Bridging the Gap: MOVING TOWARD EVIDENCE-BASED PRACTICE

Reports of Learning Communities:

Addictions
At-Risk/Prevention
Developmental Disorders
Externalizing Disorders
Internalizing Disorders
Trauma/Post Traumatic Stress Disorder

2007-2008
Executive Summary

From June 2007 through May 2008, six learning communities met for six months each to address the issues related to the diagnosis areas of Addictions, Externalizing Disorders, Internalizing Disorders, Trauma/Post Traumatic Stress Disorder, Early Childhood/Prevention and Development Disorders. Their task was to study research on psychosocial intervention for children and adolescents; assess the community in terms of needs, barriers and policies; and recommend a pilot project to implement within their diagnosis area.

Each community had a volunteer agency champion who helped review the research that each group would read and discuss. In addition, each group was provided a professional facilitator through The Harral Group to plan agendas and support the volunteers as they worked to achieve their goals. Lee LeGrice, PhD, Lena Pope Home, and Patsy Thomas, Mental Health Connection, served as ex-officio members of all learning communities and oversaw the work of all groups. Dr. LeGrice assisted each group in selecting its research articles.

A learning community is a community group of professionals and advocates who are united in their commitment to exploring, educating and advocating around an issue. It shares a vision, works and learns collaboratively, reviews new knowledge, and participates in decision-making. The benefits to the community include increased knowledge of professionals regarding issues, creation of new programs to address gaps in services in our community, and the hope for a better-informed consumer of services. A learning community may be viewed as a proactive agent of change for our community.

In the following reports, each learning community:
• Reviews research
• Identifies needs
• Recommends a pilot program to address needs
• Assesses barriers to implementation
• Recommends needed policies
• Outlines an implementation and action plan
• Makes recommendations for continuing to share information

These reports are being presented to the community with the hope that they will lead to the full funding and implementation of the pilot projects in each area. The end goals are more effective treatments and more knowledgeable consumers.

1 A review of the psychopharmacology research was not included in the work of the Learning Communities.
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Mental Health Connection of Tarrant County

Addictions

Substance Abuse
Eating Disorders
RECOMMENDED PILOT PROGRAM

The Addictions Learning Community recommends a High School Alcohol Diversion Program, based on a Campus Drug Court model, as a pilot project. This program would offer students with alcohol violations an alternative to being removed from their home schools and placed at alternative schools. The program would provide campus-based screening, assessment, intervention, and – if necessary – a referral to residential treatment.

EXECUTIVE SUMMARY

The Addictions Learning Community spent six months evaluating the research on addictions in children and adolescents. Addictions are defined by the National Institute on Drug Abuse (NIDA) as “a chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences. It is considered a brain disease because drugs change the brain’s structure and the way it works. These brain changes can be long lasting, and can lead to the harmful behaviors seen in people who abuse drugs.”

After a careful review of the literature, current policies, and programs that impact underage drinking, the Addictions Learning Community strongly felt that there was an obvious gap in services for youth involved in underage drinking. Another gap occurs because there is a community “norm” that minimizes the seriousness of alcohol use among adolescents. Underage drinking, according to the articles reviewed, carries significant consequences. Below are just a few of the emerging concerns:

- The average age Tarrant County youth begin drinking is 11.6.
- Alcohol accounts for 30-40% of hospital admissions each year.
- Drinking teens have a 10% smaller hippocampus and perform 10% poorer on memory, geometry and IQ tests.
- In a 2006 survey, approximately 37% of Tarrant County youth reported they had used alcohol in the month prior to the survey.
- Youth who begin drinking before age 15 are four times more likely to become alcoholics.
- 7,800 youth try alcohol for the first time every day.
- Female teens who drink are 63% likelier to become teen mothers.
- Alcohol is the leading contributor to death from injuries among those under 21.
- Alcohol leads to an alteration of brain structure and functioning of the developing brain, leading to consequences beyond adolescence.
- Alcohol is associated with academic failures, illicit drug use, tobacco use and medical problems.
- Alcohol increases the risk of committing or being a victim of a physical or sexual assault.
- Alcohol affects how well a young person judges risk and makes sound decisions.
- Alcohol plays a significant role in risky sexual activity.
- Texas leads the country in the number of drunken-driving fatalities, with 1,354 deaths in 2006 due to drunken driving as of July 2007. (Department of Transportation, 2007)
Learning Community Members:

- Jennifer Gilley, Tarrant County Challenge, Inc. - Agency Champion
- John Haenes, Tarrant County Challenge, Inc. - Agency Champion
- Ellen Crowl - Facilitator
  - Jenny Black, Lena Pope Home, Inc.
    - Joseph Burkett, M.D., MHMR Tarrant County (MHMRTC)
    - Angela Ceglar, Santa Fe Adolescent Services
    - Nick Damon, Lena Pope Home, Inc.
    - Daryl Dulaney, Volunteers of America
    - Trevor Gates, MHMRTC
    - Ed George, Harris Methodist Fort Worth
    - Estrella Griggs, Santa Fe Adolescent Services
    - Erin Kauffman, Lena Pope Home, Inc.
    - Monica Kintigh, TCU Counseling Center
    - Danica Knight, TCU Institute of Behavioral Health
    - Holly McFarland, Tarrant County Challenge, Inc.
    - April Mitchell, Senator Kim Brimer’s office
    - Jennifer Pankow, TCU Institute of Child Development
    - LuAnn Pelletier, Tarrant County Juvenile Services
    - Wesley Rangel, Excel Center
    - Mary Anne Smith, MHMRTC - Tarrant Youth Recovery Campus (TYRC)
    - Diane Snow, Ph.D., UTA School of Nursing
    - Greg Sumpter, Tarrant County Juvenile Services
    - Patricia Sylve, MHMRTC-TYRC
    - Kathleen Trello-Rochelle, MD, MHMRTC
    - David Woody, Ph.D., Catholic Charities

Summary of Research on Addictions

Preface to the Jar Sp Treatment Outcome Studies for Adolescents

The adolescent component in Drug Abuse Treatment Outcome Studies (DATOS) was the first designed specifically to conduct an in-depth, systematic investigation of the outcomes and effectiveness of drug treatment programs for adolescents.

The effects of Drug treatment on Criminal Behavior among Adolescents in DATOS

The primary goals of this study were to assess the effect of substance abuse treatment on adolescent crime and to identify the patient characteristics that were most closely associated with reductions in crime during the post treatment period. Results confirmed that among adolescents who had engaged in criminal activity during the 12 months prior to entering DATOS-A treatment, reductions in alcohol or marijuana use were independently associated with significant reductions in the likelihood of committing crimes during the 12-month follow-up period.

This report is structured as a public health strategy planning report and is organized into initiatives within which the Physician Leadership on National Drug Policy (PLNDP) has identified policy recommendations and priorities for further research. This report introduces the statistics around adolescent substance abuse and looks at key elements such as prevention, screening, assessment, treatment and recommendations for policy.

**Substance Abuse and the Adolescent Brain: An Overview with a Focus on Alcohol, Aaron M. White, Ph.D. (2004)**

The purpose of this summary is to briefly discuss recent findings regarding adolescent substance use, adolescent brain development and the impact of alcohol on adolescent behavior and brain function.

**Drugs, Brains and Behavior: The Science of Addiction by National Institute on Drug Abuse, National Institutes of Health (April 2007)**

This article aims to fill the knowledge gap by providing scientific information about the disease of drug addiction, including the many harmful consequences of drug abuse and the basic approaches that have been developed to prevent and treat the disease. The National Institute on Drug Abuse (NIDA) believes that increased understanding of the basics of addiction will empower people to make informed choices in their own lives, adopt science-based policies and programs that reduce drug abuse and addiction in their communities, and support scientific research that improves the nation's well-being.


Social anxiety in youth, but not other anxiety or mood disorders, seems to set the stage for marijuana or alcohol dependence. So treating adolescents with social anxiety might reduce such dependence. Individuals who are socially anxious often use alcohol or marijuana to calm their nerves. But can social anxiety actually predispose people to marijuana or alcohol dependence? The answer seems to be yes, based on a large prospective study by N.B. Schmidt, Ph.D., a professor of psychology at Florida State University, and colleagues.

**Evidence-Based Programs Identified**

- Screening, Brief Intervention, Referral, and Treatment model (SBIRT)
- CRAFFT screening tool
- Communities that Care
- Cannabis Youth Treatment
- Community Anchors (St Louis)
- Drug Court Model
- Strategic Prevention Framework
- Trauma Informed Services
- 3 in 1 Framework (alcohol)
- Motivational Interviewing
- Motivation Enhancement Therapy (MET)
- Trauma Adolescent Tool kit
- Seeking Safety
- Adolescent Transitions Program,
- Cognitive Based Therapy
- Pharmacotherapy
- Campus Drug Court
Specific Areas of Need in Tarrant County Related to Addictions

After a careful review of the literature, and current policies and programs that impact underage drinking, the Learning Community strongly felt that there was an obvious gap in services for youth involved in underage drinking as well. This is also a community “norm” that minimizes the seriousness of alcohol use among adolescents. Underage drinking creates significant needs in our community. The needs the learning community identified are:

• Early onset of drinking behaviors among youth (Tarrant County: 11 years 6 months).
• Earlier identification/ screening of alcohol issues are needed. Often times, the youth has to enter the juvenile justice system before an assessment is completed.
• An early intervention strategy is needed to prevent youth from further incursion into alcohol addiction. Currently, these youth are given a citation and possible expelled form school, but intervention or treatment if often not offered.
• Access to treatment/intervention services, compliance in attending programs and transportation to physically get to a program are significant obstacles/needs of adolescents with alcohol issues.
• There is still a significant “stigma” issue about attending treatment/intervention for addiction issues.
• Currently, a student with an alcohol violation (if occurring on school property or at a school function) is third-partied to an alternative school for a period of time. We need a response to alcohol violations that address the problem but don’t interrupt a student’s education.
• Need to influence the drinking culture that minimizes the seriousness of alcohol and adolescents (the “it’s just alcohol, not drugs” message/ culture).
• Need for information/education about the medical dangers of alcohol (effect on brain development) and the problems associated with alcohol (sexual activity, trouble with the law, accidents, etc.).

Tarrant County, like many other communities, must initiate a change in the social environment to address the issue of high-risk drinking. Currently, the general public and under-age drinking youth view high-risk binge drinking as a problem with few repercussions more serious than a hangover. Changing the perception of high-risk drinking from a rite of passage to a public health issue fraught with immediate, long-term, negative ramifications is critical to the successful implementation of any prevention, intervention or treatment among our youth. It is our hope that the High School Alcohol Diversion Program will assist our community in changing this “norm” and providing much needed prevention, intervention and treatment with our youth.

Recommended Evidence-Based Practice or Program for Addictions

The Addictions Learning Community recommends an Alcohol Diversion Program, based on a Campus Drug Court model, as a pilot project in Tarrant County. This program would offer students with alcohol violations an alternative to being removed from their home school and placed at alternative schools. The program would provide campus-based screening, assessment and intervention, as well as a referral to residential treatment if necessary. The incentive of maintaining their academic progress and social support at their home school would serve as the initial motivation for being in the program. The program would include:

• Education on the dangers of underage drinking
• Development of pro-social activities
• Improvement in communication and problem-solving skills
• Identification of needs that might be having an impact on the youth (such as mental health issues, parental engagement issues, and unresolved trauma)
An Alcohol Diversion Program would address the following:

- The community is not currently addressing underage drinking thoroughly, leaving an obvious gap in which hundreds of children are lost each year.
- There are drastic consequences associated with underage drinking, as well as a significant cost to the community.
- The program addresses the problem in a non-punitive way that seeks to provide much-needed intervention and treatment services.
- The campus-based program is easily accessed, alleviating the need for transportation and reducing the stigma associated with formalized treatment centers.
- The program incorporates motivational strategies to increase an adolescent's readiness to change and a series of incentives and sanctions to insure continued compliance.
- The program involves parents by offering them education and skill development on such issues as anger management, communication skills and alcohol education.
- The program works with one family at a time on changing the social norms regarding alcohol and adolescent development.
- The program would impact the social norms regarding alcohol use within the student body.
- The program would prevent disruption in academic performance as youth would not have to be expelled to alternative school settings, many of which do not offer the same courses the student is currently enrolled.
- The program has the potential to reduce or eliminate fees parents typically have to pay associated with alcohol citations.
- The program works to develop peer advocate systems that would increase positive support systems for youth.

The weaknesses identified by the Addictions Learning Community include:

- Referral to the program is still dependent on youth being identified through an alcohol violation, thus not addressing youth who are using alcohol but who have not been caught at school or at a school function. Creating a self-referral process to the program may mitigate this weakness.
- Although the Drug Court Model has proven to be very effective for juveniles with addiction issues, this program has typically centered on judicial systems rather than municipal or school systems. It is anticipated that motivational enhancement and significant incentives will support positive outcomes.
- The program requires parental involvement, which can be difficult to obtain but is necessary. The Learning Community hopes the motivational enhancement component of the program will engage parents in participating. Once involved, the development of various skills in managing adolescents and the knowledge of how detrimental alcohol use is for adolescents will keep parents engaged.

Clearly, there is a benefit to our community in addressing the number one health problem for adolescents in a way that increases knowledge, develops functional coping mechanisms, improves parent-child relations and addresses the harmful norm that underage drinking has few consequences. This program has the additional benefit of impacting underage drinking directly, which reduces the negative impact on adolescent brain development and maximizes a youth’s opportunities for the future.
**Barriers to Effective Implementation**

The anticipated barriers to the pilot project include the following:

- Schools may be resistant to the program as many school districts are hesitant to admit that their students may have issues with substance abuse.
- There must be an investment among school districts, school resources officers, community prevention and intervention agencies of money, time and staffing.
- There is a “community norm” regarding alcohol, which diminishes the risks the community associates with underage drinking (“just a few beers” mentality, alcohol as a rite of passage, not perceived as serious a problem as “drugs”).
- There exists a “zero tolerance” viewpoint among some agencies and school districts that has dictated policy regarding alcohol violations. Work needs to be done to help the community see that prevention and treatment are better options than just enforcement.
- Existing policy requires mandatory alternative school expulsion for alcohol violations.
- Loss of revenue from citations.

The solutions for these barriers could be achieved through the following:

- Educate school districts, law enforcement and the community on the impact of alcohol on adolescents and on the effectiveness of prevention, intervention and treatment.
- Emphasize to school districts and the community that the educational progress of students suffers with removal to alternative schools and that it is possible to develop and implement on-campus programs that are highly effective in changing problematic behaviors.
- Provide funds and services to the high school for addressing alcohol problems.
- Work with school districts on minimizing the time frame for mandatory expulsion to an alternative school.

**Needed Policies to Support this Recommendation**

The Texas Education Agency has a mandatory expulsion policy for drug/alcohol issues. It is suggested that a waiver or variance be requested for the campus willing to pilot this program. If that is not a possibility, there are some ways in which the policy can be “worked around,” including:

- Citation not completed pending acceptance into the Diversion program. If student refuses to attend, then the citation can be processed.
- Address the school districts’ time frames for alternative school expulsion. For example, shorten the mandatory time in alternative school to one day and then the student could return to the regular classroom and begin the Diversion Program.
Community-wide Implementation and Action Plan

The Addictions Learning Community recommends the following action plan for implementation of this pilot project:

• Addictions Learning Community volunteers will present the pilot program idea to targeted groups: Mental Health Connection on December 10th, MADD, Under-age drinking coalitions, ISD drug/alcohol counselors.
• Create a stakeholder group to take primary ownership of the project (interested schools, treatment and prevention providers and community volunteers).
• Identify school districts that are proactive in addressing addiction issues and have a history of working in collaboration with providers.
• Present to municipal judges to find a municipality that would be willing to participate in the program.
• Develop PowerPoint for all Learning Community volunteers to use in presenting to various community groups.

Strategies for Keeping the Knowledge Current and Widely Shared

The Addictions Learning Community has two recommendations to keep knowledge about addiction issues current and shared.

1 Fully utilize the newly developed blog on Mental Health Connection’s website. By accessing this blog, professionals and other interested parties from our community and from across the globe will have access to up-to-date information, emerging trends and statistical data that will positively impact how addiction issues are addressed. Members of the Addictions Learning Community will post new research, new evidence-based treatment programs and evaluation results from the addictions field. On-going dialogue will keep the Learning Community connected and informed, thus resulting in a higher standard of professionalism.

2 Maintain an ongoing Addictions Learning Community, with each interested agency taking responsibility for facilitating a meeting, researching new articles and presenting new evidence-based programs. Policy issues will be addressed, materials reviewed and strategies for change developed. The Learning Community hopes to continue meeting quarterly.
Recommended Pilot Program/Practice: The At-Risk/Prevention Learning Community recommends a countywide Cultural Competence Advisory Team to create responsive approaches to caring for diverse families in the community.

Executive Summary

The At-Risk/Prevention Learning Community began by reviewing the way research defines “at-risk” and “prevention of mental health issues.” In addition, a review of research regarding “risk and protective factors” was key in a discussion of the concept of prevention. The group began considering the specifics for project selection, including target population, specific risk/protective factors and evidenced-based programs/practices. Interests were very diverse as most in the group carried a particular “passion” for a specific area of focus. In reviewing the research, it also became clear just how multi-faceted and interconnected this concept of “prevention” is. A common theme did emerge: Effective prevention efforts are systemic and “all components are interrelated, and so the effectiveness of any one component is related to the availability and effectiveness of all other components” (Systems of Care: Framework for System Reform in Children’s Mental Health). Consequently, the group turned its focus to research on effective “systems of care.” In reviewing the Center for Mental Health Services’ (CMHS) evaluation of fourteen System of Care communities, a number of common barriers emerged. Chief among them was a consistent weakness in cultural competence at different levels of those systems. These findings were consistent with other research articles regarding effective implementation of evidence-based prevention programs.

Consequently, this learning community took on the task of reviewing articles that addressed culturally competent practices at both the practitioner and systemic levels. Members of the Learning Community had experiences that were consistent with the research findings. These findings held true regardless of the specific target population, risk/protective factors or evidence-based program or practice. Cultural competence is critical for positive outcomes. As cultural competence research was reviewed, the Learning Community especially noted the following findings:

- Implementing cultural competence is a complex, non-linear, multi-level process involving different levels within the system, as well as interactions with the community and other social services agencies.
- To bring about coherent, systemic and sustained change related to cultural competence, all three of the following need to be addressed:
  - Authority or policymaking level,
  - Organization/agency level and
  - Individual clinician or provider level.
- Cultural competence must be sufficiently integrated into organizational structures and functions to demonstrate long-term impact.
- Embedding cultural competence in a quality-improvement framework helps to ensure that such an initiative is lasting and ongoing, as opposed to an isolated or time-limited activity that is geared to only one part of a system.
Cultural competence is a critical factor in the successful implementation of evidence-based practices. Cognizant of the fact that there is no universal definition of “cultural competence,” the working definition for the purpose of this discussion is: “The integration and transformation of knowledge, information and data about individuals and groups of people into specific clinical standards, skills, service approaches, techniques and marketing programs that match the individual’s culture and increase the quality and appropriateness of mental health care and outcomes.” Evidence-based practices must be congruent with the cultures, values and help-seeking behaviors of those who would be recipients of such practices.

Learning Community Members

• Virginia Hoft, Santa Fe Adolescent Services - Agency Champion
• Carlela Vogel - Facilitator
  • Joan Barcellona, Parent
  • Lou Brewer, Tarrant County Public Health Department
  • Debby Butler, Tarrant County Juvenile Services
  • Pat Cheong, United Way
  • Pamela Davis, Community Solutions of Fort Worth
  • Danna Diaz, Fort Worth Independent School District
  • Trevor Gates, AIDS Outreach Center
  • Kelly Mays, MHMR of Tarrant County
  • Kenny Morgan, Lena Pope Home, Inc.
  • Stephanie Norton, All Church Home for Children
  • Barbara Perry, MHMR of Tarrant County
  • Vanessa Quach, Santa Fe Adolescent Services
  • Kristen Rice, Texas Christian University
  • Jorene Swift, Broadway Baptist Church
  • Vicki Warren, Community Solutions of Fort Worth
  • William Wright, Catholic Charities

Summary of Research on At-Risk Prevention

*Cultural Competence in Services to Children and Families (Focal Point, A National Bulletin on Family Support and Children’s Mental Health.)* (Summer 2003) Vol.17, No. 1, Pages 21-23. (Regional Research Institute for Human Services, Portland State University)

This article defines cultural competence as the services that honor a family’s beliefs and ways while also effectively addressing the needs the family has and gaining knowledge about culture and engaging in a comprehensive process. The report outlines strategies for implementing cultural competence, approaches to implementation and model steps to take during this process to move research into practice.


This article defines cultural competence as striving to always preserve and enhance the interests, dignity and integrity of children, families and the diverse cultural communities in which they live. The example used in this article concentrates on identifying the strengths of African-American communities, families and children. Research studies are conducted and the global findings are explained in the article.
Cultural Competency: Measurement as a Strategy for Moving Knowledge into Practice in State Mental Health Systems. Final Report (September 2004) National Technical Assistance Center for State Mental Health Planning (NTAC), National Association of State Mental Health Program Directors (NASMHPD)

The article defines cultural competence as implementation of a complex non-linear multi-level process involving interaction with the system and community. The article concentrates on cultural competence within the context of providing services to children and families.

Using a Book Club to Confront Attitudinal Barriers and Other “isms” National Center for Cultural Competence, Georgetown University Center for Child and Human Development, 3307 M Street, N.W., Suite 401, Washington, D.C. 20007

The article brings a uniquely family-oriented perspective to the system of care to assist families in navigating the mental health and other systems. The book club concept is presented as a catalyst for learning and change through an open discussion about the experiences of the many cultural groups.

Systems of Care, A Framework for System Reform in Children’s Mental Health. Issue Brief prepared by: Beth A. Stroul, M.Ed., National Technical Assistance Center for Children's Mental Health, Georgetown University, Child Development Center. In Partnership with Child, Adolescent and Family Branch, Center for Mental Health Services and SAMHSA

The article reviews and re-examines the system for children's mental health. There are four questions addressed in the article, concentrating on the type of system reform, the meaning of the system of care concept, why the system of care concept and philosophy should continue to be used as a framework of system reform, and how the system reform goals can be achieved.

An Analysis of Implementation of Systems of Care at Fourteen CMHS Grant Communities, (Robert Paulson, Dean Fixsen and Robert Friedman. Louis de la Parte Florida Mental Health Institute, University of South Florida, Tampa, Florida. (July 16, 2004)

The article presents a national evaluation of 14 community mental health services for children and their families, including an analysis of the collected data. The interpretation of the different grant communities, along with the demographic and other data, are explained throughout the article. There is also discussion of the importance and influence of the theory of change with the community, both for professionals and those served.

Prevention of Mental Disorders, Effective Interventions and Policy Options, Summary Report, A Report of the World Health Organization Department of Mental Health and Substance Abuse in collaboration with the Prevention Research Centre of the Universities of Nijmegen and Maastricht, World Health Organization, Geneva

The article describes evidence-based prevention mental health programs as well as existing risk and protective factors. Included are explanations of macro strategies that can improve the quality of life. The various components detailed throughout the article describe complex as well as fairly simple programs. Another part of the article describes techniques to enhance resilience and possible steps to be taken.

Identifying and Selecting Evidence-Based Intervention. Guidance Document for the Strategic Prevention Framework, State Incentive Grant Program, Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Prevention (January 2007)

The purpose of the article is to provide a guide for a strategic prevention framework, as well as the way to identify and select evidence-based interventions. The five steps of SAMHSA's Strategic Prevention Framework (SPF) are described, focusing on two analytic tasks within the SPF. The logic model and the importance of evidence-based programs for proven strategies are reviewed.
Community-Based Prevention Using Simple Low-Cost, Evidence-Based Kernels and Behavior Vaccines
Dennis D. Embry, Ph.D., PAXIS Institute

The article discusses examples of evidence-based “kernels and behavioral vaccines” that can be easily promoted across entire communities using social marketing principles. These examples can possibly provide low cost vaccines and act on core principles of prevention with risk and protective factors.


The authors examine and explore the difficulties and challenges related to the implementation of evidence-based treatment interventions into direct practice. The stages of implementation are broken down and described in detail, along with the core implementation components.

Recommended Evidence-Based Practice or Program for At-Risk/Prevention

In September 2004, the National Technical Assistance Center for State Mental Health Planning of the National Association of State Mental Health Program Directors issued a report on cultural competence. It outlined the rationale for implementing cultural competence; the approaches to implementation, including the measurement of cultural competence as a strategy; and steps that a state mental health director can take to move the cultural competence agenda from research into practice.

The steps outlined below were developed as a guide for states to use in measuring system readiness and progress. The Learning Community adopted this plan for a “Tarrant County System Change Strategy” because the action plan elements were easily tweaked to fit a smaller system of care, such as Mental Health Connection. These key activities and recommendations provide a roadmap in the development of a culturally competent system of care. Also included in the plan is a means to develop a “menu of baseline performance indicators” to measure progress and outline needed improvements. The inherent assumption is that the more these activities are implemented, the more the system moves forward with a culturally competent agenda.

- The leadership of the Mental Health System of Care (SOC) should personally lead the cultural competence initiative. To effectively develop such standards, key stakeholders must accept cultural competence as both a goal and a developmental process. System of Care leaders should lead by example within their own agencies, demonstrating to their boards of directors, members and other community stakeholders that cultural competence is a priority in providing quality mental health services. This allows the message to become embedded in a quality improvement framework that will permeate the entire mental health system. These efforts require:
  - Public commitment to a cultural competence initiative;
  - Leadership commitment to diversity at all levels of the System of Care;
  - Inclusion of cultural competence in the vision and strategic plans for the SOC and respective agencies/organizations;
  - Staff and financial support of key strategies for implementation;
  - Progress review of goals and objectives specific to cultural competence; and
  - SOC commitment to structural and policy changes that support the “family voice” and cultural diversity at all levels.

- Leadership of the Mental Health System of Care (SOC) should develop mechanisms to ensure commitment by key stakeholders, especially in all future programming. Leadership should be requested to transmit this priority and establish exemplary processes and actions that others can emulate. These efforts should:
  - Provide well-defined expectations to each agency’s leadership staff and stakeholders for the development of an agency-wide process to implement and evaluate cultural competence at programmatic and systemic levels;
  - Advocate for cultural competence in the broader mental health community and in stakeholder organizations;
  - Incorporate cultural competence in a quality improvement and accountability framework so it is an integral component of management and services;
  - Ensure that the voices of all cultures in the community are built into the decision-making structure of the system of care.
• Establish a Committee/Task Force for Cultural Competence" that has the support of SOC leadership. The role of this committee should include:
  
  Review the SOC’s policies and projects to ensure that cultural competence is kept in the forefront of strategic planning processes.

  Research and recommend evidence-based practices, assessment tools and progress evaluation procedures regarding cultural competency efforts.

  Provide appropriate culture- and diagnostic-specific information to the SOC agencies.

  Assist in the development and implementation of strategies to ensure long-term successful outcomes for the community’s diverse populations/families.

  Support the implementation of culturally specific efforts and strategies that promote cultural competence through all divisions and activities.

  Create opportunities for discursive space to discuss the policies and/or protocols and/or practices within the SOC to challenge ineffective or inequitable systems and support as agencies and organizations employ methods of change.

  Foster the development of family-driven community-based teams to impact the SOC.

  Develop systematic approaches to review the population’s utilization of services compared to the population’s need for services.

• Form a countywide Cultural Competence Advisory Team to include representation from the “sub-groups” of the Tarrant County mental health community that would include key stakeholders, consultants, family members and consumers to share expertise, experiences and challenges related to planning, implementing and evaluating cultural and linguistic competence. With the goal of eliminating mental health disparities, this group would:
  
  Include all the major race/ethnicity groups of the community, special needs groups to include both physical and mental health challenges, consumers and family members.

  Assist in the development of discursive space to discuss the policies, protocols and practices within the SOC to challenge ineffective or inequitable systems, and provide support as agencies and organizations employ methods of change.

  Review policies, evidence and practices and make recommendations regarding cultural and linguistic competence.

  Participate in strategies that increase the sensitivity of providers to avoid behaviors that may alienate rather than engage consumers.

  Participate in the development of family-driven community-based teams to impact the SOC.

  Receive updates on the progress of implementation status.

  Provide appropriate culture- and diagnostic-specific information to SOC members.

• Each agency as well as the SOC organization should perform a self-assessment. A major recommendation of the report is that each SOC should assess current conditions related to cultural competence as a starting point before any implementation plan is set in motion. These elements should be considered:

  Assessment should include a full review of all existing cultural competence initiatives and ways to identify potential disparities through data analysis and monitoring processes.

  The SOC self-assessment should include an analysis of county population and demographics, as well as the race/ethnicity/gender of SOC providers and their language capacities.

  Review the way agencies AND the SOC promote cultural competence formally (hiring, training, performance evaluations) and informally (multicultural events and celebrations).

  Conduct routine self-assessments with progress being tracked.

• To identify disparities, a cultural profile of the populations being served by the system should be compared against a profile of those populations needing to be served and should include ethnicity, age, gender, poverty level and languages spoken.

  The analysis must include utilization, outcomes and performance measures.

  The analysis should be done for different sub-populations (e.g., children, adolescents, elderly, persons with serious mental illnesses, homeless).

  Routine reports related to utilization, performance measures and outcomes should include breakout information on race/ethnicity and other relative sub-groups.
• Develop a system-wide Cultural Competence Plan that will cover all administrative organizational components. The plan should:
  
  Incorporate cultural competence as a critical component in key management activities, including planning, quality management contracts and staff training.
  
  Identify and address disparities identified through analysis.
  
  Include strategies that develop and sustain culturally specific goals.
  
  Include measurable objectives that are reviewed annually with feedback provided.
  
  Be disseminated widely throughout the system.

• “Linguistic competence is developed within system.” Linguistic competence is “the capacity to communicate effectively in a manner that is easily understood by diverse audiences, including persons of limited English proficiency, those who have low literacy skills or are not literate, and individuals with disabilities.”

  There should be organizational capacity to respond effectively to the health literacy needs of populations served.
  
  Organizations should have policy, procedures, practices and resources to support this capacity.
  
  Data should be available on the language needs of the populations to be served and the persons receiving services.
  
  Accepted industry standards should be utilized by qualified mental health interpreters.
  
  Language proficiency and preferences are available for forms, notices, service directories, educational materials, etc.
  
  Information on language assistance should be available to service providers and in service directories.

• Develop and implement standards of excellence related to cultural competence at system, agency and service provider levels.

  Standards of care should specifically address cultural competence.
  
  Cultural competence should be included in quality assurance and quality improvement activities and projects.
  
  Reporting and community assessments should include activities related to promoting and sustaining cultural competence.
  
  Standard reporting procedures should include breakouts by race, ethnicity and other identified sub-groups.

• Using the Cultural Competence Plan, identify resources needed for priority activities, including training, interpreter services and specialized programs.

  Resources are designated specifically for cultural competence training;
  
  Resources are designated for language and qualified interpreter services;
  
  Resources for culture-specific programs and services are a priority;

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**Specific Areas of Need in Tarrant County Related to At-Risk/Prevention**

Cultural competence has remained largely an ideological construct with a set of guiding principles. Research shows that the lack of a fundamental framework has resulted in implementation being at the service provider level only, without adequate guidance, resources, support, monitoring or evaluation. Greater understanding is needed about how and what organizational and inter-organizational practices reduce barriers to care. Needs include:

• A consensus on the major components that make up cultural competence in order to create a set of measurable outcomes for research and evaluation.

• An operational framework and strategy with clear guideposts for systems change and transformation.

• A system-wide cultural competence plan, including the means to assess and monitor improvement with evaluation and empirical research.

• Sustained attention.

• Validated self-assessment protocols and tools.

• Sufficient bilingual services to address the growing need as a result of increasing non-English speaking citizens.
Barriers to Effective Implementation

- Organizations may be resistant to participating in a change effort because of time and resource constraints.
- It may be difficult to build adequate and diverse participation on the Advisory Team.
- There may be reluctance to participate in the implementation phase of project.
- Past experiences of agency attempts to implement “culturally competent” efforts and their seeming failure may result in low motivation for change.
- These efforts will require a long-term commitment from agency administrators and community stakeholders.
- Lack of consensus about a definition, core elements and characteristics of cultural competence poses a significant obstacle to implementation.
- By emphasizing single-dimension implementation of cultural competence strategies, such as translation of materials, use of interpreters and mandated trainings, organizations may believe they are already “culturally competent”.

Needed Policies to Support this Recommendation

Policy creation/change in the infrastructure is an effective way to disseminate the values and principles of a system of care to all of the partner agencies at all levels. As this project proposes to effect systemic change, the following policies are needed:

- Standards of care specifically highlighting cultural competence.
- A systematically defined set of values, principles and attitudes that enables the entire system to work effectively cross-culturally.
- Policies to approve the formation of committees suggested in the work plan.
- Adoption of policies that may be suggested by the newly formed committees.
- Development of evaluation and reporting protocols resulting from cultural competence assessments.

Implementation and Action Plan

It is evident to the Learning Community that this project is very far-reaching and substantial. Therefore, commitment to this goal must be resolute and the approaches must remain conscientious.

The most immediate next steps are:

- Meet with Mental Health Connection leadership to determine support of the project.
- Form a core “implementation team” of people willing to “champion” the project. Eight members of the Learning Community have committed to participate on this team.
  
  Develop a proposal to gain support from Mental Health Connection partners and other community stakeholders.
  
  Develop a comprehensive list of experts, stakeholders and community partners who can impact the system and who have an understanding of the issues being addressed in the plan.
  
  Begin a recruitment effort to solicit membership for the Implementation Team.
- Organize a “planning and implementation retreat” for the team to review the work plan, develop a vision statement and create an action plan for the next phases of the pilot project. At this point, the action items will include identifying who is needed in terms of researchers, practitioners and policy workers.

  People are often reluctant to discuss issues associated with stereotyping, bias and prejudice between cultural groups. These discussions often evoke deep emotionally charged responses. Consequently, the cohesion of this core group is critical. Specific team-building strategies, especially around cultural issues, will need to be intentional and dynamic.
Strategies for Keeping the Knowledge Current and Widely Shared

The Learning Community proposes the following ideas to inform team members and others of the pilot project’s progress:

• Use the Mental Health Connection website to post updates, announcements and progress.

• Add an agenda item to the Mental Health Connection meetings that would allow for project updates.

• Maintain updates by email blasts.

• Utilize the annual Bridging the Gap Symposium for project updates.

• Establish a Cultural Diversity Book Club. This idea was introduced in an article reviewed by the Learning Community. There were a number of members who expressed an interest in continuing the study of cultural competence by choosing a book with a theme related to the issue. The article highlighted that “autobiographies, biographies, historical accounts, as well as novels can educate, inspire and even effect change in peoples’ attitudes and behaviors.” This forum would allow for an open, honest and supportive discussion and could be used as a “component” of the pilot project.
DEVELOPMENTAL DISORDERS

Asperger's Syndrome
Autism
Learning Disabilities
AUTISM SPECTRUM DISORDERS

Recommended Pilot Program

The Autism Spectrum Disorders (ASD) Learning Community recommends development and implementation of The Autism Resource Center, offering early identification, assessment and diagnosis for children between the ages of 18 months and 8 years.

Executive Summary

The Autism Spectrum Disorders Learning Community conducted a six-month in-depth review of research related to evidenced-based programs and practices of identification, assessment and treatment of ASD. The Committee recognized that the broad category of ASD includes diagnostic groups of Autistic Disorder, Asperger’s Disorder, Rett’s Disorder, Childhood Disintegrative Disorder and Pervasive Developmental Disorder Not Otherwise Specified. The focus of discussion, however, was held to Autism and Asperger’s. The prominent issues identified for further investigation for a pilot recommendation included the age range of those involved, whether early screening and assessment should command the committee’s attention, and/or whether the review of evidence-based practice literature should include those studies concerned with treatment interventions.

During the initial review of evidence-based practice literature, the ASD Learning Community ultimately narrowed its focus to children between the ages of 18 months and 8 years, and chose to consider research-based recommendations in one or more of the following areas:

• Assessment and screening
• Diagnosis
• Interventions based on the core concepts of Applied Behavior Analysis (ABA)
• A comprehensive program of family wraparound services.

The recommended pilot program, The Autism Resource Center, would offer early identification, assessment and diagnosis for children between the ages of 18 months and 8 years using the American Academy of Pediatrics’ algorithm for assessment and diagnosis of children. It was clear from available research that the earlier a child is identified with an ASD, the earlier supports and services can be offered. Research further finds that interventions in this period of time can cause positive changes in children. These changes are so dramatic that, in virtually every study, as many as 50 percent of the children involved in the studies never needed services again.

Services of the Autism Resource Center would also include outreach, education and training. It would provide information for families and professionals, in addition to collaborating with service providers in the community to facilitate the coordination of services for children with ASD.
Learning Community Members

- Richard Garnett, PhD, The Arc of Greater Tarrant County – Champion
- Ellen Crowl, The Harral Group - Facilitator
  - Gary Acrey, Tarrant County Juvenile Probation Department
  - Mona Alvi, M.D., MHMR of Tarrant County
  - Paul Baganz, Easter Seals
  - Mariana Bond, Consultant/Parent
  - Joe Burkett, M.D., MHMR-TC
  - David Cross, Ph.D., Texas Christian University
  - Laura Daggs, Private Practice Occupational Therapist
  - Jena Darling, Lena Pope Home, Inc.
  - Cheryl Gierkey, The Excel Center
  - James L. Greenstone, Ed.D., J.D., Private Practice
  - Jennifer Johnson, The Art Station
  - Mollie Kuchta, Cook Children's Medical Center
  - Joyce Mauk, M.D., Child Study Center
  - Bill May, XTO Employee Assistance Program
  - Kristin Nethers, Fort Worth Independent School District
  - Carolyn Presnall, Cook Children’s Medical Center

Summary of Research on Autism Spectrum Disorders

The ASD Learning Community performed exceptionally well in its review of the literature, going way beyond the cursory and superficial. The members were presented with an initial packet of 20 articles to set the stage and serve as a foundation of knowledge about “evidence-based practice” research. Over the course of the next five months, the Learning Community reviewed an additional 20 articles, research summaries, abstracts and excerpts as the group’s focus narrowed. The final recommendation for an Autism Resource Center was primarily supported by the following articles and internet resources. The first three made up the base of support. The rest are listed in no particular order. Copies of these articles can be obtained from the champion of the Learning Community.


The ASD Learning Community has chosen to recommend The Autism Resource Center as a pilot program. The Center would offer or arrange for early identification, assessment and diagnosis for children between the ages of 18 months and 8 years, using the American Academy of Pediatrics’ algorithm for assessment and diagnosis of children. It was clear from available research that the earlier a child is identified with an ASD, the earlier supports and services can be offered. Research further finds that interventions in this period of time offer the opportunity to cause positive change in children so dramatic that, in virtually every study, it was found that as many as 50% of the children involved in the studies never needed services again. It is recommended that The Autism Resource Center also be involved in outreach, education, training and the provision of information for families and professionals. It should also work in collaboration with service providers in the community to facilitate the coordination of services for children with ASD.

In addition, the Autism Resource Center would have an outreach, training and education component to promote early identification and assessment in hospitals, medical settings, schools, homes and community programs. It would serve as a resource by providing articles, research reports, books, tapes and guides on ASD. Its services would be a function of a community collaborative. Related and appropriate services and agencies would coalesce around the needs of people who manifest the characteristics of ASD and who need the support of a system navigator to guide them toward the services they need.

Specifically, the Autism Resource Center would offer an array of supports and services, such as:

- Outreach, training and education, with a goal of increasing the awareness and skills of parents and professionals so they can recognize early developmental delays, conduct early assessments for characteristics of developmental delays and ASD, and make appropriate referrals for early intervention services.
- Early assessment and identification of children so they receive complete diagnostic evaluations and referrals for services.
- Social marketing to raise awareness, attack stigma, open opportunities, support the expansion of services, and facilitate an increase in funding from local foundations and funding entities. This would require a strong public relations and community education initiative with well-developed relations with the media.
- Promotion of a standardized approach for assessing ASD in the community, both at the early assessment and identification level and at the more comprehensive diagnostic level.
- Information and education resources for parents, professionals, the media and policy makers to help clarify the confusing and complex neurobiological disorder of ASD.
The actual details of the model and infrastructure for The Autism Resource Center were left unspecified. Discussions included establishing a freestanding non-profit 501(c)(3) which would develop the programming and funding sufficient to operate a new and distinct agency. Another possibility is to include set up an incubator model business center where multiple agencies would coexist under the same roof to deliver cooperative, coordinated services. Another concept discussed briefly was to have various agencies assume specific and distinct responsibilities (early assessment, diagnosis, intervention, etc.) and have The Autism Resource Center act as the navigator to orchestrate access and flow. The Learning Community determined that the most efficient way to continue would be to form an implementation team that can shape the model and be responsive to input from agencies, funders, and clients and their families for further development of the pilot.

Specific Areas of Need in Tarrant County Related to Autism Spectrum Disorders

The incidence of ASD in children is universally accepted to be 1:150. In Tarrant County, with an estimated 2007 population of 1,717,000, the assumption might be made that there are as many as 11,446 people with ASD in our community if that rate applies to adults and children. There are 25,000 births per year in Tarrant County, with one out of every one-hundred and fifty having ASD (one child every two days). There are limited resources for identifying and treating children with ASD in Tarrant County. Where resources do exist, waiting lists, the cost of services and the limited benefits provided by public funds and insurance companies can be, at best, frustrating for families. At worst, young children lose valuable time in receiving an adequate diagnosis and referral for services. Research is clear: after the age of 7 to 8 years, the benefits of intervention are reduced dramatically.

The Learning Community confirmed that early identification and diagnostic assessment, followed by appropriate, planned interventions at the earliest possible opportunity, help the child with ASD function successfully. In Tarrant County, the Autism Spectrum Disorder Learning Community has identified several needs (gaps) in supports and services:

• There are needs related to screening and assessment.
  Tarrant County does not have a public health screening for developmental delays as outlined in the guidelines of the American Academy of Pediatrics (at ages 18 months, 24 months, 36 months and 48 months).
  There are no consistent screening programs for developmental delays in
    Offices and clinics of pediatricians and family practice physicians
    Early Childhood Intervention programs
    Preschool programs for children with disabilities
    Educational programs outside of public services
• There is little or no education related to screening tools, assessment and referral sources for:
  Offices and clinics of pediatricians and family practice physicians
  Educational personnel in public and private schools
  Daycare personnel
  Parents, family members and caregivers
  Lay public at large
• There are long waiting periods for initial ASD-specific screening and diagnostic assessment.
• There is no “one-stop center” for ASD-specific screening, diagnostic assessment, interventions and/or referral for follow-up.
• There are few training and education opportunities for parents and professionals in early identification and assessment of ASD. With so few people being aware of early signs and symptoms of developmental delays, the identification of children in need of services is reduced.
• There is no standardized assessment and diagnostic process. This can hinder communication, cause duplication of effort, cause conflicts between agencies because of competing and poorly coordinated policies, and cause unnecessary delays in intervention and treatment.
While implementation of a new program in any community has its own inherent challenges, it seems that an Autism Resource Center has challenges unique to such a new program in the field of autism. Any new program will face financial challenges, logistical and strategic hurdles, and the demands on time and effort necessary to establish its foundation. However, autism programs experience their own unique challenges. Prominent on the list of challenges are:

- **Funding necessary for:**
  - A public health screening initiative for developmental delays/differences
  - Reimbursement to offices and clinics of pediatricians and family practice physicians for screening tools and employee time to conduct the screening
  - Screening personnel and tools at ECI or PPCD locations
  - Insurance reimbursement for ASD diagnostic assessment and interventions
  - Education of:
    - Offices and clinics of pediatricians and family practice physicians
    - Educational personnel in public and private schools
    - Daycare personnel
    - Parents, family members and caregivers
    - Lay public at large

- **Fear of having to provide extensive public services where funding is currently not available for:**
  - School districts
  - Public mental health agencies
  - Private practice community (medical, psychologists, SPED specialists, BCBA)

- **Cultural differences and stigma**
  - Parents and caregivers may not seek help until a child is older or the behavior has escalated to a point where school and law enforcement officials are involved
  - Parents are often reluctant to speak up or admit that their children experience developmental delays because they fear being viewed as “inadequate parents.” Autism has been called the “stealth disability” because of parental reluctance to acknowledge the child’s developmental difficulties.
  - Difficulty in screening fidelity because agencies and personnel conduct the screenings in different ways. Without a standard measure or process, each agency is doing its own thing. As a result, many professionals and agencies are reluctant to accept the results of any assessment conducted by someone else, either in a non-standardized manner or in a manner different from their own standards or protocol.

- **Specific challenges to establishing an ASD Resource and Referral Center include:**
  - Need for funding for:
    - Physical location for the center
    - Outreach educational resources
    - Staffing
    - Social marketing campaign
  - Multi-agency Memorandum of Understanding and Participation to ensure the involvement of agencies/personnel that would continue to provide services for the child:
    - ISC Diagnostician
    - Social skills therapist
    - ABA Therapists
    - Psychiatrists/Psychologist/Mental Health Nurse Practitioner

- **Because of conflicting agency and organizational policies, diagnosing ASD might not be done as often or as early as might be expected. Additionally, confidentiality prevents sharing of information, and funding streams are often in**
exclusionary silos. In some settings, services are not contingent upon a diagnosis, while in others a diagnosis is the only way services can be obtained.

### Needed Policies to Support this Recommendation

Based on extensive discussions, the Learning Community developed a list of recommendations regarding the eventual development of policies for agencies that may become involved in the work of the Autism Resource Center.

- There will need to be a formal Memorandum of Understanding among all collaborating agencies that specifies the responsibilities of the agencies and establishes the protection of personal health information as outlined in HIPAA. It would further deal with any potentially conflicting agency policies.

- The Tarrant County Public Health Department will need policies for an initiative for general screening initiative to support early identification of developmental disorders. Recommendations from this committee include screening measurements at ages 18, 24, 36 and 48 months.

  The committee recommends that a thorough review of available screening instruments be conducted [www.firstsigns.org/screening/tools.htm](http://www.firstsigns.org/screening/tools.htm) and [www.firstsigns.org](http://www.firstsigns.org) are suggested as a starting place). All participating organizations would then decide on a standard list of screening instruments for children of all ages, but especially for ages 18 months through age 8. One caveat that has to be acknowledged is that this policy recommendation has a political element related to the possible compulsory nature of such a program.

- The Learning Community recommends that the Texas Department of Insurance develop a set of policies that address the following issues:

  **A requirement for screening of Autism Spectrum Disorders**
  
  Rules/guidelines for assessment instruments, diagnostic tests and diagnostic processes
  
  Insurance coverage for diagnosis and treatment services, beyond those established in HB1919, passed in the 2007 Legislative Session: 80 (R).

- It is recommended that HHSC and the component departments of DSHS, DADS and DARS develop policies that address the following issues:

  **A requirement for screening for Autism Spectrum Disorders (see Recommendation 2) at any state-licensed program, agency or facility and by any state-licensed professional who serves children**
  
  Rules/guidelines for assessment instruments, diagnostic tests and diagnostic activities to standardize the process in a way similar to the DMR rule for diagnosing Mental Retardation (Texas Administrative Code (TAC), Rules of the Department of Aging and Disability Services, Title 40, Part I, Chapter 5, Subchapter D).
  
  Reimbursement for diagnosis and treatment services for ASD beyond that already in place, possibly via a separate waiver for autism services.

- DARS should change its policy against the need for assigning a diagnosis of ASD in its Early Childhood Intervention (ECI) program and, in policy, recognize the critical need for early identification and intervention. This is likely to include a clarification of nomenclature and semantics that currently confuse “diagnosis” and “functional assessment.”

- It is recommended that the Texas Education Agency establish a policy that would require specific ASD screening for all children up to age 8 to identify children with developmental delays who might not be identified otherwise (for any number of reasons). This policy should include the need for a stronger working relationship with ECI during the transition stage for students leaving ECI (upon their 3rd birthday) and entering the school system (as late as age 5).

- It is recommended that the National Childcare Association and the Texas Licensed Childcare Association establish a policy requiring daycare providers to conduct ASD screenings at all of their centers for children at ages 18, 24, 36 and 48 months.
Implementation and Action Plan

The next step is to establish an Implementation Team that will carry on the work begun by the ASD Learning Community. The Team would initially be made up of volunteers from the original ASD Learning Community. It would be strengthened and expanded by volunteers from throughout the community and would include anyone willing to commit to an ongoing responsibility to see The Autism Resource Center become reality. Specific action steps would include:

• The Team would meet on a regular basis to develop the parameters and activities necessary to develop funding, collaborative partners and ongoing research discussions of related studies and articles.
• It would develop and implement a professional contact plan to promote the American Academy of Pediatrics’ algorithm for assessment and diagnosis of children.
• It would identify local, state and national experts who might provide consultation on the funding and development of an Autism Resource Center such as the one recommended.
• It would develop a skeletal project description and receive input from the professional and stakeholder community on the type of structural model the Implementation Team might pursue. It was felt that this decision would require significantly more time and effort than was possible within the Learning Community parameters and was therefore assigned to this Team.
• As the pilot model is developed, a fund development subcommittee of the Team will establish a solicitation plan, and letters requesting support will be sent to potential supporters.

Strategies for Keeping the Knowledge Current and Widely Shared

Various strategies could be utilized to communicate the progress of the recommended pilot program. These same strategies could be used for marketing and communication among stakeholders such as community agencies, consumers, funders and other interested parties.

Form a “Journal Club” to study new ASD professional publications and studies.
• Create a website dedicated to the pilot program, with a possibility of linking it to the Mental Health Connection website.
• Speak to stakeholder groups to inform them of progress and information about the Autism Resource Center. Create a process in which stakeholders can request speakers to present information to interested parties.
• Form an email list-serve community to disseminate information regarding the most recent research, policy and practice issues in ASD.
• Participate in a Mental Health Connection newsletter with a Learning Communities section to communicate implementation progress.
• Notify Learning Community members about opportunities to assist with specific implementation tasks as needed.
• Have Mental Health Connection and The Autism Resource Center host an annual conference focused on new and relevant information regarding ASD.
EXTERNALIZING DISORDERS

- AD/HD
- Oppositional Defiant Disorder
- Conduct Disorder
EXTERNALIZING DISORDERS

Recommended Pilot Program

The Externalizing Learning Community recommends a pilot project called “Quest for Competency” to help eliminate barriers and improve the efficiency and effectiveness of service delivery through research, practice and policy for Tarrant County. This effort focuses on: Gaining understanding and skill in implementing core components of proven practices Utilizing experts to train a broad range of practitioners in the use of these practices Promoting consistent implementation across agencies/entities

Executive Summary

The Externalizing Disorders Learning Community conducted a six-month in-depth evaluation of research as it related to evidence-based programs and practices for externalizing disorders in children and adolescents. Externalizing disorders during childhood include conduct disorders (CD), oppositional defiant disorder (ODD) and attention deficit/hyperactivity disorder (AD/HD). These disorders are particularly problematic in at least three ways:

• their characteristic symptoms (e.g., antisocial behavior, aggression, fighting, high activity levels),

• their relatively high prevalence (3%-5% for AD/HD in school-aged children, 6%-16% for CD in boys and 2%-9% in girls), and

• their association with a range of poor outcomes during adolescence and adulthood including school failure and drop out, substance use and abuse, criminal activity, early and inadequate parenting, and unemployment (Farmer, Compton, Burns, & Robertson, 2002).

During the literature review, the Externalizing Disorder Learning Community identified the need for individualized, child-centered, family-focused and culturally relevant treatments delivered in the least restrictive setting. Additionally, it was suggested that practitioners employ, in relationship with the parents/caregivers, multiple treatment strategies. Externalizing disorders do not lend themselves to one-dimensional treatment approaches because they are chronic, pervasive and often exist in conjunction with other disorders. (Anastopoulos & Farley, 2003).

Unlike evidence-based programs, which tend to be curriculum based and manualized, evidence-based practices promote a set of core practice components which – when implemented together – produce proven changes in children and families. As noted in the research, externalizing disorders respond best to interventions that include participation by parents/caregivers and focus on concrete changes in behavior. Therefore, the two practice areas suggested in this pilot include Parent Management Techniques and Cognitive Behavioral Therapy practices.

In addition to utilizing experts to provide training, coaching and follow-up consultation to practitioners, the Externalizing Disorders Learning Community recommends the building of a collaborative relationship with researchers to evaluate the pilot project utilizing evaluation instruments to measure fidelity. Based upon the research findings, the Quest for Competency pilot project will utilize the information for continuous performance and quality improvement. Furthermore, the Quest for Competency pilot project will employ researchers to identify new initiatives and research studies to keep knowledge of evidence-based programs and practices for externalizing disorders.
Learning Community Members:

- Sara Ramirez, Catholic Charities - Champion
- James Holcomb - Facilitator
  - Gary Acrey, Tarrant County Juvenile Services
  - Jennifer Anderson, Community Solutions of Fort Worth
  - Lisa Benton, Community Solutions of Fort Worth
  - Robin Brake, Excel Center
  - Angela Bryant-Cruz, Santa Fe Adolescent Services
  - Angela Ceglar, Santa Fe Adolescent Services
  - Dr. Kathryn Denkowski, Private Practice
  - Dawn Edwards, Lena Pope Home, Inc.
  - Margaret Fields, MHMR Tarrant County
  - Nancy Gonzales, Lena Pope Home, Inc.
  - Paula Hood, All Church Home
  - Christine Jaimez, Catholic Charities
  - Barbara Keeney, Harris Springwood
  - Monica Kintigh, TCU Counseling Center
  - Mollie Kuchta, Cook Children’s Medical Center
  - Susanne Luebke, Lena Pope Home, Inc.
  - Ira Mackey, Lena Pope Home, Inc.
  - Sonya Mosley, Lena Pope Home, Inc.
  - Judy Saunders, The Women’s Center
  - Sonia Smoak, Lena Pope Home, Inc.
  - Dicey Smith, Excel Center
  - Jacklyn Smith, Lena Pope Home, Inc.
  - Carla Story, All Church Home
  - Angie Walston, TCU Institute of Child Development
  - Vicki Warren, Community Solutions of Fort Worth
  - Rachel Wilkes, Austin College
  - Beth Williams-Ewing, The Women’s Center

Summary of Research on Externalizing Disorders


This article focuses on identifying promising treatment approaches for internalizing disorders, externalizing disorders and other conditions. The article highlights the findings on current research for treatment outcomes, illustrates several promising treatments that have received empirical support, and identifies key issues to advance further development of efficacious and effective treatments.

*Evidence-Based practice in Psychology, APA Presidential Task Force on Evidence-Based Practice*

This report focused on the integration of science and practice by describing psychology’s fundamental commitment to evidence-based psychological practice. It took into account the full range of evidence that policymakers must consider. This report provides a rationale for and expands discussion on the policy statement developed by the Task Force and adopted by the APA Council of Representatives in August 2005.
This report presented a selective review of research about factors that contribute to emotional, behavioral and addictive disorders in adolescents. The report summarizes what is known regarding the antecedents of these disorders and prevention programs that might help to alleviate the symptoms. It also reviewed research pertaining to each layer of an adolescent’s internal and external world.


This article reviewed controlled research on treatments for childhood externalizing behavioral disorders. The results suggest positive outcomes for a variety of interventions (particularly parent training and community-based interventions for disruptive disorders and medication for AD/HD). This review also highlighted the need for additional research examining effectiveness of treatment for children 6-12 and strategies to enhance the implementation of effective practice.


This chapter provided an in-depth discussion of Parent Training, one of the more commonly employed interventions for AD/HD. The chapter presented an overview of the aspects of AD/HD in relation to the use of Parent Training, a discussion on the rationale for using Parent Training, and a detailed description of the Parent Training Program originally developed by Barkley (1987) and later modified (Anastopoulos & Barkley, 1990; Barkley, 1997).

**Children and Evidence-Based Practice**, B. Burns (2003).

The intent of this article was to provide, with a limited update, a sense of what will be required to nurture and strengthen mental health treatments for children. This article provided a summary of interventions for youth with emotional and mental disorders, identified exemplary child initiatives to launch evidence-based practices, and presented models that narrow the gap between research and practice.

**Empirically Supported Treatments for Children and Adolescents: Advances toward Evidence-Based Practice**, T. Ollendick, N. King (2004)

This chapter described some of the early work undertaken to identify empirically supported psychosocial treatments for children and contentious issues associated with the treatments. The chapter identified the continued need for dialogue between clinicians and researchers to address three major concerns:

- The effectiveness of some treatments over others,
- The use of treatment manuals and the independence of therapist, and
- The transportability of treatments from the research setting to the clinical setting.

### Specific Areas of Need in Tarrant County Related to Externalizing Disorders

The Externalizing Disorder Learning Community identified three specific areas of need for Tarrant County:

- The lack of information and accessibility of evidence-based programs and practices for externalizing disorders in Tarrant County;
- The lack of fidelity of evidence-based programs and practices currently being utilized in Tarrant County (organizations and practitioners not modeling the program/practice as it was intended); and
• The need to strengthen child mental health services in Tarrant County including:
  The involvement of multiple core components to address the consumer’s needs
  The involvement of parents in the child’s treatment
  The involvement of researchers to hold practitioners accountable in providing reliable services via evaluation of the programs/practices

Externalizing behaviors are among those most commonly recognized in children with mental health disorders. Consequently, Tarrant County practitioners, clinicians and other direct care workers are familiar with many of the diagnoses associated with Externalizing Disorders, including Attention-Deficit Hyperactivity Disorder (AD/HD), Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD).

In spite of this knowledge, there remains the question of how best to impact positive change in these children. Recent efforts made by the Tarrant County mental health community to increase knowledge of effective practices has resulted in the realization that – while there are evidence-based programs and practices currently being implemented in Tarrant County – there is limited understanding of which ones are most effective in addressing externalizing behaviors. Additionally, many evidence-based programs and practices currently implemented in Tarrant County are frequently inaccessible to families due to strict eligibility criteria. These two issues – the lack of accessibility and the need for a system for managing knowledge of the latest research regarding effective programs and practices – should be addressed at a county level. Effective and accurate information and services need to be readily available and accessible to practitioners, consumers and the community at large.

Closely linked to increasing knowledge of effective practices is the ability to implement those practices with fidelity. In order to accomplish this, the Externalizing Learning Community identified a need for the training and coaching of front line staff across the county in core components of effective practices. Broadening the training scope to include staff across agencies promotes consistency in implementation and demonstrates Tarrant County’s “no wrong door to the right service” philosophy. Likewise, training followed by an accountability process that includes consultation and coaching by local and national experts would help ensure effective implementation and increase fidelity to the practice/program model.

**Recommended Evidence-Based Practice or Program for Externalizing Disorders**

The Externalizing Learning Community supports the implementation of a pilot project called Quest for Competency. This effort focuses on gaining understanding and skill in implementing core components of proven practices, utilizing experts to train a broad range of practitioners in the use of these practices, and promoting consistent implementation across agencies/entities. Unlike evidence-based programs, which tend to be curriculum-based and manualized, evidence-based practices promote a set of core practice components which – when implemented together – produce proven changes in children and families. As previously noted in the research, externalizing disorders respond best to interventions that include participation by parents/caregivers and focus on concrete changes in behavior. Therefore, the two practice areas suggested in this pilot include Parent Management Techniques and Cognitive Behavioral Therapy practices.

The Quest for Competency project recommended by the Externalizing Disorders Learning Community will include:

• Utilizing experts to provide training, coaching and follow-up consultation to practitioners
• Building a collaborative relationship with researchers to evaluate the pilot project utilizing evaluation instruments to measure fidelity
• Utilizing the information for performance and quality improvement as it relates to Externalizing Disorders
• Employing researchers to identify new initiatives and research studies for keeping evidence-based programs and practices knowledge current in Tarrant County as they relate to externalizing disorders.
Barriers to Effective Implementation

The Externalizing Learning Community acknowledges that in order to execute the Quest for Competency pilot project effectively, we must be able to recognize potential barriers to effective implementation. Additionally, we must be able to identify solution-focused strategies that will help overcome these systemic barriers. Without addressing both components, the sustainability of the pilot project would be unlikely.

There is an understanding that, with the implementation of this pilot project, the Externalizing Disorders Learning Community is seeking a cultural change for Tarrant County. Research shows that it takes an average of four years to create cultural change; however, we believe that this process has already started in Tarrant County and the recommended pilot project is a result of that cultural change. To sustain the cultural change, the Quest for Competency pilot project acknowledges the following barriers and suggestions to overcome obstacles:

- Funding for the pilot project will have to be outlined in advance so all stakeholders have a general understanding of the investment Tarrant County is making in implementing excellence in service delivery. Such costs include the fee for training, coaching and supervision provided by experts in the field of Parent Management Techniques and Cognitive Behavioral Therapy practices. Additionally, there will be the cost for travel, training site locations and materials utilized by practitioners, researchers and consumers.

- As providers go through training, parents and other caregivers of children with Externalizing Disorders must be educated about:
  
  Evidence that supports the effectiveness of evidence-based programs and practices in providing relief for the symptoms that their children are experiencing
  
  The need for them to participate actively in the treatment if it is going to be effective for their children
  
  Accessibility of the program, including informing caregivers of the existence of the program, who provides it and what funding is available to help them pay for the services.

- Tarrant County will need to create incentives to build commitment and confidence in the pilot project, as many ventures expire after the excitement of the project wears off. In order to maintain the pilot project, the Externalizing Disorders Learning Community recommends the implementation of creative recruiting efforts that engage community members to participate. Such efforts can include fiscal responsibility, as well as alignment with professional and organizational mission, vision and values.

- Youth with externalizing disorders are served in many different settings. Therefore, another barrier to successfully implementing the pilot project is that of linking the various organizations, practitioners, schools, hospitals and researchers with each other to provide continuity and structure in all settings for children in treatment. While there is a growing willingness of Tarrant County agencies to collaborate in improving treatment outcomes, practitioners in general know very little about what other providers are doing. This has resulted in conflicting and overlapping services that create confusion for the families seeking help. Families are often referred for help to a program, only to find they are ineligible to participate. In addition, families might be referred by different service providers to participate in programs at various agencies for the same purpose – such as parent education – which teach different and conflicting strategies to solve problems.

- The Quest for Competency pilot project must receive marketing and public relations efforts to raise awareness regarding externalizing disorders and the need for evidence-based programs and practices within the community. Underlying all of the above barriers is the barrier of generalized knowledge about the frequency with which externalizing disorders affect youth, families, schools and the community at large. The general public also does not understand the cost to the community of leaving individuals with externalizing disorders untreated. A community-wide effort through the media – including television, radio, newspapers and the internet – should educate the community about the symptoms, resulting problems and costs associated with untreated externalizing disorders. This campaign will heighten awareness of the need for the Quest for Competency pilot project. It should also address the cost benefits of identifying and treating individuals with these disorders at an early age. The result may be increased financial support for training, caregiver education, assessment and provision of such evidence-based programs and practices in Tarrant County.
Needed Policies to Support this Recommendation

The Externalizing Learning Community identified several policies needed to address the implementation and monitoring of the Quest for Competency pilot project in relation to Mental Health Connection’s Standards of Care. Additionally, in keeping with Mental Health Connection’s mission statement, the needed policies and procedures should include:

- The development of a service philosophy statement
- The development of a logic model that includes core values, principles, strategies, short-term outcomes, medium-term outcomes, and long-term outcomes
- The development of a performance and quality improvement monitoring system that includes:
  - Annual work plan
  - Inputs, outputs and outcomes
  - Measurement and assessment tools
  - Monitoring of outputs and outcomes on a monthly, quarterly and annual basis
  - Feedback mechanism to share information
  - Grievance policies and procedures
  - Development of a task force and/or action plans to address discrepancies in benchmarks

Important to the implementation of the Quest for Competency pilot project is the support of the community, which will be utilizing this pilot project both as providers and as consumers. The policies and procedures will need to clearly outline what is expected from organizations, practitioners, researchers, consumers and the community to increase the likelihood of the pilot project’s success and to maintain fidelity to the components of the pilot project. Additionally, participation in the program will require time and resources from all involved, and the policies and procedures should clarify the responsibilities and expectations of each of the participants including confidentiality agreements and participation in research and evaluation.

Implementation and Action Plan

A framework for the implementation of the Quest for Competency pilot includes identifying a task force consisting of members from the Externalizing Disorders Learning Community, Mental Health Connection members and other key players to:

- Identify local, state and/or national experts to train, coach and provide consultation on core components in Parent Management Techniques and Cognitive Behavioral Therapy in addressing externalizing disorders. The experts should include methodologies and assessment tools.
- Identify professionals who will participate in the Quest for Competency pilot project (private practitioners, organizations, agencies, schools and hospitals).
- Identify researchers to evaluate and test for fidelity of the Quest for Competency pilot project, including the development of an evaluation instrument.
- Determine the process for referral, assessment, intake and tracking of clients participating in the pilot.
- Schedule and coordinate training in Parent Management Techniques and Cognitive Behavioral Therapy practices, as well as ongoing consultation and coaching with identified expert.
- Develop a sustainability plan, including identification of local community experts who can provide future training for agency staff across Tarrant County.
The Externalizing Disorders Learning Community also recommends the creation of a community-wide needs assessment. This assessment will identify all evidence-based mental health programs and practices currently being utilized in Tarrant County. The assessment also should include the fidelity of the currently implemented evidence-based programs and practices. It also will identify the need for additional evidence-based programs and practices in order to bridge the gap between mental health service providers and consumers.

**Strategies for Keeping the Knowledge Current and Widely Shared**

In any endeavor, the key to long-term success and sustainability is keeping it “new” long after its beginning has passed. The effort to assess the needs, identify evidence-based practices to meet those needs, and provide training, information and up-to-date in Tarrant County is both bold and different. It is also necessary for the future development of mental health treatments in Tarrant County.

The Externalizing Disorders Learning Community therefore proposes the following to keep community knowledge about the best evidence-based programs and practices current, fresh and usable by all mental health providers in Tarrant County:

- Document the community needs as they relate to mental health.
- Identify community leaders who are recognized and who will be heard by the community to recommend the utilization, development and growth of the best evidence-based programs and practices available to meet those community needs. Agencies that use the best evidence-based programs and practices could be recognized publicly through public relations efforts and the media.
- Utilize the Mental Health Connection Website to maintain a list of current evidence-based programs and practices being utilized in the community for specific mental health issues.
- Provide consumers with the contact information so they can learn more about the evidence-based programs and practices, including ways to connect with providers.
- Maintain a list of current research in the field on the website. Update that list monthly for review and study.
- Provide web links for journal and research articles to identify the evidence-based programs and practices currently in use in the community and to identify new ones.
- Work with community leaders to develop a support system for implementation of evidence-based programs and practices in the community.
- Provide training and ongoing consultation to those seeking to utilize an evidence-based program or practice.
- Arrange for professionals to come to Tarrant County, where they will discuss the value of evidence-based programs and practices.
- Conduct a symposium every three years to address the links and gaps between research, practice and policy in the community.
- Review current evidence-based programs and practices offered in the community and have researchers audit them for compliance.
- Conduct a cost/benefit analysis of the evidence-based programs and practices.
- Invite businesses, organizations, practitioners, hospitals, schools, universities, researchers, local representatives and state representatives to be a part of Mental Health Connection and participate in the pilot project.
INTERNALIZING DISORDERS

Depression
Anxiety
Bi-polar disorder
INTERNALIZING DISORDERS

Recommended Pilot Program:

The Internalizing Disorders Learning Community recommends a countywide Cognitive Behavioral Therapy Certification (CBT)/Training Program as its pilot project.

Executive Summary

The Internalizing Disorders Learning Community engaged in a six-month effort to review the research on evidence-based practice related to treatments for children and adolescents with internalizing disorders, particularly depression, anxiety and bipolar disorder.

The focus on these three primary internalizing diagnoses was chosen due to the prevalence of depression, anxiety and bipolar disorder among the child and adolescent mental health population. The Internalizing Disorder Learning Community chose to narrow its focus to Depression and Anxiety Disorder after a review of literature from SAMHSA that revealed 9% of adolescents aged 12 to 17 experience at least one episode of major depression; and 13 out of every 100 children and adolescents aged 9 to 17 experience some kind of anxiety disorder. These children are at risk for suicide, drug use and other risk behaviors.

The Learning Community selected its recommended pilot program for three reasons:

• After the literature review, the Learning Community believes that Cognitive Behavioral Therapy is the best treatment option for children with Internalizing Disorders.
• Based on the findings of the Community Solutions survey completed for the “Bridging the Gap” Symposium (June 2007), the Learning Community identified a gap regarding the evidence-based practice of CBT.
• The Learning Community believes that training, certifying and implementing CBT consistently across Tarrant County would give more children affected by internalizing disorders an opportunity to participate in evidence-based treatment. It would also offer parents options for treatment that would be convenient and accessible according to their specific family needs.

Learning Community Members:

• Rikki Harris, MHMR Tarrant County - Champion
• Carlela Vogel - Facilitator
  • Joan Barcellona, Parent
  • Kay Barkin, Parent
• Kathryn Brown, MHMR Tarrant County
• Sherri Chapel-Pratt, The Women’s Center
• Kristin Connor, Excel Center
• Pamela Davis, Parent
• Dr. Jennifer Farnum, Psychologist, Tarrant County Juvenile Services
• Dena Hart, Catholic Charities
• Tammy Heinz, Mental Health Association
• Mike Herndon, All Church Home
Summary of Research on Internalizing Disorders

*Children and Evidence-Based Practice*, Barbara J. Burns, Ph.D. (2003)

This article summarized interventions to identify exemplary child initiatives for the launch of EBT. It also identified models for narrowing the gap between research and practice. Key models identified were Parent-Child Interaction Treatment (PCIT), Cognitive-Behavioral Therapy (CBT), Multisystemic Therapy (MST)

*Evidence-Based Psychotherapies for Depressed Adolescents: A Review and Clinical Guidelines*, Richard Gallagher, Ph.D.

This article outlined and described Cognitive-Behavioral Therapy (CBT), Primary and Secondary Control Enhancement Therapy (PASCET), Interpersonal Psychotherapy for Adolescents (IPT-A) and Systemic-Behavioral Family Therapy (SBFT). It indicated that all of these models except SBFT contributed to improvements in depressive symptoms for adolescents with all forms of depression.


This article identified two treatments that are fairly well developed and have achieved marked and enduring changes through the follow-up periods: CBT for child anxiety and coping skills training for children with depression.


This article researched the treatment of depression and suicidality in adolescents using data from Brent et al. (1997), specifically the efficacy of CBT, mechanisms of CBT action and treatment effects.


This article focused on combining a skills-and-thoughts depression framework with the PASCET. This program grew out of the cognitive-behavioral tradition and builds on the primary-secondary control model of change.


This article utilized the Adolescent Coping with Depression (CWDA) program to treat adolescent depression. The skill module includes cognitive restructuring, behavioral therapy, problem solving, communication, negotiation, relaxation training and goal setting.
Specific Areas of Need in Tarrant County Related to Internalizing Disorders

The Internalizing Disorders Learning Community (IDLC) agrees that the areas of need within Tarrant County for treating children with depression are varied. The professionals agreed that the broadest area of concern for Tarrant County is the need to provide evidence-based treatment and access to psychiatric treatment for all Tarrant County youth who struggle with depressive symptoms. The learning community believes that the use of research-driven program implementation is an area in which Tarrant County could strengthen its services for consumers of mental health treatment.

Further analysis led the IDLC to identify a need for an evidence-based practice in Cognitive Behavioral Therapy (CBT) that would be consistent among all the providers of mental health treatment in the county. Because the research reviewed by the IDLC almost exclusively supported CBT as a best practice for treating child and adolescent depression, the IDLC agreed the community needs to improve the use of CBT among providers in Tarrant County. The IDLC also learned that few local training opportunities are available in Tarrant County that offer certifications for evidence-based programs.

In June 2007, the Bridging the Gap Symposium for mental health treatment providers in Tarrant County was held, and a local survey was presented by Community Solutions. Noted in the survey was a matrix of evidence-based programs that were being utilized by mental health providers in Tarrant County. Community Solutions reported that while many providers identify the use of CBT in treating depressed youth, most providers did not identify an evidence-based CBT program.

The aforementioned needs identified by the IDLC are the reasons for choosing a pilot project directed toward countywide training and certification in CBT for providers.

Recommended Evidence-Based Practice or Program for Internalizing Disorders

Pilot Project:

The IDLS recommends implementation of comprehensive, ongoing training and consultation in Cognitive-Based Treatment for Youth with Depression to representatives of the Mental Health Connection agencies

Outcome:

Tarrant County becomes a Center of Excellence in Cognitive-Based Therapy for Youth with Depression

Intent of the Pilot:

To train and certify enough professionals in Tarrant County to offer families expertise in CBT, utilizing a certification program for CBT. The long-term goal would be to successfully treat more children and adolescents with internalizing disorders in Tarrant County. An ongoing training and consultation plan will be important criteria for the certification program.
## Countywide Training Program for Cognitive-Behavioral Therapy:

<table>
<thead>
<tr>
<th>Evidence-Based Program</th>
<th>Cognitive Behavioral Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Target Population</strong></td>
<td>Tarrant County children and adolescents, age 6 to 17 years, who have symptoms or are diagnosed with depression or anxiety</td>
</tr>
<tr>
<td><strong>Need Addressed</strong></td>
<td>Depression and anxiety</td>
</tr>
<tr>
<td><strong>Delivery Setting</strong></td>
<td>Home, school, office, community (wherever child and parent feel comfortable)</td>
</tr>
<tr>
<td><strong>Duration of Intervention</strong></td>
<td>Flexible, 12-16 sessions as determined by clinician, follow-up booster sessions</td>
</tr>
<tr>
<td><strong>Strengths of the Model</strong></td>
<td>Flexible program (pick and choose which session to do) to meet client needs</td>
</tr>
<tr>
<td></td>
<td>Individuality of program (modules to fit symptoms going on right now)</td>
</tr>
<tr>
<td></td>
<td>Family involvement</td>
</tr>
<tr>
<td></td>
<td>Well-researched (most researched model)</td>
</tr>
<tr>
<td></td>
<td>Training would create local experts</td>
</tr>
<tr>
<td></td>
<td>Can be utilized and generalized across Tarrant County</td>
</tr>
<tr>
<td></td>
<td>Will impact more children and families with a county wide implementation plan</td>
</tr>
<tr>
<td></td>
<td>Improves outcomes for depression</td>
</tr>
<tr>
<td><strong>Weaknesses of Model</strong></td>
<td>Don't know the long-term benefit</td>
</tr>
<tr>
<td></td>
<td>Don't know how effective this plan is with co-morbidity</td>
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<tr>
<td></td>
<td>Manualized, step-by-step process</td>
</tr>
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<td></td>
<td>Clinicians may be resistant</td>
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<tr>
<td></td>
<td>Lack of trained clinicians</td>
</tr>
<tr>
<td></td>
<td>Language/culture barriers</td>
</tr>
<tr>
<td></td>
<td>No existing way to measure a training program's impact and outcome for clients</td>
</tr>
</tbody>
</table>
Benefits of Project:
• Creates a stronger workforce
• Establishes a sustainable source of CBT clinicians
• Brings evidence-based treatment to families
• Enhances the reputation of the mental health community in Tarrant County
• Enhances collaboration between agencies
• Contributes to ‘no wrong door’ mentality

Barriers to Effective Implementation

The IDLC identified the following barriers to implementing the recommended pilot program:
• Limited space
• Cost in dollars and time
• Selection of people to participate
• Agency buy-in
• Language
• Culture
• Resistance to evidence-based training

Recommended Solutions
• Make use of multiple dates and times to offer training, which will allow more attendees to participate as well as limit the space needed each time training is offered
• Request the use of community partners’ sites without expense
• Identify possible grant funds to cover expenses
• Utilize a planning committee that will commit to meeting the goals and monitoring costs of the training program
• Market through the use of the Mental Health Connection website as well as in monthly MHC membership meetings to gain agency buy in and participation
• Announce the training opportunity at the next Bridging the Gap symposium

Needed Policies to Support this Recommendation

No specific local or state policies were identified as barriers to the training project. The IDLC believes that local agencies already widely support the use of CBT. Offering certified training is a benefit to local agencies by strengthening the Tarrant County workforce. Because CBT is so broadly known as one of the most effective treatments of depression and anxiety in both children and adults, the state currently supports the use of CBT in its mental health centers.
Implementation and Action Plan

The IDLC recommends creation of a task force to implement the pilot project. The role of the Task Force will be:

• Identify the CBT Training Program that will be used for the Tarrant County training
• Determine the best way to implement the pilot project
• Develop a timeline and a budget

Next Steps:

• Solicit members for the CBT Training Task Force at MHC December 10th meeting
• Task Force Chairs (Rikki Harris and Jennifer Farnum) will develop and organize the Task Force to implement the countywide CBT Training Program. It will be composed of:
  
  Current members of the IDLC who are interested and have the time to work on implementing the CBT pilot project
  Agencies practicing CBT
  Volunteers interested in CBT who are recruited at the Mental Health Connection December 10th meeting
• Meet with member agencies to discuss representation
• Hold organizational meeting and develop a work plan
• Review CBT training options available
• Select CBT Training Program for Pilot
• Establish a time line
• Develop a budget
• Bring in expert
• Implement program (champion agency implements pilot project)
• Have a stakeholder meeting that includes parents in order to educate community about the pilot project
• Solicit funds to accommodate the project

Strategies for Keeping the Knowledge Current and Widely Shared

The IDLC is committed to identifying a training program that offers ongoing consultation and continuing education. It is the belief of the IDLC that training of this nature not only provides support for clinicians, but also continuity of care for clients.

The Task Force of the IDLC will seek permission from Mental Health Connection and Mental Health Association of Tarrant County to post CBT training opportunities on their Web sites. The IDLC recommends a two-phase implementation plan that will allow the Task Force to present the training to an initial group and then allow the first group to help market the second phase.
The Trauma/PTSD Learning Community recommends that the evidence-based practice, Trauma Focused-Cognitive Behavioral Therapy (TF-CBT), be implemented as a pilot program in Tarrant County.

Executive Summary

The trauma and post-traumatic stress disorder (Trauma/PTSD) Learning Community reviewed a series of research articles in an effort to identify an evidence-based practice (EBP) that could be introduced as a pilot program to Tarrant County. In the quest for an evidence-based practice, the Trauma/PTSD Learning Community first explored the DSM-IV diagnosis for PTSD and how it applied to children and adolescents. The team members agreed that the use of the DSM-IV diagnostic criteria for PTSD should be considered the recommended practice. However, based on the experiences of some team members (and supported by literature), the diagnostic criteria have some limitations with respect to children and adolescents. In particular, they do not include children and adolescents who present a history of trauma but do not meet other criteria of the diagnosis. Failure to receive or meet criteria for a DSM-IV diagnosis for PTSD could result in the denial of services for consumers, even if they present with a clear history of trauma. Attempting to influence future revisions of the DSM-IV diagnostic criteria was beyond the scope of the assigned project, although committee members did agree that the writers of the DSM-IV should be encouraged to consider a broader or different set of criteria for children and adolescents.

The team agreed upon the following working definitions that would assist in the development of the Trauma/PTSD Learning Community’s recommendations. It is important to note that these definitions are not intended to establish a new standard for trauma diagnosis nor are they intended to be adopted outside of the Learning Community framework.

Trauma: Trauma events involve:

- experiencing a serious injury to one’s self or witnessing a serious injury to or the death of someone else
- facing imminent threats of serious injury or death to one’s self or others or
- experiencing a violation of personal, physical and/or emotional integrity.

PTSD:

- Clinical definition of the group of maladaptive symptoms and related disorders that stem from experiencing trauma.

A consistent theme throughout discussions dealt with the need within Tarrant County to develop a method to accurately identify trauma in children and adolescents in a congruent manner across the community. Such a process would assist lay individuals and professional personnel who have direct contact with children, adolescents and families to acquire the necessary skills to recognize trauma. Therefore, the team began to discuss a system that would incorporate a comprehensive screening and assessment process to substantiate whether trauma was present at a level suggesting the need for services to be provided. This framework of a community-wide assessment and referral process would be known as TARP – Treatment Assessment and Referral Process.
TARP will provide a foundation for community agencies to:

- Effectively implement evidence-based practices and programs
- Learn about trauma-informed services
- Receive training and coaching in conducting trauma-informed assessments, and
- Implement other trauma-informed practices.

After extensive discussion, the learning community reached consensus on recommending Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) as the evidence-based practice to be piloted in Tarrant County within the context of a universal Treatment Assessment and Referral Process (TARP) developed by the Trauma/PTSD Learning Community.

Learning Community Members

- Carolyn Hanke, Millwood Hospital and Mental Health Advocate - Agency Champion
- James Holcomb - Facilitator
  Deborah Caddy, The Women's Center
  Paige Chambers, Lena Pope Home
  desAnges Cruser, University of North Texas Health Science Center
  Diana Davis, Alliance for Children
  Jan Finch, The Parenting Center
  Holly Garrett, Lena Pope Home, Inc.
  E. Brooke Knox, Mental Health Association of Tarrant County
  Lee LeGrice, Lena Pope Home, Inc.
  Becka Meier, The Women's Center
  Bill Menchaca, Tarrant County
  Monica Olson, Lena Pope Home
  Linda Ragsdale, Mental Health Association of Tarrant County
  Derek Robertson, AIDS Outreach Center
  Zeba Salim, MHMR of Tarrant County
  Alan Schonborn, All Church Home for Children
  Erin Snell, Lena Pope Home, Inc.
  Kelly Willis, Tarrant County

Summary of Research on Trauma/PTSD

The following research articles were reviewed to provide insight into the nature and consequences of childhood trauma. Additionally, multiple empirically-supported treatment protocols were analyzed to determine their relative strengths and weaknesses with respect to the needs of assessing and treating traumatized children in Tarrant County.

The Long Term Consequences of Early Childhood Trauma: A Case Study & Discussion

Provides a case example that sheds light upon the impact of early childhood trauma. The authors provide insights into the neurobiological sequelae of early childhood trauma, as well as how young children encode and remember traumatic events. The authors explain how this is impacted by young children’s inability to readily express their recollections of the traumatic event in words.
Disseminating Early Interventions Following Trauma

Identifies the evidence base for effective early interventions for treating child survivors of trauma. It highlights the importance of both assessing the needs of children following a traumatic event and identifying what role therapy should play, based upon the child's identified needs. The authors highlight the need for treatment developers to effectively disseminate information to treatment providers.

Sexually Abused Children Suffering From PTSD: Assessment & Treatment Strategies

An analysis of the recent advances in the assessment tools used to identify symptoms of PTSD. Recommendations are made for a multi-informant and age-sensitive assessment. The article examines the research on treatment and concludes that structured cognitive-behavioral interventions can help alleviate PTSD symptoms. Furthermore, the authors assert that both the child and the non-offending caregiver should participate in the therapeutic process to maximize the treatment benefits.

Childhood Trauma & Psychotic Disorders: a Systematic, Critical Review of the Evidence

A meta-analysis of the available research that explores the relationship between childhood trauma and psychotic disorders. The research identified multiple methodological flaws in the existing research. However, there was enough evidence to suggest a link between childhood trauma and psychotic disorders, as well as highlighting the need for additional research in this area.

Creating a Trauma-informed Child Welfare System

This article underscores the need for the child welfare system to utilize the available information and research on childhood trauma to effectively respond and intervene in cases of childhood abuse. The authors identify eight essential elements to create a framework for a responsive and healing welfare system. They recommend that the children in the welfare system be assessed to identify treatment needs. The importance of developing a community protocol is emphasized.

Evidence Based Treatment for Children in Child Welfare

The article identifies and describes exemplary trauma-focused treatments, as well as the components of these treatments. Additionally, the authors recommend these practices be implemented and circulated throughout the country.

Prevention and Treatment of PTSD in the School Setting

Examines the impact PTSD may have on children. The article provides a review of the relevant literature on the prevention and treatment of PTSD. Furthermore, the authors provide a comprehensive, broad-scale, school-based model for preventative interventions.

Factors Affecting the Diagnosis & Prevention of PTSD Symptomology in Children and Adolescents

This article examines the diagnostic validity and risk factors for PTSD. The results of the research indicate a child is more likely to have PTSD symptoms if there are prior external behavior problems. The authors also discovered that the diagnostic criteria for PTSD likely results in the under-diagnosing of PTSD in preschool age children. Finally, the authors recommend seeking information from both the survivor of trauma as well as the caregiver when determining if the child meets the criteria for PTSD.

Evidence-Based Programs and Practices explored:

• Trauma Systems Therapy (TST)
• Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
• Abuse-Focused Cognitive Behavioral Therapy (AF-CBT)
• Parent-Child Interaction Therapy (PC-IT)
Recommended Evidence-Based Practice or Program for Trauma/PTSD

The Evidence-Based Practice selected by the Trauma Learning Community was chosen based on its ability to appropriately meet the needs of the proposed populations. The Trauma/PTSD Learning Community recommends that the evidence-based practice Trauma Focused-Cognitive Behavioral Therapy (TF-CBT) be piloted in Tarrant County. This evidence-based practice is included on the National Child Traumatic Stress Network (NCTSN) website.

TF-CBT will be used to treat children age 3 to 18 who are living in the community (Cohen, Mannarino, and Deblinger, 2006). This is listed as one of the Promising Practices endorsed by NCTSN. Factors driving this selection include:

• TF-CBT has the strongest evidence for treating trauma in children (Cohen, et al., 2004)
• The program has been effective with children experiencing an array of traumas
• The program is effective for young children as well as adolescents
• The program was developed with input from a wide variety of stakeholders
• The program can be delivered in a wide array of settings and/or locations
• The program has been culturally adapted to ensure treatment effectiveness with various populations (i.e., Indian County Child Trauma Center, Depelchin Children’s Services)

The program has a strong component of outreach to parents and family members

While TF-CBT is the recommended evidence-based practice to be piloted in Tarrant County, this treatment program alone is only one facet of the committee’s recommendation.

The Learning Community also recommends that TF-CBT be offered within the context of a universal Treatment Assessment and Referral Process (TARP) developed by the Trauma/PTSD Learning Community. See Figure A for an overview of TARP, including its strengths and barriers to implementation. Figure A also presents the incorporation of the evidence-based practice TF-CBT within the TARP model. As noted, this model also has the potential to include future evidence-based practices.

After identifying the definitions of trauma and PTSD, the team determined the need within Tarrant County for development of a method that will accurately screen trauma in children and adolescents in a congruent manner across the community. This process would help lay individuals and professionals who have direct contact with children, adolescents and families to acquire the necessary skills to recognize trauma. The team then began to discuss a system that would incorporate a comprehensive screening and assessment process to substantiate whether trauma is present at a level suggesting the need for services. This assessment process would need to utilize a set of instruments and measures that are both reliable and valid. These measures, selected especially for consumers identified with trauma, would be used by providers in a multitude of settings to assist in supporting and enhancing clinical and perceptual judgments. Once an individual is assessed for trauma, this process would also assist with linking the individual with the appropriate treatment. This framework of a communitywide assessment and referral process would be known as TARP – Treatment Assessment and Referral Process.
TARP will provide a foundation for community agencies to:

• Effectively implement evidence-based practices and programs
• Learn about trauma-informed services
• Receive training and coaching in conducting trauma-informed assessments
• Implement other trauma-informed practices.

The goals of this process are to:

• Increase the number of children receiving trauma-informed services
• Improve children’s treatment outcomes
• Increase the percentage of child-serving professionals who utilize trauma-informed practices and services in Tarrant County, in part by providing training for these professionals

Figure A: Incorporation of the Evidence-Based Practice TF-CBT (Trauma Focused-Cognitive Behavioral Therapy) in TARP (Trauma Assessment and Referral Process)

• The TARP Advisory Group drives the community model and includes members from the Trauma/PTSD Learning Community. Additional members will be recruited based on the needs of the target population. Tasks will include working with the community and Mental Health Connection (MHC), as well as coordinating trauma identification, referral, assessment and trauma intervention training(s).
• Mental Health Connection’s Social Marketing Committee will provide the experience and strategy needed to identify and engage key community leaders in the implementation of trauma-informed services. In addition, committee
members will design promotional materials such as billboards, fliers and public service announcements (PSAs) that de-stigmatize trauma, educate and communicate how to access services.

- The Education component of the TARP model focuses on two areas: community education and skills training. MHC and the TARP Advisory Group will work in conjunction with social marketing efforts to develop a curriculum that will be used to educate the general community about trauma. The TARP Advisory Group will offer presentations using the curriculum to address areas such as:
  
  What is trauma and what does it look like?
  How does one screen and assess for trauma?
  What is the prevalence of trauma?
  What are the examining differential diagnoses and how do they differ from anxiety and depression?

- These presentations will be directed toward individuals and groups who work or have contact with children and adolescents. Examples include teachers, school counselors, PTAs, emergency responders, child protection workers, civic leaders and representatives. A standardized curriculum will help to ensure a consistent understanding in identifying and recognizing trauma and, in turn, encourage individuals and groups to make appropriate referrals to community service providers. The skills training component will focus on the standardized delivery of TF-CBT. The skills component will ensure that community providers are treating trauma-related symptoms with the necessary skills and utilizing TF-CBT properly.

- Following the education component is the Screening and Referral stage. The lay individuals and professionals in the community, now trained in trauma-related symptoms in children and adolescents, will make appropriate referrals of these individuals to community service providers for assessment, referral and treatment. Community services providers will then conduct a comprehensive assessment (utilizing a community-wide assessment protocol) within a culturally sensitive context as part of the initial referral. This assessment will be designed to accurately identify trauma and related mental health needs. The correct identification of trauma and other issues will increase the likelihood that consumers receive the most effective intervention. As discussed in the education component, community treatment providers will be trained in conducting in-depth trauma assessments. These assessments will include the use of a series of trauma-specific instruments such as the Trauma Systems Checklist and Child Behavior Checklist. The assessment instruments will be agreed upon in advance by all community partners.

- Community service providers will be responsible for providing TF-CBT after the assessment process. The proposed intervention will be offered in both English and Spanish when available and will be accessible through various delivery settings.

- Evaluation of the TARP process TF-CBT implementation will be conducted on multiple levels and include assessments of community organizations, TF-CBT intervention and client services. Results from these evaluations will be fed back into the system through the TARP Advisory Group to refine services, address consumer needs and provide the qualitative and quantitative data needed to sustain the TARP initiative. Development of a cost-benefit analysis will be considered as a long-term goal.

There are several major strengths in using TARP. First, it provides a structure not only for the evidence-based practice TF-CBT, but also for future evidence-based practices. Second, it addresses the need for standardizing measures and reaching a communitywide consensus regarding the identification, screening, referral, assessment and treatment of trauma/PTSD. Third, with an improvement in the methods of screening, an increased number of children and adolescents presenting with trauma-related symptoms will be identified and served. Finally, by providing additional services to these individuals and their families, the incidents of family violence and juvenile delinquency are expected to decline while school productivity increases.

**Specific Areas of Need in Tarrant County Related to Trauma/PTSD**

Major Needs and Opportunities: In the past five years, reports of abuse and neglect in Tarrant County have significantly increased. More children are entering substitute care with limited services being provided to the entire family. Research indicates that the vast majority of these children have suffered from trauma. Without an understanding of how to adequately assess and treat these children, the demand on our child welfare system will continue to grow, and the impact in social and economic terms will increase as these children become adults. (See Table 1).
In 2005, United Way of Tarrant County conducted a comprehensive assessment of health and human needs in the community. The study involved both primary and secondary research, including the design and administration of surveys to residents and community leaders and extensive reviews of 64 subject areas. A number of findings from this study point to the need for trauma-informed services in Tarrant County, and are included in Table 2.

### TABLE ONE

<table>
<thead>
<tr>
<th>Texas Department of Family and Protective Services child abuse statistics – Tarrant County</th>
<th>2001</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alleged victims of child abuse and neglect</td>
<td>12,615</td>
<td>19,652</td>
</tr>
<tr>
<td>Confirmed victims of child abuse and neglect</td>
<td>2,188</td>
<td>5,529</td>
</tr>
<tr>
<td>Children removed from home</td>
<td>226</td>
<td>646</td>
</tr>
<tr>
<td>Children provided services</td>
<td>1,314</td>
<td>3,194</td>
</tr>
<tr>
<td>Children in foster care</td>
<td>896</td>
<td>1,776</td>
</tr>
<tr>
<td>Children in substitute care</td>
<td>1,042</td>
<td>2,139</td>
</tr>
<tr>
<td>Foster care expenditures</td>
<td>$11,563,088.25</td>
<td>$19,496,992.45</td>
</tr>
</tbody>
</table>

Source: Texas Department Family Protective Services 2007 and 2001 Data Book.

### TABLE TWO

<table>
<thead>
<tr>
<th>Perceived sources and prevalence of violence in Tarrant County</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Family Violence</strong></td>
</tr>
<tr>
<td>Percent reporting that family violence is a problem in their neighborhood:</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Violence in the Community and School</strong></td>
</tr>
<tr>
<td>Percent reporting that their child had been bullied at school</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Sexual Assault</strong></td>
</tr>
<tr>
<td>Percent reporting that sexual assault is a problem in their neighborhood</td>
</tr>
</tbody>
</table>

Source: United Way of Tarrant County 2005 Community Needs Assessment
In addition to the number of children who have experienced abuse and/or family violence, the needs of those children who have suffered trauma due to natural disaster continue to unfold in Tarrant County. The Dallas-Fort Worth area ranked second in the state in the number of relocated evacuees following the Hurricane Katrina disaster in August 2005. As evacuees began to stream into Tarrant County, mental health support to displaced families living in shelters was provided. The community’s response to this immediate and overwhelming crisis was timely and effective in addressing the basic needs of families. However, following the initial response, there has been no coordinated effort to serve the residual mental health needs of these families. According to the 2006 report from the Texas State Health and Human Services Commission, there are significant numbers of families who have remained in North Texas following Hurricanes Katrina and Rita. The North Texas Housing Coalition has recognized significant need and limited availability of culturally responsive mental health services for those still struggling with the loss of homes, loved ones and economic stability.

Of the evacuees surveyed, 38% stated they have delayed or avoided seeking medical/mental health care, while 30% stated they had trouble accessing the care they need. These percentages correlate with the number of families who had Medicaid and Children’s Health Insurance Program (CHIP) benefits prior to the hurricane, but have been unable to access coverage since. This information, when coupled with the number of families still requiring housing assistance and social service assistance, suggests that there are children and families in Tarrant County who continue to struggle with the aftermath of Hurricanes Katrina and Rita and whose mental health needs are not being addressed.

**Barriers to Effective Implementation**

Despite the numerous advantages and opportunities a model such as TARP can bring to the community, it is not without barriers to its implementation. Often these barriers can be incredibly challenging to overcome. A major barrier is the need for collaboration from individuals, agencies and other entities that work with children and adolescents. They must work together toward a model that includes widespread use of standardized screening, assessment and referral procedures. The cost of implementing TARP is also a major concern. In addition to the training costs for community education and skills training, there is a cost to provide the trauma-specific instruments for all community service providers. Plus, to make sure community service providers continue to administer TF-CBT properly, assigned individuals will be needed to provide ongoing oversight. The evaluation costs for both TARP and TF-CBT will also have to be considered.

**TABLE THREE**

<table>
<thead>
<tr>
<th>Description</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of evacuees remaining in Texas as of June 2006</td>
<td>251,000</td>
</tr>
<tr>
<td>Number of evacuees remaining in the Dallas-Fort Worth area as of June 2006</td>
<td>66,000</td>
</tr>
<tr>
<td>Percentage of evacuees anticipating remaining in Texas past May 2008</td>
<td>44%</td>
</tr>
<tr>
<td>Percentage of DFW evacuees between the ages of 1 and 17</td>
<td>39%</td>
</tr>
<tr>
<td>Percentage of DFW evacuees who are adult females with children in the home</td>
<td>61%</td>
</tr>
<tr>
<td>Percentage of DFW evacuees who stated their health had declined post hurricane</td>
<td>20%</td>
</tr>
<tr>
<td>Percentage of DFW evacuees who stated their mental health has declined post hurricane</td>
<td>40%</td>
</tr>
<tr>
<td>Percentage of DFW evacuees who are employed post-hurricane</td>
<td>33%</td>
</tr>
</tbody>
</table>
Another major barrier is the common resistance to change that exists for everyone involved. This anticipated resistance can be evident in both the private and non-profit sector. Some of this uncertainty and resistance can arise in circumstances where community providers treat consumers without having the skills or experience with trauma-informed interventions, ignore trauma-specific needs, and do not refer out to those with the specialized training. Moreover, there are no clearinghouses or directories that can be used to identify those providers with the requisite skills and experience for referral purposes. While the cost and amount of work involved appear to be barriers to laying the foundation of such a model, the overall process could reduce costs in the long run.

Beyond the TARP process, implementing TF-CBT creates other specific barriers for implementation:

- **Money** – The cost for training and implementing the necessary screening and testing tools can be expensive, and some agencies may not be able to make the financial commitment.
- **Limited Scope** – Although TF-CBT is a well researched and highly recommended form of treatment, it does not address all types of trauma and therefore has some limitations.
- **Investment** – Because TF-CBT does not address all types of trauma, and because the training can be costly, some agencies may not want to make the commitment to invest the time or financial resources in something that may not address all of their clients' needs.
- **Fidelity** – Ensuring that the fidelity of the model is being maintained across treatment locations and clinicians will be challenging. Specific and certified training must be enforced for those individuals implementing the model.
- **Change** – Implementing TF-CBT would mean changing the way we are currently treating clients who have experienced trauma. As a result, some agencies may show some resistance or fear of changing their current practices.
- ** Modifications** – TF-CBT will require modifications when working with clients who are acutely suicidal, substance dependent or cognitively impaired.

**Needed Policies to Support this Recommendation**

- The Trauma Learning Community recommends policies that support trauma-informed services at the local and state levels. Trauma exposure among children and youth is associated with lifelong health, mental health and related problems, as well as with related increased costs.
- Policies are needed that will increase education and awareness in the lay and professional communities.
- Policies are needed that will increase the funding and availability of preventive and comprehensive services for all consumers who might benefit from them.
- Policies must include responsive financing, cross-system collaboration, training, accountability and infrastructure development.
- A trauma screening tool needs to be used community-wide to assess for possible trauma. The universal screening tool would be used by schools, counselors, law enforcement, hospitals and community agencies.
- A policy should make funding contingent upon providers' utilizing an evidence-based practice.
- Providers receiving public support and using TF-CBT in Tarrant County should be required to register their trauma-focused practice with Mental Health Connection to ensure their fidelity to the model. The community wants to stop harmful practices that reduce the resolution of trauma or cause the re-traumatization of youth in child-serving settings.
**Implementation and Action Plan**

- Community-Wide Training for all individuals and groups who work or have contact with children and adolescents
- Obtain and/or develop procedural and training manual
- Educate about free online basic training
- Hold meeting of people serving children and evaluate community readiness
- Identify those who is interested in implementing
- Identify screening and assessment measures
- Assess whether services are working
- Data Management
- Evaluation

**Strategies for Keeping the Knowledge Current and Widely Shared**

- Use current website with Mental Health Connection blog
- Hold a training annually, and share information on other training opportunities
- Process how programs are working - pay attention to evaluation/outcomes
- Implement cost benefit analysis measures
- Hold monthly brown bag sessions
- Establish a Trauma Advisory Council to continue reviewing the latest research in trauma
- Establish a monthly reading club