-old children scored above the cutoff and are likely to have the diagnosis of PTSD; 10% of 7-12 year-old children scored above the cutoff; and 17% of 13-18 year-old children scored above the cutoff. With all three age groups combined, 10% are likely to have the diagnosis.

By **child report** for PTSD, 3-6 year-old children do not fill out the TBH; 13% of 7-12 year-old children scored above the cutoff, and 29% of 13-18 year-old children scored above the cutoff. With both older age groups combined, 19% are likely to have the diagnosis.

Joint report is the combined score from using both the caregiver and child answers. A unique aspect of the TBH scoring is that it anticipates caregivers and children will answer the questions differently at times. The joint score utilizes the highest score that has been endorsed by either the parent or the child. For example, if a child reports a 3 on experiencing nightmares, but a parent reports a 2 on the same question, the joint score will utilize the child's higher score when calculating the results. By **joint report**, the proportions of those likely to have the diagnosis of PTSD are higher than child report alone or caregiver report alone; 17% of 7-12 year-old children scored above the cutoff, and 37% of 13-18 year-old children scored above the cutoff. **With both older age groups combined, 24% are likely to have the diagnosis of PTSD.**

Figure 1. TBH Results on New Cases for the Entire State.

Number of Respondents - All Regions			
Age	Caregiver	Child	Joint
3-6	2401		
7-12	2326	2090	1962
13-18	1240	1281	1143



By **joint report**, the proportions of those likely to have the diagnosis of an internalizing disorder are 13% of 7-12 year-old children and 28% of 13-18 year-old children. **With both older age groups combined, 18% are likely to have an internalizing diagnosis.**

By **joint report**, the proportions of those likely to have the diagnosis of ADHD are 11% of 7-12 year-old children and 19% of 13-18 year-old children. **With both older age groups combined, 14% are likely to have the diagnosis of ADHD.**

By **joint report**, the proportions of those likely to have the diagnosis of an externalizing disorder are 15% of 7-12 year-old children and 21% of 13-18 year-old children. **With both older age groups combined, 17% are likely to have an externalizing diagnosis.**

All of these data can be viewed broken down by regions and age groups at [latrauma.com](http://latrauma.com).

With thousands of TBH screens collected, DCFS now has an enormous amount of standardized data on the emotional and behavioral problems of their clients, which opens up a whole world of possibilities of ways to inform policy, legislative, and funding initiatives. The illustration of data in Figures 1 represent only some of the broadest ways to examine the data.

**There are many uses for TBH data at the individual level:**

- Determine a need for any mental health services.
- Determine the specific type of mental health services needed.
- The process of completing the TBH is educational for caregivers.
- By completing the TBH, clients may feel that their emotional and behavioral needs are being addressed.
- Caseworkers may feel greater satisfaction in their jobs because they are able to serve their clients' needs better with these data.
- Caseworkers can detect clients who are getting worse over time by repeating the TBH.
- For clients who improve with clinical services, caseworkers can demonstrate empirically that clients are improving by repeating the TBH.
- We have seen and heard first-hand examples of all of these uses during our follow-up site visits in DCFS offices.

**There are many uses for TBH data at the agency level:**

- Compare regions of the state to each other.
- DCFS administrators must frequently present their needs to legislators and justify their funding requests. These data can provide empirical support to justify funding requests for taxpayers' money to maintain current programs and to create new programs to improve screening, tracking, and clinical services for mental health problems.
- These data can be used in future grant applications.
- Pinpoint greatest areas of need or areas of unmet needs for CQI-style exploration.
- Support new initiatives with partner agencies to meet clients' needs better.
- Show the incongruity of the high burden of client problems against the very limited access to clinical care.

## Data Management Workforce Needs

There is a saying that “no good deed goes unpunished.” With thousands of TBH screens completed comes a massive amount of data that needs to be managed, and the amount keeps growing. Data management involves checking screens for completion, researching and following-up on screens with incorrect identification, eliminating screens with too much missing data, summarizing the results, and presenting the data in visually-pleasing graphs and figures.

During the LCTP, this was nearly the full-time job of one of our analysts. This will be an important position for DCFS to fund to manage this wealth of information.

#### QUESTION #4: HOW TO MAKE THE TBH SCREENING DATA USEFUL?

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*Darlene (not her real name) was a DCFS caseworker in the Alexandria region. She had attended the initial 1.5-hour training that the LCTP team conducted in her office the month before. Following the initial training she had one of her clients and the clients' foster mother fill out TBH screens. Darlene brought the screens back to her office, keyed the answers into the online data entry system, and printed out the results. The results showed that this client probably suffered from full PTSD, and in addition was elevated above the cutoff on the Internalizing scale. The client was below cutoffs on the Externalizing and ADHD scales. The client was already enrolled in counseling at the local children's advocacy center, however Darlene did not know how frequently she was meeting with the counselor or what problems they were working on. Darlene knew from the initial TBH training that this client ought to be receiving an evidence-based treatment for PTSD, such as cognitive behavior therapy. As Darlene slipped the printout into the client's case file and moved on to her next case, she thought to herself, "Now what?"*

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**A** fourth question is how to translate these screen results into clinical treatment. Clinical providers are a separate industry apart from child welfare. How do you get caseworkers and clinicians to talk with each other? Are there enough providers? Are there providers in rural areas? Are there providers who are equipped to handle children in this population? Are there providers who know how to treat trauma-related problems with evidence-based practices?

When a child is identified with an emotional or behavioral problem, the ideal resolution is that the child can be seen by a provider who is well-trained to handle that specific type of problem. Not every provider is best-suited for every type of problem. A very young child with PTSD needs a different treatment than an adolescent with first-break psychosis.

Prior to the implementation of the LCTP, there were few data available regarding the service arrays available to youths. One of the tasks every grantee was required to perform for these projects was to determine "the existence, reach, and quality of available behavioral and mental health screening, assessment, case planning and referral tools and processes." To that end, LCTP team members held many discussions with partner agencies (DCFS, Medicaid, and OBH) during the early planning period. We held six discussion groups involving >30 DCFS front-line caseworkers and managers. It became evident that Medicaid electronic service claims data was the most comprehensive database about services usage, but was severely limited to data on age, race, sex, level of care (e.g., inpatient vs. outpatient), diagnosis, number of inpatient re-admissions, and length of stays in hospitals. There were no data available on whether evidence-based practices were used in outpatient settings. Several evidence-based interventions are offered in limited areas of the state. These included multi-systemic therapy (MST) (for delinquent behaviors), Functional Family Therapy (FFT) (for delinquent behaviors and substance abuse), and Homebuilders (family preservation). Medicaid offered higher reimbursement rates for FFT and MST compared to other comparable services. It was not clear that stakeholders in all systems understood the evidence base of what MST, FFT, and Homebuilders have been tested for

(delinquency, substance abuse, or family preservation) and what they were not tested for (PTSD, depression, anxiety, other disruptive syndromes). Medicaid has data fields for MST and FFT, but it's not clear how reliably data on these are collected.

The Coordinated System of Care (CSoC), launched in March 2012, is an initiative of the state's four child-serving agencies—DHH, DCFS, DJJ, and Department of Education. Magellan Health Services was awarded the contract as the statewide management organization. The program targets youths 0-21 years of age who are at imminent risk of out-of-home placement. The services include Parent Support and Training, Youth Support and Training, Crisis Stabilization, Independent Living/Skills Building, and Short-Term Respite. At the time our project began, CSoC was active in 3 regions: Alexandria, Monroe, and Shreveport. Approximately 70 of the 220 active CSoC cases were child welfare recipients.

Lastly, it was common knowledge that many clinicians have received training on CBT for PTSD through various initiatives over the past decade but there has been no follow-up case consultation, and actual use of CBT was not monitored.

**Our analysis of the service array was that the array of evidence-based treatments was underdeveloped relative to other states. But the situation in the rest of the country was not much better.** It has been estimated that 54% of those with serious mental illness received no treatment at all in the past 12 months (Kessler et al., 2001). The percentages are likely even higher for less serious psychological problems. Yet, for those who receive treatment, treatment as usual in community clinics appears to provide suboptimal quality with outcomes inferior to controlled trials.

These troubling facts about the quality of treatment appear to be due to two major problems. **The first major problem for access to good care is the poor quality of psychotherapy in treatment-as-usual settings.** There is an enormous amount of evidence now that evidence-based treatments (EBTs) are usually more effective than treatment as usual in community clinics. Weisz and colleagues (2013) conducted a meta-analysis of 52 studies that compared EBTs head-to-head with usual care in youth samples. They found that while there were some instances in which usual care was as effective or better, the superiority of EBTs was widespread and consistent (Weisz et al., 2013).

Despite the enormous expenditure to disseminate EBTs in the last three decades, **few clients in community clinics actually receive EBTs.** In a 2009 review of the literature, the authors found that less than half of patients with a variety of disorders received EBTs, and even when an EBT was delivered, it was delivered suboptimally (Shafran et al., 2009). In one clinic, which was actually devoted to providing cognitive behavior therapy (CBT), of 150 adult patients with PTSD, only 28% completed a course of CBT (Zayfert et al., 2005). Because 80.0% of psychotherapists are solo practitioners (Curran, 2016), they are, as an industry, very difficult to train, supervise, and monitor.

### **CBT for PTSD Training**

Concurrent with the training of caseworkers to screen with the TBH and detect youths in need of clinical services, another aim of the LCTP was to enhance the service array in anticipation of greater referrals. Given the high rate of trauma exposure in child welfare populations and the expected high rate of PTSD (confirmed in Figure 1), the LCTP team opted to train clinicians in CBT, which is the most well-studied and well-supported evidence-based treatment for PTSD.

As described above, Learning Collaboratives are the most popular method for training in the trauma field, but we identified numerous barriers to using this method in this project. Learning Collaboratives are designed to change agency cultures, but the goal of agency culture shift is irrelevant when considering that 80% of psychotherapy businesses are solo practices (Curran, 2016). Learning Collaboratives are costly to the trainers, usually requiring three-day trips, hotel rooms, and time away from other responsibilities.

For this project, a different training model was created that could reach any willing solo practitioner with minimal travel, cost, and time involved for trainees and trainer. Clinicians who could be invited to our CBT trainings were identified by searching the online Medicaid behavioral health providers' online directory. Providers were also identified by asking local DCFS administrators and staff for lists of licensed clinicians and agencies to whom they regularly refer children for psychotherapy. Clinicians from publically funded behavioral health services clinics, ("Human Services Districts"), were also invited to the training.

A total of ten one-day trainings were offered, with at least one training in each of the nine state regions. The timing of the trainings coincided with the roll-out of training DCFS workers to use the TBH in each region. As part of the registration process, applicants agreed to complete at least one case using the CBT model and to attend weekly consultation calls for six to nine months to receive case consultation.

The LCTP trainer, Devi Murphy, PhD, trained clinicians in Youth PTSD Treatment (YPT; Scheeringa & Weems, 2014), an individually delivered, 12-session manualized protocol for youth, ages seven to 18 years, with PTSD. Youth PTSD Treatment (YPT) was chosen because of its highly structured, manual-based format that facilitates dissemination among novice CBT therapists. More details about the training process and outcomes are available in Murphy and Scheeringa (in press).

The **sidebar on this page** reports the number of clinicians invited to and the number/percentage who completed various levels of trainings.

In order to bridge the gap in communication between DCFS caseworkers and clinicians, LCTP trainers highly encouraged the use of the YPT-trained clinicians during the TBH training and subsequent site visits. Caseworkers were given printed rosters of clinicians within the region, and were also frequently shown how to access the rosters online through the LCTP website.

The aims of the LCTP were not focused on individual child PTSD treatment progress because of concerns about creating resistance among clinicians if they knew they would be required to complete extra paperwork. Data on the efficacy of the YPT delivered are therefore limited. Nevertheless, the trainer tracked 102 clients discussed during consultation calls. Of these, 64 (62.7%) successfully completed treatment and clinicians completed pre- and post-measures with 17. Of those for whom pre-post treatment data were available, all showed a reduction in PTSD scores by either caregiver or youth report. Further, 15 (88.2%) had a reduction in post-treatment PTSD score by at least a third of the pre-treatment score, including nine (52.9%) no longer meeting the cutoff for PTSD.

## Training Clinicians in CBT for PTSD

The LCTP team invited a total of 2,036 clinicians to the ten trainings.

Of those invited, 335 clinicians attended a one-day training.

Of those 335 who attended, 117 clinicians participated in follow-up consultation calls.

**Forty-five clinicians achieved Advanced Training.** Once a clinician had implemented the YPT protocol (completed at least seven sessions of the 12-session protocol) with at least one youth and had attended weekly calls to receive consultation on his/her case, the clinician was designated as having received Advanced Training in YPT and received certificates of completion.

**Thirty-eight clinicians achieved Basic Training.** Basic Training indicated that clinicians had attended at least five group consultation calls over a six-month period as they attempted to identify clients appropriate for the model. These clinicians participated in YPT case discussions, but did not complete their own cases using the model.

Thirty-four clinicians attended at least one consultation call but dropped out after one to two calls.

### Access to Any Provider Was the Biggest Concern

The second major problem for access to good care was lack of access to any provider, regardless of the quality of care provided. Very early in this project, we realized that the most common issues that caseworkers wanted to talk about with us was the lack of clinicians who would accept referrals. Yet, when one looked at the provider directories of the Medicaid insurance network, it appeared that many providers were available. We decided to systematically investigate the extent of the problem.

We instituted a mystery shopper project to investigate the actual extent of access to providers that existed in the Medicaid network of Louisiana. In this project, women on our team posed as a kin foster caregiver who was taking care of a nine-year niece or nephew with anxiety problems. We made a list of every individual and group provider listed on the Medicaid directories. We called every individual or group and asked if a new patient appointment could be made.

The main outcome data of this mystery shopper project are shown in Table 4, and we hope to make full details of the project available in a future publication. The brief summary is that the Medicaid online provider directories contained 2,643 listings of individuals or groups that accepted children. Nine hundred ninety-six of these listings however were duplicate listings. For example, if one individual worked at three different physical locations, this appeared as three listings, when in fact it is only one individual who is available to see patients. Four hundred seventy-six of the listings could not be contacted because the listed phone numbers were disconnected, wrong, or the individuals would not return voice mails. Four hundred sixty-one of the listings were not able to see our hypothetical nine-year patient because they either no longer accepted Medicaid or didn't actually see children. **That left a total of 674 providers in the entire state who accepted Medicaid and would see children, which represents 26% of the 2,643 listings.**

**Table 4. Number of Providers in Advertised Medicaid Networks Compared to Number of Unique Providers Who Actually Accept Youth Cases.**

Region	Number of Providers Listed on Insurance Websites	Number of Unique Providers (duplicate listings removed)	Number Who Met Criteria*
Covington	398	296	163 (41%)
Baton Rouge	231	173	83 (36%)
Lafayette	77	63	12 (16%)
Alexandria	83	57	23 (28%)
Monroe	167	113	74 (44%)
Orleans	525	394	114 (22%)
Thibodaux	594	139	70 (12%)
Shreveport	378	250	96 (25%)
Lake Charles	190	126	39 (20%)
<b>Totals</b>	<b>2,643</b>	<b>1,611</b>	<b>674 (26%)</b>

\*Met Criteria = a provider was reached by phone and was willing to provide an appointment for a youth with Medicaid (no matter how long the wait).

Reasons for listed providers to not meet criteria included that they could not be reached, they did not actually accept Medicaid, or they did not accept youths.

The American Academy of Child & Adolescent Psychiatry has estimated that the appropriate level of access for youths to child psychiatrists (i.e., MD's trained in this age group) ought to be 47 child psychiatrists per 100,000 youths. The most recent U.S. census reports place the number of youths in

Louisiana at approximately 1,200,000. In the LCTP mystery shopper project, we identified 79 child psychiatrists who met our criteria. This represents 6.6 child psychiatrists per 100,000 youths, which is seven times lower than the recommendation. There are no known comparable level-of-access recommendations for psychotherapists such as licensed clinical social workers or licensed professional counselors.

LCTP evaluators asked caseworkers about whether their client was able to obtain appropriate treatment. In terms of referrals, caseworkers indicate that child clients in the DCFS system who need PTSD treatment receive appropriate referrals approximately half of the time (mean of 4.74 on an 11-point scale; where 0 = none of the time, 10 = all of the time). In addition, CQI reviewers indicate that caseworkers are using the TBH data to make referrals to treatment in only one-third of the cases they reviewed.

### **Use of TBH Data to Track Change Over Time**

As noted earlier, DCFS caseworkers obtained repeat TBH screens on cases that remained open at six-month intervals. By tracking whether youths scored above validated cutoffs for the TBH subscales at two different time points, we can obtain estimates of whether youths are getting better, getting worse, or staying the same. Figure 2 illustrates this. Figure 2 shows the data for youths who had TBH screens completed when their cases were newly opened (T1) and then repeated after the first six months (T2). This represents a subset of all youths with repeated screens because some youths had screens repeated at 12 months or 18 months, and they are not included in Figure 2.

Figure 2 illustrates changes over time only for PTSD symptoms by caregiver report. Those who scored below the cutoff for PTSD at T1 and remained below the cutoff at T2 represented 83% of those who had two screens completed, and was by far the largest proportion of clients (blue slice).

Those who scored below the cutoff at T1 but were above the cutoff at T2 represented 8% (green slice). The presence of this subgroup suggests that these youths are becoming more symptomatic while in the care of the child welfare system. Because of this concern, we spoke with caseworkers to investigate a handful of these cases to untangle whether this was true or not. In some cases, there were ongoing or new stressors in the lives of the clients (external to the care provided by DCFS) which seemed to explain why they became more symptomatic (e.g., a teenager delivered a child). In other cases, the clients had not truly become more symptomatic. Rather, caregivers endorsed more symptoms for youths on the second administration because they had more time to get to know the youths and/or the youths became more willing to disclose their symptoms.

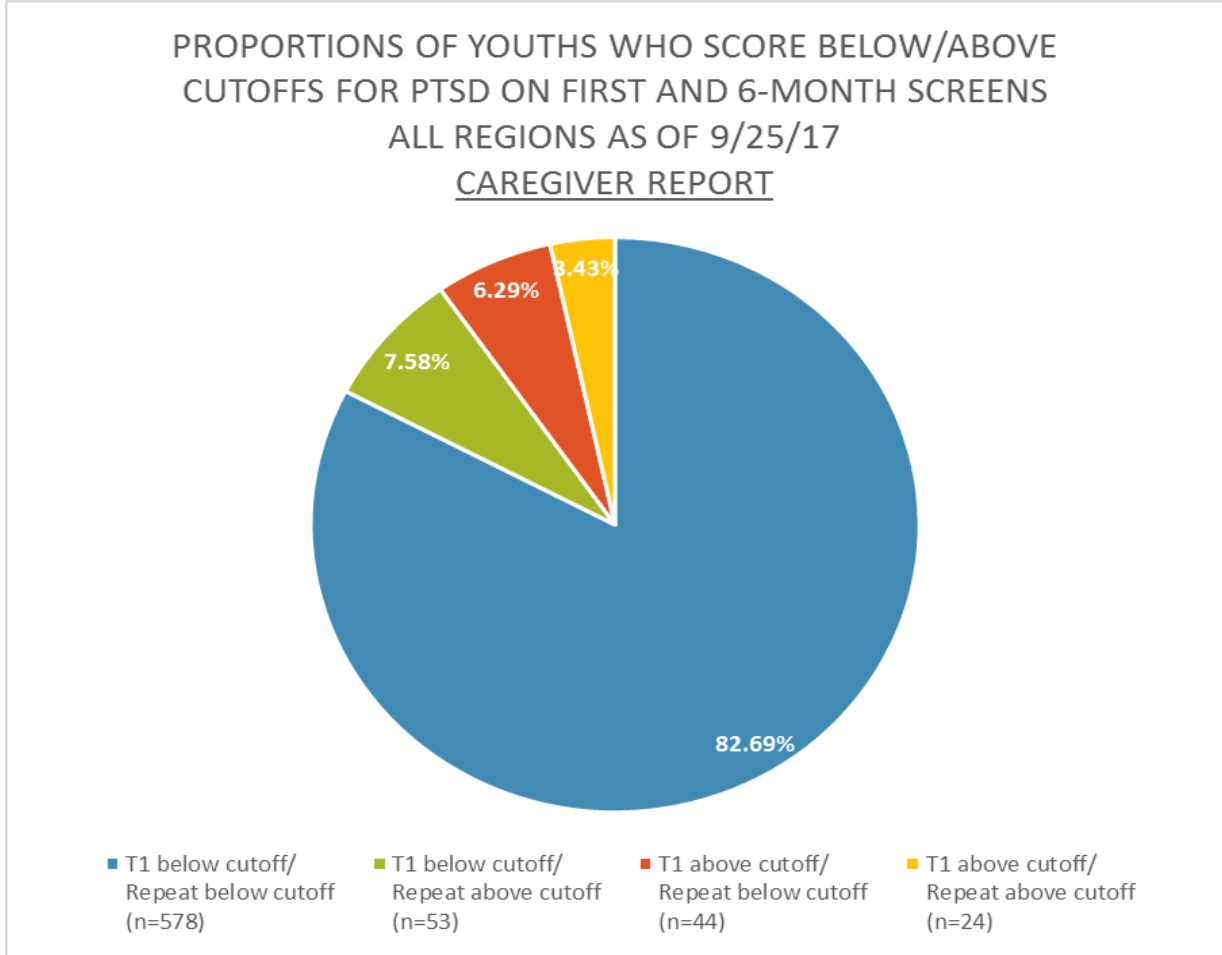
Those who scored above the cutoff for PTSD at T1 and scored below the cutoff at T2 represented 6% (red slice). The presence of this subgroup suggests that they are either naturally improving over time or they have received appropriate clinical interventions.

Those who scored above the cutoff for PTSD at T1 and remained above the cutoff at T2 represented 3% (yellow slice). The presence of this subgroup suggests that these youths may not be receiving appropriate interventions to ameliorate their PTSD symptoms.

Out of all 109 youths who scored above the cutoff for PTSD at T1, 79 of them (72%) improved and scored below the cutoff at T2, whereas 30 of them (29%) did not improve enough to score below the cutoff at T2.



**Figure 2. Repeat TBH Results for All Ages of Youths in All Regions With Two Caregiver Reports Separated by 6 Months.**



Note that the data in Figure 2 are from caregiver reports. Similar figures could be created for child report data or joint report data for PTSD, and could also be created for the Internalizing, Externalizing, and ADHD subscales, but are not included here due to space. The totals are lower than the number of repeats in Table 3 because (1) 0-2 yrs are not included in this table (their symptoms do not have to be reported); (2) this graph only includes screens that completed 80% of the questions pertaining to PTSD symptoms and (3) only screens completed within the 6-month interval of the initial screen are included.

## QUESTION #5: HOW TO DISSEMINATE RESULTS TO STAKEHOLDERS

**A** fifth question is how to disseminate the massive amount of data that can be collected from screening to all of the stakeholders. This is, of course, the same type of question that has been faced by all social welfare organizations, government agencies, public policy think tanks, and consumer advocate organizations for decades. There are several different types of groups that need to be reached including agency leaders, legislators who fund these programs, clinicians, judges, attorneys, school administrators, and foster parents, and different strategies are needed for each. All of those groups could not be addressed in the scope of this project.

### Regional Stakeholders

Our original model to engage stakeholders in every region included a strategy to create regional advisory boards that would meet in person. We successfully accomplished that in the first three regions, but this strategy ran into two problems that forced us to alter that strategy. The first problem was that the flow of information was mostly one-way. We provided information to the stakeholders about the project, but we did not have actionable tasks for them to work on, which limited their enthusiasm for additional meetings. The second problem was distance. We were able to arrange in-person meetings in those first three regions because stakeholders all lived close together. As the later regions were more rural and larger, it became apparent that it was impractical to expect stakeholders to drive long distances for a 1-hour meeting.

For the remaining six regions we altered our approach to reach out to stakeholders by email. We created a **series of 90-second animated videos** and sent links to the videos in emails. While this new approach lost the personal touch, it actually had the benefit of reaching more stakeholders. For example, instead of reaching five stakeholders in a region with an in-person meeting, we could send emails with links to our animated videos to nearly 200 stakeholders in the same region.

Six short animated videos were created that highlighted the objectives, progress, and research findings of the LCTP (**see sidebar this page**). The aim of these videos was to educate the stakeholders about the prevalence of PTSD in youths and the scope of our project. Stakeholder lists were a compilation of DCFS's original stakeholder contacts as well as extensive research into hundreds of community representatives and institutions related to the child welfare population and children affected by trauma.

DCFS administrators and managers were included in these emails so that they could distribute them to their regional line staff.

### Steering Committee

We formed a state-level **Steering Committee** that met quarterly for four years. The initial composition in 2013 included the director of child welfare, a representative from the Office of Behavioral Health, and a representative from Magellan Health. A Medicaid representative was added to

## Animated Dissemination Videos

1. Project Overview
2. TBH Results
3. Training Clinicians to use CBT for PTSD
4. What is CBT?
5. TBH Results, Part II: How Scores Change over Time.
6. The Mystery Shopper Project

Each video was approximately 90 seconds to keep the attention of viewers. The videos were created by student interns with GoAnimate.com software.

the Committee in 2016. This Steering Committee was a useful way to facilitate the planning of the project, as well as relevant policies and procedures meeting the project's missions and goals.

The **DCFS director of child welfare** was the key representative from DCFS. Through most of the project, this person was Rhenda Hodnett, LCSW, PhD. Over time, multiple other state-level DCFS administrators participated on the Committee as needed.

The **Office of Behavioral Health (OBH)** representatives were Jody Levison-Johnson, LCSW, Deputy Assistant Secretary for Children and Family Operations for 2013-2014, and then Connie Goodson, LCSW for 2014-2017. They were useful for facilitating the sharing of data on service usage through the Medicaid program and providing knowledge about the service array and availability of specialized programs.

The **Magellan Health** representative was Foley Nash, PhD for 2013-2015. Dr. Nash was useful for sharing data on service usage and answering various questions about insurance network issues. In 2016, the administration of the Medicaid system changed drastically with Magellan being replaced by five separate insurance networks. In 2016, representatives from two of these five networks (Amerigroup and Louisiana Healthcare Connections) briefly joined the Committee.

### **National Dissemination**

From the beginning of the project, we made all of our products and results publicly available on a website that was created and hosted by Tulane University. In the final year of the project, we contracted with a local professional website development company to create a more advanced website. This website includes our training materials, an online directory of clinicians trained in YPT, links to download the TBH, access to electronic data entry for the TBH for caseworkers and clinicians, interactive graphs of our main results for every region, and an online training portal for CBT for young children with PTSD.

In the final year of the project, we created this white paper to serve as a free, easily accessible document of the history and accomplishments of this project. We had noticed that many initiatives had been conducted on related topics over the years by various groups, but there were never historical records of what had been tried or accomplished.

### **THE BENEFITS**

**T**he key products (e.g., training manuals, resource guides for participants, etc.) that were developed as part of the project are briefly listed below.

1. TBH (Caregiver and Child version): DCFS will continue using the TBH screens, which will remain free and available to the public.
2. "What is Trauma?" rack cards: At the request of Covington, the project's pilot region, a rack card was made to inform individuals of trauma and the symptoms of PTSD. DCFS staff were asked to place these rack cards in their waiting rooms or distribute them to caregivers and relevant agencies.
3. Quick Reference Guide: This one-page document was included in the training packet to DCFS caseworkers to summarize the main points in the administration of the TBH, as well as how and where to access the necessary website and resources.
4. TBH Training PowerPoint: This PowerPoint was used in all of the TBH trainings. It informed caseworkers of the prevalence of trauma, how and when to administer the TBH, and the recommended evidence-based therapy for PTSD. It has been modified and annotated so DCFS trainers can knowledgeably train incoming caseworkers.
5. TBH Training Videos: During the TBH trainings and site visits, Tulane presented several training videos to aid DCFS caseworkers. Two initial training videos were produced to inform caseworkers about LCTP,

trauma, and the TBH. Additionally, Tulane also provided three live video recordings of patients being interviewed with questions very similar to the TBH; these videos provided insight into how to sensitively administer the TBH interview-style. All of these videos have been updated for sustainability. The first two training videos were ultimately consolidated into one video, and excludes mention of the LCTP as an ongoing project; the new video instead reflects the official implementation of the TBH into DCFS policy. The three live video recordings were animated at the end of the project to maintain confidentiality of the original subjects.

6. LCTP Website: LCTP's website ([latrauma.com](http://latrauma.com)) provides a central location for all resources necessary for DCFS caseworkers, including materials, FAQs, and videos. Because the website will be left up indefinitely, Tulane is currently working to ensure that the website, and all links and materials on the website, are updated, relevant, and convenient for caseworkers after the project ends. For example, Tulane will confirm that contact information for all trained clinicians is up-to-date; the FAQ will include new, helpful questions that we have gathered from recent TBH trainings and site visits; information for foster parents is available, and resources will be easier to find.

7. Online database entry site: The online database entry site was created so caseworkers could enter in the TBH electronically, and receive a TBH results page with the child's clinical scores for referral. DCFS will eventually integrate the website into their own website, modifying it so caseworkers can enter in identifying information. The plan is to integrate the TBH data base in to the CCWIS system currently being developed.

8. Moodle training for DCFS caseworkers: The online Moodle training is intended to be used by caseworkers who were unable to attend the TBH training. Completing the Moodle training allowed caseworkers to receive 1.5 credits.

9. Six animated videos for dissemination of LCTP results.

10. Rosters of clinicians that we trained in CBT for PTSD.

## LIMITATIONS AND LESSONS LEARNED

The LA child welfare system, namely DCFS, is continually challenged to respond to the needs of children and families in a deeply impoverished state where allocations for child welfare services are limited. In 2009, LA Children's Protective Services workers handled an average of 101 reports per worker, compared to the national average of 70. The number of total intake, screening and investigations workers in LA relative to the total state population of children is approximately 20 per 1,000 children; conversely, the national average is nearly two and a half times that, with over 48 workers per 1,000 children (Children's Bureau, 2010).

The challenges for implementation of the TBH screen included high staff turnover, higher-than-the-national-average caseloads, limited manpower within DCFS to help with dataset issues, poor access to clinicians, frequent changes in administrators and agencies, and the occasional natural disaster.

In November 2014, one year into the LCTP, Magellan learned that its contract with the state would not be renewed and their administration of the Medicaid program would end on December 1, 2015. As Magellan's priorities abruptly shifted and many of their employees were terminated or left for new jobs, no additional progress was made on obtaining data on medication usage with Magellan. With this shift in strategy, we took the opportunity to roll psychotropic medication into the new Data Sharing Agreement with Medicaid. Kerri Lea of Medicaid was able to identify the variable names of the available data. We had anticipated receiving the first data feed in late April 2017, but this had not occurred as of the data of this report (October 2017). The delay in the data feeds appears to be due to limited manpower and the relatively low priority for this task within Medicaid.

The challenges for reconfiguring the service array included a limited culture of evidence-based clinical treatments across the state, inflexibility of Medicaid networks to try innovative strategies, use of a manualized EBT is not common in the current practices of most clinicians, dependence on voluntary cooperation of clinicians, many private practice clinicians who work in a fee-for-service model that does not incentivize the use of EBT's, and clinic agencies that are reluctant to release clinician time for weekly consultation.

A major lesson learned for dealing with these many challenges was that commitment by DCFS leadership was critical to our successes. DCFS committed two staff on a daily part-time basis to facilitate all aspects of the implementation. This unwavering commitment of DCFS to this project at the highest levels and a chain of command structure allowed the workforce to pivot rapidly to new responsibilities.

## CALL-TO-ACTION

**T**hrough the forward thinking of the Children's Bureau, in partnership with the leadership of the DCFS of Louisiana, this project has created a comprehensive screening program for the emotional and behavioral needs of youths in the child welfare system. **Given that Louisiana is a state-wide child welfare system, and many other states are county-wide programs, Louisiana currently may have the largest universal child welfare screening program for mental health issues in the nation.** This is not only a major advance for Louisiana, but provides a rich database for the entire nation. As the inevitable budget cuts and pressures to streamline programs arise in the future years, we urge stakeholders to remember the national value of this program.

More, however, can still be done to build on and expand the current accomplishments:

- DCFS would benefit from a data analyst dedicated to managing TBH data and integrating the data with other agency data.
- Expanded and updated dissemination of data to stakeholders.
- More linkage of data to actual clinical services and outcomes is needed. As the LCTP neared completion, the first-ever data sharing agreement between Medicaid and DCFS was being finalized. TBH data needs to be linked to Medicaid service claims data to determine if the appropriate children are receiving services and if services are producing symptom reductions.
- More training in EBT's needs to be conducted. We have shown the feasibility of training clinicians on CBT for PTSD.
- Oversight of fidelity to EBT's needs to be created. Training is only useful if clinicians take the training back to their offices and consistently and faithfully implement the new techniques.
- Incentivize clinicians to provide EBT's. Innovative models are needed to help clinicians take the next step and move from practice as usual and take advantage of the tremendous scientific advances in treatment in these areas.
- Most importantly, DCFS caseworkers need continued training on a variety of mental health issues to help them learn best how to use these screen results to connect to the right types of providers so that youths get the treatment they really need, not just any treatment by any willing provider.

DCFS cannot, and should not, accomplish all of these tasks alone. Successful execution of these tasks will require cooperation between legislators, insurance networks, Medicaid administrators, OBH, community clinicians, and other key stakeholders as needed.

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