

# STATEWIDE IMPLEMENTATION OF BEST PRACTICES:

The Connecticut TF-CBT Learning Collaborative

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# IMPACT

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CHDI

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## INTRODUCTION

There has been much progress in the development and dissemination of best practices in children's mental health over the past 15 years. Evidence-based treatments (EBTs) – approaches that have been demonstrated by research to be effective in treating targeted health problems – have become more widely available to treat a variety of mental health conditions in children and adults. There are now 120 distinct EBTs for children and adolescents listed on the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Registry of Evidence-Based Programs and Practices. However, few of these treatments are widely available in community settings. As the number of effective treatments expands, we have been faced with the challenge of how to disseminate EBTs and train providers within a statewide system of care.

EBTs are sometimes criticized for not being sufficiently “transportable” to real world settings. As a result, the availability of EBTs in communities continues to lag behind treatment development and research. Further, when community-based

providers have attempted to implement EBTs, efforts have often been challenged by organizational, policy, and staffing barriers<sup>1</sup>. Research has consistently shown that the traditional training methods typically used to implement a new practice are often ineffective for creating sustainable changes<sup>2</sup>.

In order to address the challenge of disseminating evidence-based treatment within a statewide system of care, the State of Connecticut recently applied an innovative implementation strategy to train providers in community-based outpatient settings. The Learning Collaborative methodology, an implementation process that incorporates continuous quality improvement and adult learning principles, was utilized to disseminate an evidence-based treatment, Trauma-focused Cognitive Behavioral Therapy (TF-CBT), to 16 provider organizations across Connecticut over a three year period. This report describes the TF-CBT Learning Collaborative as a case example of a successful statewide dissemination of an EBT in children's mental health.

## The Challenges of Bringing Science to Practice

Changing practice is difficult, especially with a service as complex and varied as psychotherapy. Past efforts to bring EBTs to community-based settings, primarily through traditional didactic trainings lasting from a few hours to several days and with little or no follow-up consultation, have had limited success<sup>3</sup>. For example, staff that attend a traditional training may attempt to utilize a new treatment model but then face unanticipated challenges with their clients, agency, or community. Without ongoing support, supervision, and quality assurance, many staff will revert to what is comfortable rather than continue to struggle on their own to use a new treatment.

Other approaches to dissemination have included highly structured models with clearly defined training and quality assurance requirements. For example, Multisystemic Therapy (MST), an in-home EBT for adolescents with conduct problems, has been disseminated internationally through MST Services, a central organization that provides initial and ongoing training, supervision, and quality assurance to certify MST providers<sup>4</sup>. MST, however, varies from many other EBTs in that the model is highly structured and fidelity is rigorously monitored by MST Services or licensed systems supervisors. Further, MST clinicians typically only provide MST and do not utilize other treatment models or serve other populations. In outpatient settings, staff routinely work with children and adolescents with a range of mental health concerns

and must be familiar with a wide variety of intervention techniques. In addition, the intensive quality assurance and supervision associated with MST is costly and not always practical in outpatient community mental health settings.

Providing an EBT with fidelity in an outpatient setting is inherently challenging, and barriers to changing practice exist at multiple levels. For example, clinicians may be resistant to changing their approach to therapy because of limited time, lack of ongoing support or supervision, or perceptions that the new intervention is not compatible with their treatment philosophy or clientele<sup>5</sup>. Supervisors may lack adequate experience with the new practice to effectively supervise their staff and monitor treatment fidelity. Agencies may lack resources to support a new program, may not have buy-in from key staff, or may have systems in place that are incompatible with the new practice. The high rate of staff turnover common to community-based agencies – typically from 25-50% of staff per year<sup>6</sup> – further impedes sustainability of EBTs. Agency, state, or federal policies or reimbursement mechanisms may also be a barrier to implementation. Addressing many of these barriers requires the participation of provider staff in different roles within an organization who understand and support the reasons for implementing a new practice. Unfortunately, many of these key staff do not typically attend traditional clinical trainings, and when they do there is little guidance provided on supporting implementation and sustainability.



## The Learning Collaborative Model

Confronted with the challenge of bringing research to practice, the Institute for Healthcare Improvement (IHI) developed an approach to implementing practice improvements in community settings. IHI originally developed the Learning Collaborative to provide a framework for creating improvements in health care<sup>7</sup>. A Learning Collaborative typically involves a 6-15 month process that differs from traditional training in several important ways, as shown in Figure 1. For example, Learning Collaboratives include staff with diverse roles in a team-based approach, employ several in-person trainings and individual consultation throughout the year, emphasize the use of data for quality improvement, utilize active-learning techniques, and focus on organizational change and sustainability.

Promising results have been found for the IHI Learning Collaborative model in health care fields, including the successful implementation of a chronic illness care model, a 53% reduction in waiting time at Veteran's Health Administration outpatient clinics, a 75% reduction in adverse drug events across six hospitals in the Midwest<sup>7</sup>, and improvements in preventive services provided by pediatricians<sup>8</sup>. Learning Collaboratives have also been used to improve health promotion practices in after-school programs<sup>9</sup> and to improve the quality improvement infrastructure of county mental health agencies<sup>10</sup>.

**Figure 1: Comparison of traditional training and the Learning Collaborative methodology**

	Typical Traditional Training	Learning Collaborative
<b>Duration</b>	Usually one week or less	6-15 months
<b>Days of training</b>	1-5, sometimes more	6-8 throughout the training period
<b>Focus of training</b>	Individual staff (often cannot implement a new practice themselves, and knowledge is easily lost due to staff turnover)	Team-based (knowledge and skill embedded in a diverse team)
<b>Participants</b>	Mostly clinicians, usually from many different agencies	Teams of 6-12 clinicians, supervisors, senior leaders, parents, and others from 5-6 agencies
<b>Different training tracks and curricula for each role</b>	Rarely	Training tracks are developed by faculty and include specific learning objectives and activities for staff from various roles
<b>Consultation and Technical Assistance</b>	Possibly several follow-up phone consultations, but rarely more	Monthly consultation calls, intranet discussion board, weekly technical assistance, site visits, weekly site-based team meetings
<b>Cross-Site Learning and Interaction</b>	Rarely	Cross-Site interaction and sharing innovations are integrated into all Learning Sessions, consultation calls, and other activities
<b>Training Approach</b>	Didactic, perhaps with videos and/or brief small group discussions	Didactic and interactive activities based upon adult-learning principles; group discussions, role-plays, and other active learning techniques
<b>Training Content</b>	Clinical skills	Clinical skills, organizational change, quality improvement, use of data, and sustainability planning
<b>Use of data</b>	None or limited to recommendations about assessment tools, with little to no follow-up	Data used at all levels for quality improvement, from clinical assessments to monthly metric data about implementation; staff held accountable for data use
<b>Quality Improvement</b>	Rarely addressed	All staff are trained to use IHI's Model for Improvement, and to collect and use data for improving practice and implementation



**“We found the metrics to be very helpful. They provided a lens that everyone was able to focus through. It helped staff to really understand the training modules, to shape their behavior and change their practice. I thought it was very, very effective for us in that way.”**

*A TF-CBT Senior Leader*

While initially designed to implement practice improvements in health care, the Learning Collaborative model is flexible enough to apply to a variety of practices and fields. For example, the National Child Traumatic Stress Network’s (NCTSN) National Center at Duke University has adapted the Learning Collaborative model to disseminate EBTs for treating child traumatic stress<sup>11</sup>. The NCTSN is funded by SAMHSA, part of the U.S. Department of Health and Human Services, and is comprised of a network of more than 60 sites across the country. The NCTSN has adopted the Learning Collaborative as the primary

mechanism for disseminating EBTs across NCTSN sites nationally, and has coordinated over 35 regional or national Learning Collaboratives. The Learning Collaborative model has also recently been used to successfully improve engagement in child mental health services across five agencies in New York<sup>12</sup>.

The following case study illustrates how the Learning Collaborative model was used to disseminate an EBT to outpatient clinics of community mental health agencies throughout Connecticut.





## Case Study: The Connecticut TF-CBT Learning Collaborative

**Background.** Administrators from the Connecticut Department of Children and Families (DCF) recognized that many Connecticut children, particularly those in the child welfare system, suffered from undiagnosed or untreated traumatic stress symptoms secondary to physical abuse, sexual abuse, violence exposure, and other forms of trauma. For example, common traumatic stress reactions among this population include posttraumatic stress disorder (PTSD), depression, and anxiety symptoms. Exposure to trauma, particularly when chronic, damages the developing brain, resulting in long-term disabilities in mental health, learning, relationships, and health<sup>13</sup>. Untreated traumatic stress often persists into adulthood and is associated with an increase in health care costs<sup>14</sup> and lost work productivity<sup>15</sup>. Increased awareness of the needs of traumatized children, previous successful statewide implementations of in-home EBTs, and recognition that virtually no outpatient EBTs were widely available in the state led DCF administrators to seek to bring an EBT for children suffering from traumatic stress reactions to Connecticut outpatient clinics.

Several effective, well-studied interventions to treat child traumatic stress exist. Trauma-Focused

Cognitive Behavioral Therapy (TF-CBT) is the most widely studied model<sup>16</sup>. TF-CBT is a short-term, family-centered treatment that is designed for children suffering from traumatic stress symptoms resulting from exposure to abuse, neglect, domestic and community violence and other forms of risk or harm. TF-CBT includes psychoeducation and teaching practical skills for children to manage thoughts and feelings associated with traumatic stress reactions, the development of a “trauma narrative” and sharing of the narrative with a caregiver in a safe therapeutic setting, and skills to enhance future safety and development. TF-CBT is supported by at least seven clinical trials demonstrating improvements in children’s PTSD, depression, and anxiety symptoms, and improvements in parental distress and parenting skills. The model is also listed on SAMHSA’s National Registry of Evidence-Based Programs and Practices. Because TF-CBT is short-term and results in relatively rapid symptom improvement, it may be more cost-effective than longer-term traditional treatments and may reduce the need for more intensive and costly services in the future. The NCTSN has also successfully used the Learning Collaborative model to disseminate TF-CBT across the country<sup>17</sup>. Based upon this

The Learning Collaborative motto is *share relentlessly and steal shamelessly*.



research, consultation with local experts in child trauma including Clifford Beers Clinic, as well as evidence of prior successful disseminations of TF-CBT nationally, DCF selected TF-CBT as the best available EBT for child traumatic stress to disseminate in Connecticut.

DCF administrators recognized that statewide dissemination of an EBT would be challenging and would require external support for training and quality improvement. In consultation with the National Center for Child Traumatic Stress at Duke University, DCF staff designed a proposal outlining the structure of a statewide learning collaborative and released a request for proposals to identify a Coordinating Center for the initiative. In early 2007, DCF selected the Connecticut Center for Effective Practice (CCEP), a division of the Child Health and Development Institute of Connecticut (CHDI), as the Coordinating Center. CCEP functioned as an intermediary organization<sup>18</sup> by collaborating with DCF, treatment developers and trainers, family members, and community providers to develop the structure of the Learning Collaborative, including the training, evaluation and quality improvement plan. From 2007 through 2010, 16 community mental health agencies (shown in Figure 2) were awarded contracts with DCF to implement TF-CBT through this initiative. Figure 3 presents a timeline of the Learning Collaborative, which highlights the training cohorts and key activities during each training year.

Figure 2: Agencies Participating in the TF-CBT Learning Collaborative

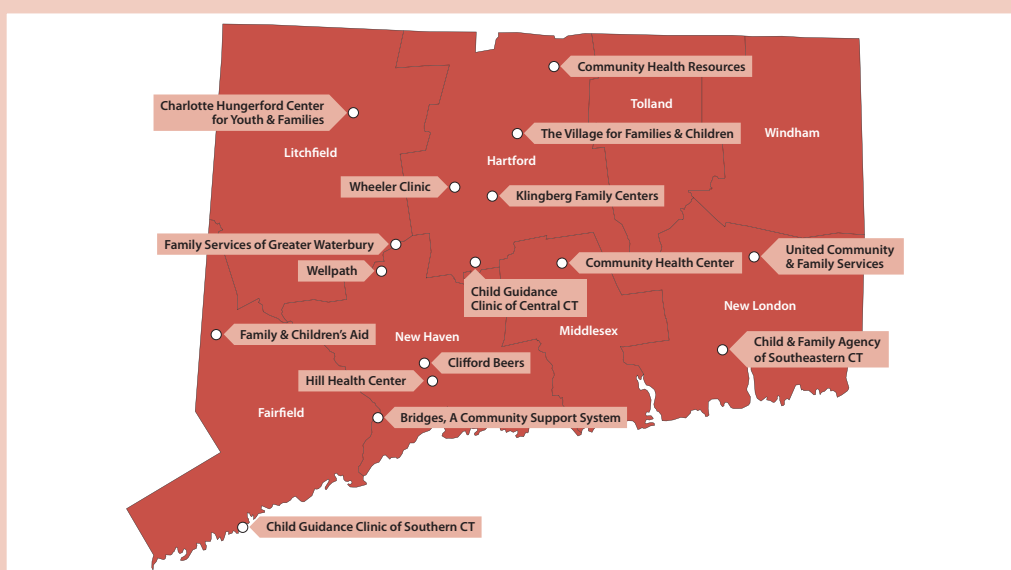
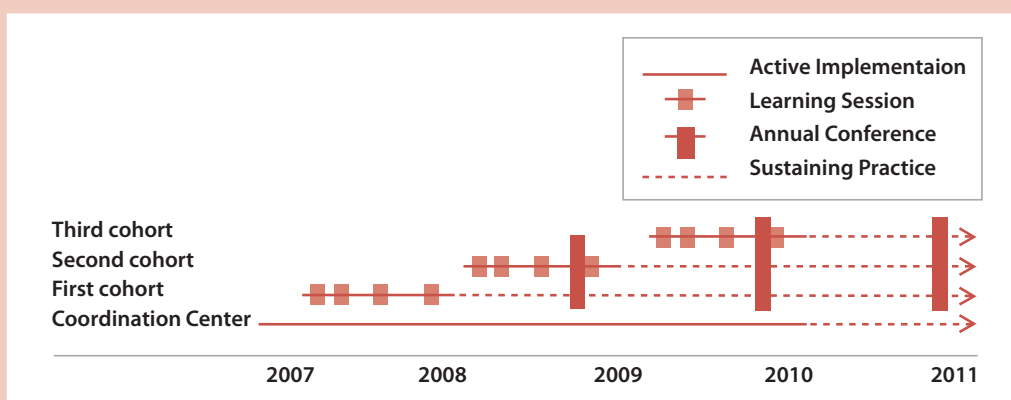


Figure 3: Timeline of the Connecticut TF-CBT Learning Collaborative



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**Funding.** The initiative was funded by DCF at an annual cost of approximately \$427,000 per year for three years. Funds were used to establish and support the TF-CBT Coordinating Center, faculty, and all training, quality assurance, and evaluation activities, as well as a small annual stipend for each participating agency to offset lost productivity due to training and to pay for a part-time TF-CBT site coordinator. The goal was that following a year of participation in the Learning Collaborative, the TF-CBT model would be sustainable in each provider organization and services would be reimbursed as outpatient care through private insurance or Medicaid.

**Faculty and Planning Team.** The Coordinating Center assembled a Learning Collaborative faculty and planning team, which was comprised of the Director and Project Coordinator from CCEP, the DCF program officer, a TF-CBT train-the-trainer, an expert in child trauma assessment, and a family representative. This team planned all trainings, consultation, and quality improvement activities required to implement TF-CBT using the Learning Collaborative methodology. The faculty and planning team consulted with experts from the NCTSN to adapt the Learning Collaborative methodology for this initiative.

**Agency Team Structure.** Teams of staff from four to six community mental health agencies were trained per year, for each of three years. Each agency's team

of 7-12 staff included clinicians, clinical supervisors, administrators (referred to as "senior leaders" in the Learning Collaborative model), and a family partner or consumer from their community (who was not a staff member). Each team also designated a TF-CBT site coordinator; typically a clinician or supervisor on the team. The site coordinator was responsible for managing the team's data, running the weekly team meetings, and communicating with the project coordinator weekly. The team-based approach provided opportunities to address clinical, supervisory, and organizational implementation barriers and allowed staff to share experiences and learn from peers in similar roles at other agencies. It also strengthened each agency's capacity and expertise to deliver TF-CBT by focusing training efforts on a TF-CBT team rather than training several individuals. For example, when a trained clinician leaves an agency, the TF-CBT team remains and can train new team members internally to sustain the program. Over the course of the initiative, over 250 staff and family partners were trained.

**Learning Sessions.** All staff participated in seven full days of in-person training, or Learning Sessions, during the training year. Learning Sessions were designed, based upon adult learning techniques, to minimize didactic presentations in favor of interactive activities. Training activities included role plays, small group discussions, interactive games,

**“The agency leadership break-outs during the Learning Collaborative gave us a chance to share and to really focus on some of the barriers to implementation that we would not have had a chance to otherwise.”**

*Agency Administrator*

and other participatory techniques. Staff worked in a variety of different groups; for example, some activities required meeting together as an agency team, some by staff role (e.g., all supervisors met together), and some in small groups with diverse roles. Participants also led presentations and developed activities to share their innovations and successes with staff from other agencies in the spirit of a common Learning Collaborative motto: “Share relentlessly and steal shamelessly.” All training activities were developed to enhance clinical skills required to assess child traumatic stress and to implement TF-CBT, as well as provide training in implementation and quality improvement techniques.

**Training Tracks.** Distinct training tracks, including separate break-out activities, were developed for clinicians, supervisors, senior leaders, and family partners. Training was provided for staff from each track at learning sessions and through monthly consultation calls specific to each role. For example, supervisors had break-out sessions and consultation calls focused on how to supervise staff new to an EBT and how to monitor treatment fidelity of their clinicians. Senior leaders met together to discuss organizational challenges to implementing a new practice, including staff turnover, reimbursement issues, using agency implementation data, and spreading the practice to other program areas.

**Model for Improvement.** Staff were trained to utilize IHI’s Model for Improvement methodology<sup>7</sup> to make practice improvements that support





**“The collaborative is a fantastic idea, and it’s unique, and I think it’s a great way to include parents. I have really become a team member.”**

*Family Partner*



implementation of TF-CBT. The Model for Improvement involves identifying a specific barrier or problem, defining simple and creative approaches to making improvements, and using data to evaluate which improvements are effective. These “small tests of change” are typically conducted rapidly and by any team member. Successful improvements are then spread throughout the team, agency, and collaborative. For example, an agency that is struggling with identifying appropriate clients to receive TF-CBT may conduct several cycles of small tests of change that try out a variety of creative approaches, but each on a small scale (e.g., with one or two clients initially). Those approaches that data show are effective are then spread to additional clients or clinicians. Strategies continue to be refined, and effective techniques are spread throughout the team and eventually throughout the entire collaborative. The Model for Improvement can be used to address clinical, supervisory, administrative, policy, or any other barriers to implementation.

**Action Periods.** In the Learning Collaborative approach, the periods of time between Learning Sessions are referred to as “action periods” in order to emphasize the importance of putting into practice what was taught at Learning Sessions. During action periods, each agency’s TF-CBT team met weekly to discuss implementation of TF-CBT, each site coordinator received consultation from the project coordinator, and all staff participated in cross-site consultation calls. Separate monthly consultation calls were held for clinicians, supervisors, and senior leaders to focus discussion on issues relevant to



each group. Specific and measurable goals for each action period for each staff role were developed by the faculty and presented to teams. For example, clinician goals for the first action period were to complete the web-based TF-CBT training, read the treatment manual, assess four potential clients for TF-CBT appropriateness using standardized

measures, and identify two appropriate children with whom to begin TF-CBT. When participants re-convened at the next Learning Session, activities were developed to assess progress towards meeting action period goals and addressing barriers to implementation.

### Case Example: Changing Practice Within an Agency

A Connecticut child guidance agency serving a primarily urban population participated in the Learning Collaborative with a team of nine: one senior leader, two supervisors, five clinicians, and a family partner. Prior to the start of the Learning Collaborative, this agency was not regularly screening any children for trauma history, did not utilize standardized assessments of traumatic stress symptoms, and did not provide TF-CBT or any evidence-based trauma-focused treatment.

By the fifth month into the Learning Collaborative, the agency was screening 100% of new child outpatient clients for trauma history and was completing 10 to 20 comprehensive trauma-focused assessments each month, using standardized assessments of PTSD and depression symptoms to determine eligibility for TF-CBT. The agency was also providing TF-CBT to 30 children monthly, and clinicians received an average of 5 hours of TF-CBT specific supervision each month. At the end of the training year, the team had begun TF-CBT with 71 children, had increased capacity to serve 60 children each month, and had completed TF-CBT successfully with 7 children.

During the twelve months following the training year, the two supervisors and two of the clinicians from the original team left the agency. New staff joined the team and were trained internally by the experienced staff, and one clinician was promoted to the position of supervisor. Despite this staff turnover and the end of regular external training and consultation, this TF-CBT team completed assessments with 69 children, began TF-CBT with 52 children, and completed treatment successfully with 33 children during the post-training year. The agency also continued to screen 100% of new intakes for trauma history, and the TF-CBT team continues to meet weekly, receive TF-CBT specific supervision for their cases, complete standardized assessments, and to utilize monthly metric reports to improve practice. The agency is committed to the sustainability and expansion of TF-CBT at their agency, and has made the model a permanent part of their service array.

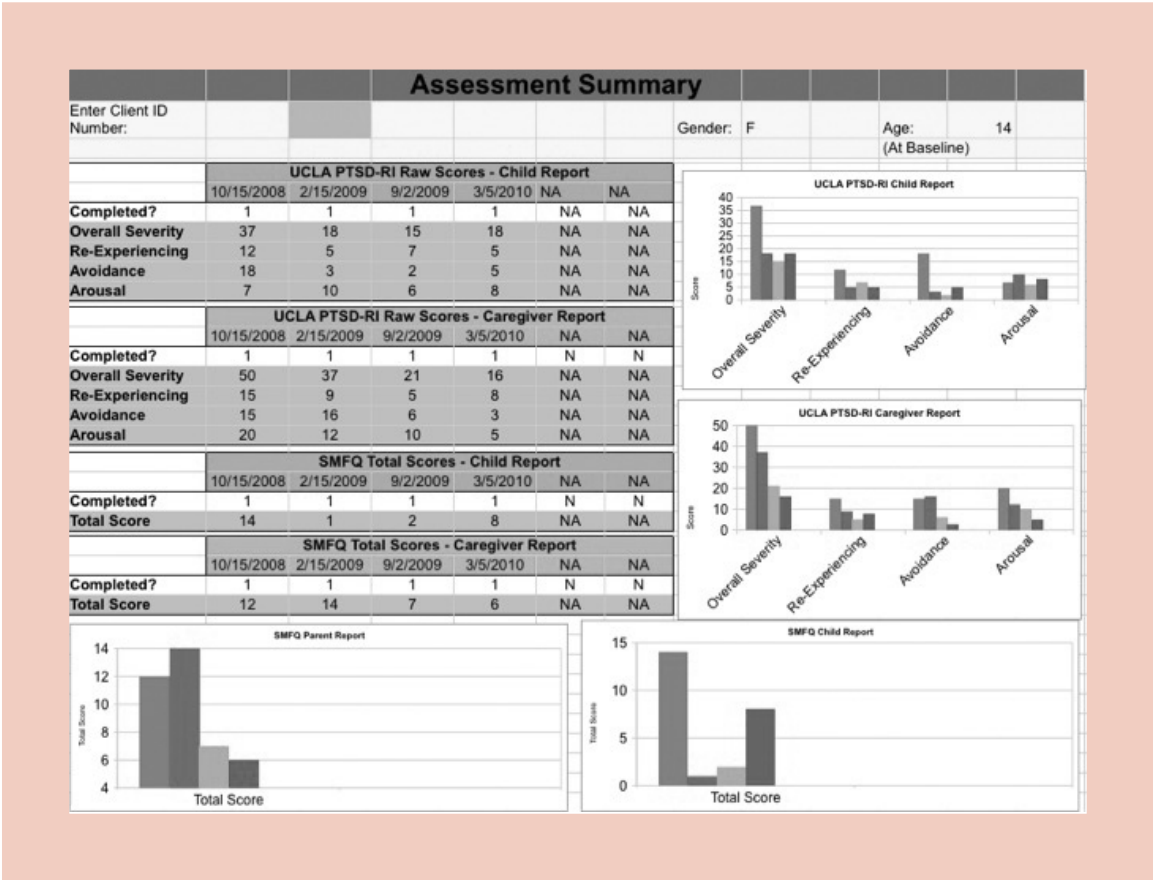
“I was involved in another state’s initiative to roll out TF-CBT last year and it was a very different experience. We had a two day training and then bi-weekly calls, but beyond that we didn’t have a team and we didn’t have the learning sessions. A lot of people in my agency lost the motivation because they just didn’t feel supported. [The Connecticut TF-CBT Learning Collaborative] was just so different - there was more support, and the training carried through, so there were things that I had learned in the model this time, that I was saying, ‘wow, I wish I had known that the first time.’”

Clinician

**Use of Data.** All staff were trained to use data for clinical and quality improvement purposes. Standardized assessment measures were used with all children receiving TF-CBT prior to treatment, every three months, and at discharge. Staff were trained on how to administer and interpret these assessments, how to use the data to determine whether a child was appropriate for TF-CBT, and how to understand and use data over time to inform treatment. In addition, all staff completed

monthly “metric” surveys about their use of TF-CBT, clients served, and treatment fidelity. These data were summarized and reported to each agency monthly, and were an integral part of the Learning Collaborative training and continuous quality improvement process. All staff were trained to understand their agency’s metric data, to identify successes and challenges in their implementation of TF-CBT, and to utilize the data to make practice improvements using IHI’s Model for Improvement.

Figure 4: Sample Clinical Assessment Summary Report



**Online Data Collection.** Online tools for facilitating data collection and reporting were developed by the Coordinating Center. De-identified data from clinical assessments were entered into a secure online database by each site coordinator, were computer scored, and a printable score report was immediately provided and returned to the clinician (see Figure 4 for an example). This system allowed for rapid scoring of assessments so that results could be used in the next therapy session, had capacity for summarizing multiple assessments for any child to evaluate progress over time, and allowed the Coordinating Center to monitor outcome data in real-time. Staff also completed monthly metric reports online, with instructions and reminders delivered via email. This system simplified metric reporting for staff and eliminated lost or late paper surveys and redundant data entry for the Coordinating Center.

**Family Involvement.** All participating agencies were required to identify a “family partner” to be part of their local TF-CBT implementation team and to participate in selected Learning Collaborative activities. Family partners, who were typically paid as contractors by each provider agency, were required to attend one TF-CBT team meeting per month and to attend several training days to provide the “consumer” perspective to the TF-CBT team. For example, family partners participated in discussions around family engagement, family-centered practice, cultural competency, community resources, a family’s experience participating in TF-CBT, and other relevant topics. The time family

partners spent outside of these commitments varied but included, for example, time to co-develop a family-focused TF-CBT brochure, to act as a “mystery shopper” at a clinic, or to assemble a community resource list for the clinical staff.

**Ongoing Training.** In addition to building each agency’s capacity to provide training internally, two additional methods were used to train new TF-CBT team members (who may join because of staff turnover or program expansion) or experienced staff:

- An annual statewide TF-CBT conference including introductory training for new staff, advanced topics for experienced staff, and opportunities for staff to present their own innovations and successes related to TF-CBT
- A TF-CBT Fellowship program providing advanced instruction in TF-CBT and training to several promising staff each year in order to further build capacity of experienced providers in the state

These additional training opportunities allowed TF-CBT teams to be sustained, and even grow, despite the high rate of turnover among trained staff.

**Post-Training Support.** Following the Learning Collaboratives, the state of Connecticut has continued to support limited training and quality improvement activities to promote sustainability. This funding provides the annual intensive introductory TF-CBT training for new staff, the annual statewide TF-CBT conference, maintenance

## Children who completed TF-CBT showed an average 43% reduction in PTSD symptoms and a 55% reduction in depression symptoms following treatment.

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of statewide TF-CBT staff rosters, implementation and outcome data collection and reporting, and site-based technical assistance.

### Results of the Connecticut TF-CBT Learning Collaborative

Over 250 staff and family partners from the 16 participating agencies received training in TF-CBT through this initiative. Since completing training, each of these 16 agencies continues to sustain (and often expand) their TF-CBT team and continues to provide TF-CBT to new clients. Each agency also continues to report monthly TF-CBT metric data and to use standardized assessment measures to promote continuous quality improvement.

As of December 2010, provider staff have evaluated over 1,200 children for TF-CBT using standardized assessments of trauma history and PTSD and depression symptoms. Embedding the practice within a core team of staff in each agency, and providing opportunities to train new staff, has allowed the practice to continue despite staff turnover, competing demands, a difficult economic climate, and other challenges. In fact, only 33% of current TF-CBT team staff participated in the initial Learning Collaborative training, while the other 67% have been subsequently trained internally by their team and through ongoing training opportunities. Providers have expressed concerns that potential barriers to sustainability of TF-CBT included lack of available training for new staff (due

to turnover) and the increased time demands of utilizing an EBT, including use of assessments, data reporting, and preparing for sessions.

Maintaining fidelity to TF-CBT has been an important focus of the initiative and has been reinforced throughout all trainings and consultation. While measuring treatment fidelity in a statewide implementation is challenging, available data indicate that staff have maintained good fidelity to the TF-CBT model. Specifically, staff report an 89% fidelity rate to the required TF-CBT components for completed cases. The mean treatment length has been 22 sessions (typically 45-50 minutes each) for completed cases, which is consistent with the treatment model guidelines. Finally, there has been active caregiver participation in 95% of all completed cases, which is a fundamental component of the TF-CBT model.

Qualitative feedback from participating staff indicated that providers were extremely satisfied with the training received. They emphasized that the amount of consultation and technical assistance, the consistent use of data for quality improvement, the cross-site connections among staff, and the interactive nature of the activities distinguished the training from others in which they have participated. In addition, participants anecdotally reported increased feelings of self-efficacy and competence in working with traumatized children and their families. As a result, many reported increased satisfaction with their jobs and role as

clinicians. While at times staff expressed frustration with the time required for participation, nearly all agreed that the intensity of the training and consultation was a key to being able to successfully implement and sustain TF-CBT.

Perhaps most important, more than 1,000 children began TF-CBT and 225 completed the full course of treatment. Initial results from the ongoing outcome evaluation indicate that children who completed TF-CBT showed an average 43% reduction in PTSD symptoms and a 55% reduction in depression symptoms following treatment. These results are especially significant for outpatient community mental health care and are comparable to outcomes from TF-CBT clinical trials<sup>19,20</sup>. Further, due to the significant reductions in PTSD and depression symptoms, many children who complete TF-CBT show full remission of the PTSD diagnosis. Additionally, caregivers who participated with their children in TF-CBT expressed a very high level of satisfaction with treatment. Overall, the outcome results indicate that the TF-CBT Learning Collaborative has been highly successful and strongly support the Learning Collaborative methodology as an effective approach for implementing an EBT within a state system of care.

## CONCLUSIONS

The Learning Collaborative methodology was successfully used to disseminate TF-CBT to community mental health agencies in Connecticut. This is especially significant in light of the multiple demands placed on agency staff, the additional time required to utilize an EBT, the diversity among agencies, staff, and their clientele, and the high rate of staff turnover.

The Learning Collaborative methodology addresses barriers to implementation through an innovative and, based upon these results and those from other initiatives using the methodology, an effective approach to training. This approach may require additional start-up time, money, expertise, and support than traditional forms of training, but the outcomes appear greater in terms of sustainability, and the costs for ongoing training are likely to be significantly less. A Learning Collaborative equips agencies to implement a new practice, to efficiently use data for quality improvement, and to sustain and support the practice within the agency. This emphasis on organizational change is not only critical to the sustainability of an EBT, but builds capacity for an agency to adopt other EBTs and to improve practice agency-wide.

**“It was the first time I've ever been in a Learning Collaborative, and I think it's an invaluable part of the implementation process. At our first meeting, we sat down with our senior management, supervisors, and the clinicians. I don't think there's ever been a forum like this at our agency. It was a unique process in which everyone at every level is joining together and doing their part.”**

*Agency Administrator*

## RECOMMENDATIONS

### ***1. The Learning Collaborative model should be considered for other implementation, dissemination, and training initiatives.***

Qualitative and quantitative evaluations strongly support the effectiveness of the Learning Collaborative for implementing and sustaining TF-CBT in Connecticut. The available evidence from this and other research on implementation and the Learning Collaborative model suggests it is more effective at creating sustainable change than traditional training approaches. It is also likely to be more cost effective to provide training through a Learning Collaborative than via traditional training, because the practice is more likely to be sustained and it is more efficient to train multiple providers simultaneously. Thus, it is recommended that the Learning Collaborative methodology be utilized to disseminate other evidence-based or promising practices within a state system of care.

***2. Continued support for training and quality improvement should be built into implementation and dissemination efforts.*** Opportunities for experienced staff to receive advanced training should be provided to build capacity for local experts in the treatment model. In addition, ongoing training for new staff, due to turnover or team growth, should continue to be available following the training period. Further, ongoing use of data to drive continuous quality improvement and monitoring of fidelity is critical to the sustainability

of an EBT in community-based settings. A clear plan for ongoing collection, data management and reporting of outcome and implementation data should be developed to promote continuous quality improvement and to support treatment fidelity.

***3. Incentives and support should be available to providers who use EBTs.*** It is strongly recommended that state and federal policies provide adequate support and incentives for agencies that use EBTs. Sustaining an EBT with fidelity requires resources for ongoing training, adequate supervision, use and interpretation of data, preparing for sessions, and time for team meetings. Many agencies face financial challenges that force them to choose between providing these resources or re-directing staff time to seeing more clients, albeit without using evidence-based treatment models. External incentives for using EBTs would improve the adoption and sustainability of EBTs. Even modestly enhanced reimbursement rates for the use of EBTs would be a significant incentive.



### Case Example: A Child Receiving TF-CBT

A 15-year-old Latina named “Lily” who was living in a foster home was referred for treatment at a TF-CBT agency because of behavior problems at home and school. Lily was screened for exposure to traumatic events as part of the agency’s routine intake process. The screening revealed an extensive trauma history, with exposure to at least 13 different kinds of traumatic events, including violence exposure, the death of multiple close friends and relatives, being the victim of a kidnapping, and escaping from a serious fire which ultimately burned her house down. The most distressing trauma reported was sexual abuse, which had occurred years earlier but for which Lily had not received treatment. She was referred for a TF-CBT evaluation, and she and her foster mother completed the standardized assessment with a TF-CBT team clinician. Both Lily and her foster mother reported that Lily had extremely high levels of PTSD and depression symptoms, including having flashbacks to the sexual abuse, difficulty sleeping, significant distress when reminded of the abuse, and depressed mood much of the day. Lily had avoided talking about the sexual abuse for years. Lily was diagnosed with PTSD and began TF-CBT with some reluctance, which is common for children suffering from PTSD.

Following the TF-CBT treatment model, the initial sessions focused on helping Lily understand and manage her traumatic stress reactions and associated feelings and thoughts. In the second phase of treatment, Lily wrote the story of her sexual abuse and several other traumatic experiences with her therapist using “trauma narratives,” which were eventually shared with her foster mother in sessions in order to facilitate communication and support. Finally, the last phase of treatment focused on enhancing Lily’s future safety and healthy development.

Lily’s treatment lasted 30 sessions. By the end of treatment, she was able to talk about her sexual abuse and other traumatic events without becoming overly distressed, she was more focused on her goals, and she was showing improvements in behavior and functioning at home and at school. Lily no longer met criteria for PTSD or depression, and the post-treatment assessment indicated that her symptoms had diminished by 60%. Both Lily and her foster mother expressed great satisfaction with treatment. Following completion of TF-CBT, Lily was discharged from the agency successfully and did not require further intervention.



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