Psychotropic Medication Use Among Children in Foster Care: Technical Assistance Webinar Series

IMPLEMENTING TRAUMA-INFORMED APPROACHES TO CARE

November 19, 2013

3:00 PM-4:30 PM EST
Dial-In: 866-598-9781 // Passcode: 2839328
**Questions?**

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Behavioral Health Needs of Children in Foster Care

- Children in foster care represent a high-need, high cost population within Medicaid
- Fostering Connections requires a collaborative approach to meeting their behavioral health needs
- Children in foster care have experienced abuse, neglect or both that may result in trauma
- An effective approach to identifying and responding to trauma can reduce reliance on psychotropic medication

A trauma-informed child- and family-service system is one in which all parties involved recognize and respond to the impact of traumatic stress on those who have contact with the system including children, caregivers, and service providers. Programs and agencies within such a system infuse and sustain trauma awareness, knowledge, and skills into their organizational cultures, practices, and policies. They act in collaboration with all those who are involved with the child, using the best available science, to facilitate and support the recovery and resiliency of the child and family.

Definition developed by the National Child Traumatic Stress Network’s Trauma-Informed Service Systems Working Group.
Trauma-Informed Systems in Action

- Routinely screen for trauma exposure and related symptoms
- Use culturally appropriate evidence-based assessment and treatment for traumatic stress and associated mental health symptoms
- Make resources available to children, families, and providers on trauma exposure, its impact, and treatment
- Engage in efforts to strengthen the resilience and protective factors of children and families impacted by and vulnerable to trauma
- Address parent and caregiver trauma and its impact on the family system
- Emphasize continuity of care and collaboration across child-service systems
- Maintain an environment of care for staff that addresses, minimizes, and treats secondary traumatic stress, and that increases staff resilience

Characteristics proposed by the National Child Traumatic Stress Network’s Trauma-Informed Service Systems Working Group.
Speakers

- Joyce Pfennig, Administration for Children and Families
- Connecticut
  - Marilyn Cloud, Connecticut Department of Children and Families
  - Jason Lang, Connecticut Center for Effective Practice
  - Christian Connell, Yale School of Medicine
- Texas
  - Audrey Deckinga, Department of Family and Protective Services
Systems that Identify, Assess, and Treat Children’s Trauma: ACF Trauma-Informed Care Grants

Joyce Pfennig, PhD
Administration for Children and Families
Children’s Bureau
Mental Health Use among Children and Youth in Foster Care

Data source: HHS, 2010
Challenges among Children Known to Child Welfare

- Developmental Problems (0-5 years-old)
- Cognitive Problems (4-17 years-old)
- Emotional/Behavioral Problems (1.5-17 years-old)
- Substance Use Disorder (11-17 years-old)

## Symptoms that Overlap with Child Trauma and Mental Illness

<table>
<thead>
<tr>
<th>Mental Illness</th>
<th>Overlapping Symptoms</th>
<th>Trauma</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attention deficit/hyperactivity disorder</td>
<td>Restless, hyperactive, disorganized, and/or agitated activity; difficulty sleeping, poor concentration, and hypervigilant motor activity</td>
<td>Child trauma</td>
</tr>
<tr>
<td>Oppositional defiant disorder</td>
<td>A predominance of angry outbursts and irritability</td>
<td>Child trauma</td>
</tr>
<tr>
<td>Anxiety disorder (incl. social anxiety, obsessive-compulsive disorder, generalized anxiety disorder, or phobia)</td>
<td>Avoidance of feared stimuli, physiologic and psychological hyperarousal upon exposure to feared stimuli, sleep problems, hypervigilance, and increased startle reaction</td>
<td>Child trauma</td>
</tr>
<tr>
<td>Major depressive disorder</td>
<td>Self-injurious behaviors as avoidant coping with trauma reminders, social withdrawal, affective numbing, and/or sleeping difficulties</td>
<td>Child trauma</td>
</tr>
</tbody>
</table>

Griffin, McClelland, Holzberg, Stolbach, Maj, & Kisiel, 2012
Administration on Children, Youth and Families (ACYF) Activities to Support States Regarding Psychotropic Medication Use in Foster Care

- Dept. of Health and Human Services (HHS) Interagency Work (e.g., coordination with Centers for Medicare & Medicaid Services (CMS) on State Director Letters and Informational Bulletins)
- Information Memorandum and Program Instruction on psychotropic medication use in foster care
- Information Memorandum on well-being
- Webinars
- Cross-system summit, Because Minds Matter
- Making Healthy Choices: A Guide on Psychotropic Medications for Youth in Foster Care (developing a companion guide for foster parents)
- Online resources (www.childwelfare.gov)
Reauthorization of Promoting Safe and Stable Families (PSSF) includes new language addressing trauma and vulnerable populations:

• State plans shall include an outline of “how health needs identified through screenings will be monitored and treated, including emotional trauma associated with a child’s maltreatment and removal from home”

• Plans must include a description of “the oversight of prescription medicines, including protocols for the appropriate use and monitoring of psychotropic medications”
Integrating Trauma-informed and Trauma-focused Practice in Child Protective Service Delivery “Trauma I”

Grant specs: Up to $640,000 per year for up to 5 years

• Massachusetts Department of Children and Families, Boston, MA
• North Carolina Department of Health and Human Services, Raleigh, NC
• Connecticut Department of Children and Families, Hartford, CT
• The University of Montana, Missoula, MT
• University of Colorado Denver, Aurora, CO
Initiative to Improve Access to Needs-Driven, Evidence-Based/Evidence-informed Mental and Behavioral Health Services in Child Welfare  
“Trauma II”

Grant specs: Up to $640,000 per year for up to five years

- Western Michigan University, Kalamazoo, MI
- Trustees of Dartmouth College, Hanover, NH
- New York University School of Medicine, New York, NY
- Rady Children's Hospital, San Diego, CA
- Oklahoma Department of Human Services, Oklahoma City, OK
- University of Washington, Seattle, WA
- Franklin County Children Services, Columbus, OH
- Tulane University, New Orleans, LA
- District of Columbia Child and Family Services, Washington, DC
Promoting Well-Being and Adoption after Trauma
“Trauma III”

Grant specs: Up to $500,000 per year for up to five years

- University of Kansas Center for Research, Inc., Lawrence, KS
- University of Louisville Research Foundation, Inc., Louisville, KY
- New Hampshire Division for Children, Youth and Families, Concord, NH
- Harmony Family Center, Inc., Knoxville, TN
- The University of Vermont and State Agriculture College, Burlington, VT
- Rhode Island Department of Children, Youth and Families, Providence, RI
Validated Screening

Clinical Assessment

Case Planning for Safety, Permanency, and Well-being

Evidence-based Intervention(s)

Outcomes: Safety, Permanency, Well-Being

Progress Monitoring

social-emotional functioning

context: therapeutic, responsive & supportive settings & relationships

Achieving Better Outcomes
Establishing the Right Services Array: De-scaling What Doesn’t Work, Scaling Up What Does

De-scaling what doesn’t work

Parenting Classes

Anger Management

Generic Counseling

Evidence-Based Parenting Interventions

Evidence-Based Trauma & Mental Health Interventions

Trauma Screening & Functional Assessment

Investing in what does work

INEFFECTIVE APPROACHES

RESEARCH-BASED APPROACHES
Trauma-Informed Practice

- **Knowledge building and developing practice**
  - Training staff and foster parents
  - Providing supports to staff to address secondary trauma
- **Validated, trauma-informed screening and assessment**
  - Screening and continual outcome monitoring that gathers information from multiple sources
- **Case planning and management**
  - Requires trauma-informed, sensitive and responsive relationship between child and social worker, birth parents, foster parents, etc.
  - Requires processes and infrastructure that support timely exchange of information needed for decision-making within and across systems
- **Scaling-up of evidence-informed services**
  - Skilled mental health providers available
  - System readiness and capacity to deliver trauma-focused mental health treatment
- **Cross-system partnerships and system collaboration**
  - Work with Medicaid and mental health to share information and respond to trauma-informed needs being identified

Emerging Observations/Key Challenges

• Measure selection isn’t easy
• No two systems are alike
• Implementation matters
• Constant course corrections required
• System change requires planning and strategic action, patience, flexibility, good communication and collaboration
Advancing Trauma-Informed Care in Connecticut’s Child Welfare System

Marilyn Cloud, LCSW
CT Department of Children and Families

Jason Lang, PhD
CT Center for Effective Practice
Child Health and Development Institute

Christian Connell, PhD
The Consultation Center,
Yale School of Medicine
Background

- Introduction to evidence-based practices (1999)
- Trauma Summit (2007)
- Trauma-Focused Cognitive Behavioral Therapy dissemination (2007-2010)
- New Department of Children and Families (DCF) leadership (2011)
- Changing federal policies (2010-present)
  - Safety (physical and psychological safety)
  - Permanency (addressing trauma, fewer disruptions, less medication)
  - Well-being (emotional and social)
  - *Child and Family Services Improvement and Innovation Act* of 2011 (P.L. 112-34)
- Administration for Children and Families (ACF) Trauma Grant Connecticut Collaborative on Effective Practices for Trauma (CONCEPT) Grant (2011-2016)
- Newtown school shooting (12/14/12)
- CT legislative response
Collaborative on Effective Practices for Trauma (CONCEPT) Overview

$ 3.2 million, 5-year trauma grant

Project Aims

• To enhance DCF’s capacity to identify and respond to children who have experienced trauma
• To enhance access to evidence-based, trauma-informed interventions in the community
• To provide education/support to the DCF workforce to reduce/prevent secondary traumatic stress

Project Activities

• DCF and mental health provider workforce development
• Child welfare system-wide trauma screening and assessment
• Dissemination of Trauma-focused Cognitive Behavioral Therapy
• Dissemination of child and family traumatic stress intervention
• Evaluation of child and system outcomes
Building a Trauma-Informed Child Welfare System

• **Embedded within child welfare operations**
  • Strengthening Families practice model; key principle of care
  • Trauma-informed care policy/practice guide
  • Ongoing review of DCF policies/practice guides
  • Trauma champions and worker wellness/support teams

• **Focused on workforce development**
  • Train-the-trainer approach with DCF Training Academy
  • National Child Traumatic Stress Network Child Welfare Trauma Toolkit Training (2 days)
  • Mandatory for workers/supervisors/program managers/office directors
  • Cross training with providers

• **Focused on practice transformation**
  • Universal trauma screening and referral
  • Assessment, case planning, ongoing evaluation, service delivery
Linkages with DCF Medication Unit

- Centralized medication consult unit (2007)
- Central office trauma consultant
- Central office child psychiatry consultations

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of DCF-Committed Children</th>
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<tbody>
<tr>
<td>2010</td>
<td>3600</td>
</tr>
<tr>
<td>2011</td>
<td>3400</td>
</tr>
<tr>
<td>2012</td>
<td>3200</td>
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</table>

<table>
<thead>
<tr>
<th>Year</th>
<th>% Committed Children Receiving Psychotropic Medication</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>25.5</td>
</tr>
<tr>
<td>2011</td>
<td>24.5</td>
</tr>
<tr>
<td>2012</td>
<td>22.5</td>
</tr>
</tbody>
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Psychotropic Medication Use by Children (TF-CBT Cohort 1 Assessment Referrals)

# Psychotropic Medication Types

- None: 75%
- 1: 15%
- 2: 8%
- 3: 2%

Type of Medication

- ADHD
- Antidepressant
- Anti-Anxiety
- Anti-Psychotic
- Mood Stabilizer
TF-CBT Dissemination

- Learning collaboratives began in 2007
- 28 community clinics and 500+ clinic staff
- Statewide infrastructure for support/quality assurance
- 2,900+ children served
  - 1/3 have child welfare involvement
Goals of Trauma Screening

• Trauma-informed child welfare practice
• Early identification of children who may be suffering from traumatic stress
• Connect with trauma-focused assessment/evidence-based treatments
• Integrate trauma-focused treatment into Child Protective Services case planning
Feedback from Staff about Trauma Screening

- Tremendous interest in trauma
- Little awareness about trauma-focused evidence-based treatments
- Integrate with Child Protective Services practice
- Keep it simple
- Make it mandatory
- Avoidance
- Secondary traumatic stress
Systems Effected by Trauma Screening

- Programs
  - Community Treatment Providers
- Information Systems
- Training Academy
- 15 Area Offices
  - Investigations
  - Differential response
  - Adolescent services
  - Foster care and other units
  - Managers and supervisors
- Central Office
- Policy
- Quality Assurance
- Congregate Care Facilities
- EAP
Proposed Screening Process

• Face-to-face screen (child and caregiver) and records
• Worker enters into Statewide Automated Child Welfare Information System (SACWIS)
• Automated recommendation generated
• Standardized behavioral health referral form generated
• Needs are pre-populated into case plan
• Required in ongoing services (every 6 months)
• Trauma passport
Trauma Screening Pilots

• 3 pilots completed during development
  • 2 area offices; 1 learning collaborative
• Resulted in changes to tool/process/training
• Resulted in not requiring screening at intake
• Last pilot with 15 DCF workers in the learning collaborative
  • 49% learned new information about trauma history
  • 86% learned new information about trauma reactions
  • 64% said it helped inform their casework
Next Steps

• SACWIS redesign
• Integrate with standardized child welfare assessment group
• More piloting
• Collect data to inform tool development
• Continuing integration/coordination with behavioral health providers
Evaluation Components

• Planning Phase
  • System-level readiness and capacity assessment

• Implementation Phase
  • Process evaluation – implementation activities and fidelity
  • Outcome evaluation
    • Effects of workforce development (learning collaboratives, child welfare trauma training, etc.)
    • Effects of evidence-based practices
    • Changes in system-level readiness and capacity

• Cost evaluation – costs to deliver CONCEPT components
Evaluation Milestones

• Planning Year
  • DCF statewide trauma-readiness and capacity survey
  • Stakeholder focus groups
  • Access to SACWIS and provider data for service population

• Implementation Phase
  • Longitudinal data collection to assess child welfare trauma training effects on managers/supervisors and front-line staff
  • Completed pre/post surveys and focus groups with learning collaborative cohorts in 6 TF-CBT sites
  • Initiated child/caregiver assessment measures and implementation metrics with TF-CBT providers
Contacts

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Funding for the Connecticut Collaborative on Effective Practices for Trauma (CONCEPT) was provided by the Department of Health and Human Services, Administration for Children and Families, Children's Bureau, Grant #0169
Questions?

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Trauma-Informed Approaches for Children in Foster Care

Implications for Psychotropic Medication Use

Audrey Deckinga, LMSW-MSSW
Assistant Commissioner for Child Protective Services
Since 2004, Texas stakeholders have collaborated to improve health care, provide oversight of psychotropic medication use, and more recently, to develop a trauma informed system of care for foster children in Texas:

- In 2005, Texas released the *Psychotrophic Medication Utilization Review Parameters for Foster Children* (“the Parameters”)
- In 2005, 2007, and 2013, laws were passed to improve healthcare, strengthen processes related to psychotropic medications, and ensure the appropriate use of non-pharmacological interventions
- In April 2008, STAR (State of Texas Access Reform) Health began for all Texas foster children and young adults
- In 2011 and 2012, the Department of Family and Protective Services (DFPS) launched a trauma-informed care initiative and a strategic plan
• Child Protective Services (CPS) staff and caregivers are trained on trauma-informed care and Texas has a network of therapists providing trauma-informed cognitive behavioral therapy (TF-CBT)
• Multiple stakeholders with diverse views working together
• DFPS has engaged the expertise of state and national experts for trauma-informed care and psychotropic medication use in Texas foster care
• 34% reduction in the use of psychotropic medications for 60 days or more between 2004 and 2012
Psychotropic Medication Use among Texas Foster Children

Percentage of Children in Texas Foster Care

- Psychotropic Meds 60 days+
- Class polypharmacy
- Five or more Meds polypharmacy


- 34% decrease since 2004
- 66% decrease since 2004
- 69% decrease since 2004
Oversight of Psychotropic Medications by Multi-tiered Child Welfare System

- Trained medical consenters knowledgeable of child’s health needs, sign acknowledgement of need to use appropriate non-pharmacological interventions
- CPS staff acting as “parent” to oversee all health care
- Residential operations ensuring compliance with DFPS policies, rules, and licensing requirements
- Courts reviewing medical care and ensuring appropriate use of non-pharmacological interventions
- Attorneys and guardians ad litem seeking child’s input on medical care and advocating for child
- STAR Health overseeing prescribers and providing Psychotropic Medication Utilization Review (PMUR)
Managed care organization contracted with Texas Medicaid agency to provide comprehensive, coordinated medical, dental, vision, behavioral health (BH) care, pharmacy, and Health Passport for children in Texas foster care:

- Committed to trauma-informed care
- Developed a network of BH therapists trained in TF-CBT
- Provides training to CPS staff, residential providers, caregivers and health care providers on TIC
- Provides PMUR
Responsibilities of STAR Health

• Screen all children re: psychotropic medication use
  o Telephonic health screenings when child enters foster care, changes placement, or has significant changes in medical condition
  o Automated pharmacy claims screening
  o External requests—CPS nurse consultants, DFPS staff, foster parents, attorneys, foster care agencies, Court Appointed Special Advocates
Responsibilities of STAR Health

Conduct PMUR when:

• Telephonic health screening indicates outside parameters

• Pharmacy fills psychotropic medication prescription for:
  o Any child under age 4
  o 2 or more meds in same class (3 or more mood stabilizers)
  o 4 or more psych meds for more than 60 days

• Court requests review
Responsibilities of STAR Health

Once PMUR triggered:

• Gather information from caregiver and available documentation
• Submit information to child and adolescent psychiatrist for formal review:
  o Outreaches to prescriber
  o Issues a formal report with a finding
• Conduct Quality of Care review for prescribers with persistent prescribing patterns of concern
• Can require corrective action from prescribers or terminate them from network
DFPS recognizes the long-term effects of adverse childhood experiences

Launched initiative in 2011 to transition the Texas child welfare system into trauma-informed system over next 5 years

Desired outcomes include:
- Helping children heal from abuse and neglect
- Decreasing reliance on psychotropic medications
Texas Stakeholder Workgroup definition:

A trauma-informed system of care is one in which all persons working in and connected to the multi-level child welfare system are knowledgeable and responsive to the individualized impacts of trauma in the lives of people served and on those serving within the system. A trauma-informed system incorporates the child and family's story and the child's developmental level, while establishing an evidence-based approach to policies, training, leadership, and service practice.
• Core Steering Committee and 4 major subgroups
  1. Assessment/Screening
  2. Training
  3. Caregiver support
  4. Secondary trauma

• Guidance from nationally and state known experts

• Support across multi-tiered child welfare system

• Partnership with organizations affiliated with the National Child Traumatic Stress Network

• Training workgroup developed trauma-informed care training and embedded it into agency required basic skills development
Trauma-Informed Care Initiative

• Pre-service and annual training required for CPS caseworkers, residential providers and foster parents on informed consent, psychotropic medications and trauma-informed care

• Collaboration to strengthen assessments, and infuse successful, non-pharmacological interventions across the multi-tiered child welfare system

• The Texas Health and Human Services Commission (Texas Medicaid) and Department of Family and Protective Services are reviewing all screenings/assessments/evaluations for children in CPS custody
Recommended Trauma Screenings

• Child and Adolescent Needs and Strengths Trauma Exposure and Adaptation Version (CANS-TEA)
  o Ages 18 and under

• Self-Report of Childhood Anxiety and Related Disorders (SCARED) Brief Assessment of Anxiety and Post-Traumatic Stress (PTS) Symptoms
  o Ages 7-17

• Child Welfare Trauma Referral Tool (CWT)
  o Ages 18 and under
Recommended Trauma Assessments

Administered by master’s level behavioral health providers:

- Trauma Symptom Checklist for Children
- Trauma Symptom Checklist for Young Children
- An Interview for Children: Traumatic Events Screening Inventory

Optional instruments when indicated:

- Child Sexual Behavior Inventory

When PTSD suspected:

- UCLA PTSD for DSM 5 - Child Version, Revision I
- UCLA PTSD for DSM 5- Adolescent Version Revision I
- UCLA PTSD Index for DSM 5 Parent Version Revision I
What Works Well

• One health care network statewide
• Each child has medical consenter knowledgeable about their medical condition and needs
• STAR Health able to provide trauma-informed assessment and network of health care providers with trauma-informed care training
• Multi-tiered oversight and monitoring process with shared decision-making
• All children’s psychotropic medication regimens are screened
• Processes for raising concerns
• Method to outreach to prescribers to enhance practices
• Forum and support at the state level for stakeholders across the multi-tiered child welfare system to work together to improve systems
• Brochures and training guides
• Continue Trauma-Informed Care initiative to provide non-pharmacological interventions as an alternative to psychotropic medications
• Improve assessment and evaluation process
• Continue efforts to strengthen informed consent and psychotropic medication monitoring
Psychotropic Medications – A Guide to Medical Services at CPS

http://www.dfps.state.tx.us/Child_Protection/Medical_Services/guide-psychotropic.asp

Trauma-Informed Care Training

http://www.dfps.state.tx.us/training/trauma_informed_care/
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<table>
<thead>
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<th>Month</th>
<th>Topic</th>
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<tbody>
<tr>
<td>January 2014</td>
<td>Facilitating cross-system data sharing; use of multi-system data for oversight and monitoring</td>
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<tr>
<td>March 2014</td>
<td>Education/Engagement of Providers</td>
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<tr>
<td>May 2014</td>
<td>Education/engagement of stakeholders (including family and youth) regarding policy and practice</td>
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<td>July 2014</td>
<td>Psychiatric consultation models</td>
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<tr>
<td>September 2014</td>
<td>Red flag and response systems; implementation of oversight and monitoring policies and processes</td>
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Thank you for participating in today’s webinar!

Please complete the brief evaluation as you exit the webinar.