



The Telehealth Outreach Program: Using Technology to Address the Needs of Trauma-Exposed Youth in Schools

**Wednesday, February 24, 11am-12pm
EST**

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The Telehealth Outreach Program: Using Technology to Address the Needs of Trauma-Exposed Youth in Schools



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February 24, 2021



Thank You to Our Collaborators

Some of the examples or materials presented today come from presentations with a few of our collaborators. We wanted to take a moment and acknowledge their contributions.



Michael de
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Ph.D.



Learning Objectives

1. Participants will be able to describe how an evidence-based, trauma-focused mental health program is utilizing telehealth technology to provide treatment to children and adolescents.
2. Participants will be able to identify changes that were made to the program in response to the public health emergency.
3. Participants will learn to access resources shared in this webinar.

Defining Trauma

- Distressing or dangerous experience resulting in intense and overwhelming emotional, physical, and behavioral responses.
 - › Domestic violence
 - › Physical, sexual, psychological abuse
 - › Community violence
 - › Natural disasters
 - › Violent loss of a loved one
 - › Mass shootings
 - › Motor vehicle crashes
 - › Intrusive medical procedures



Prevalence of Trauma

- 40-80% of youth experience some type of traumatic event during their lifetime
 - › Physical Abuse: 4-19%
 - › Sexual Abuse: 8-10%
 - › Adolescent girls (13-17%) vs. adolescent boys (3-5%)
 - › Community Violence: 38-70%
 - › Domestic Violence: 9-33%
 - › Traumatic grief: 1 in 5 adolescents has lost a family member or friend as a result of homicide
 - › Natural disasters: 15%
 - › Motor vehicle accidents: 21%
- 20-50% of youth report exposure to more than one traumatic event during their lifetime



Childhood Trauma Exposure in South Carolina

- Prevalence of child trauma exposure is high
 - In SC, >35,000 reports of child abuse and neglect annually
 - Actual maltreatment estimated to be about 3 times higher
- Rates increased 8.4% between 2009-2014
- Significant disparities exist in trauma exposure and child maltreatment for racial and ethnic minority youth
 - For example:
 - In SC, African Americans account for 27.8% of the population
 - BUT:
 - 38.1% of children in foster care
 - 35.4% of child maltreatment victims



Common Reactions

- Traumatic stress in youth may manifest as an experience of intense distress and difficulty coping, resulting in:
 - Disturbed sleep
 - Anger and irritability
 - Behavioral difficulties
 - Difficulty paying attention and concentrating
 - Repeated and intrusive thoughts
 - Extreme distress when faced with trauma reminders
 - Avoidance of trauma-related cues
 - Functional impairment at home, school, and in relationships

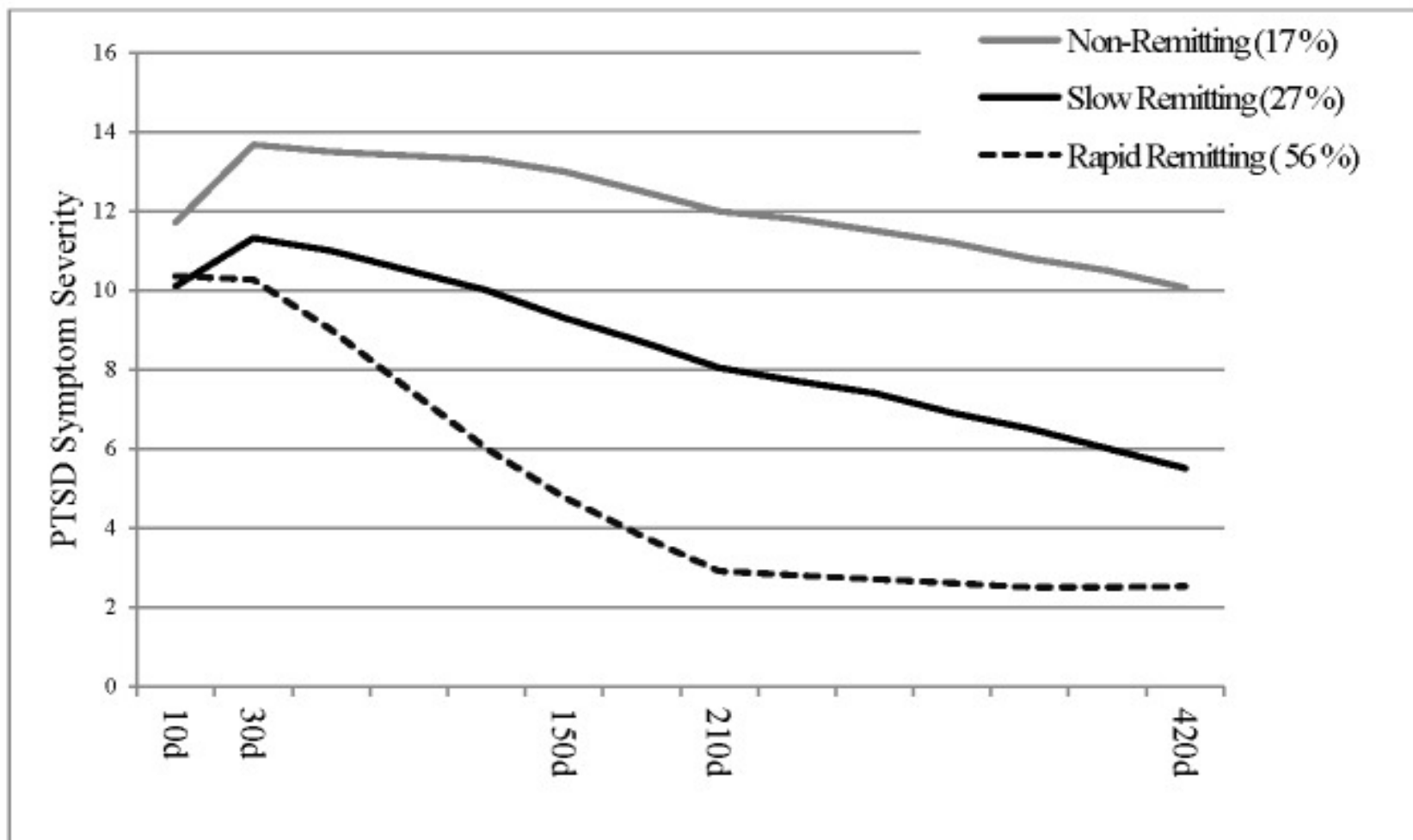


Consequences of Trauma Exposure in Youth

- Trauma exposure has been linked with a range of detrimental outcomes for children and adolescents:
 - PTSD (4.7%- females having greater prevalence than males, 7.2% vs. 2.2%)
 - Suicidality and self-injury (10-15%)
 - Substance abuse (8-21%)
 - Depression
 - Anxiety
 - Risky behaviors
 - Increased risk of future perpetration



Natural Recovery is the Norm



Note: x-axis indicates number of PTSD symptoms reported on the PSS-I. Y-axis represents time from 10 days to roughly 420 days Trajectories represent estimated marginal means.

So, do all children need trauma treatment?

Not necessarily.

Some children naturally recover (even after really awful, scary things happen to them).

We are targeting the children that are stuck in this “non-recovery” phase.

The Good News

There has been a dramatic increase in the development of evidence-based treatments for trauma-related problems in youth in the past few decades



The Bad News

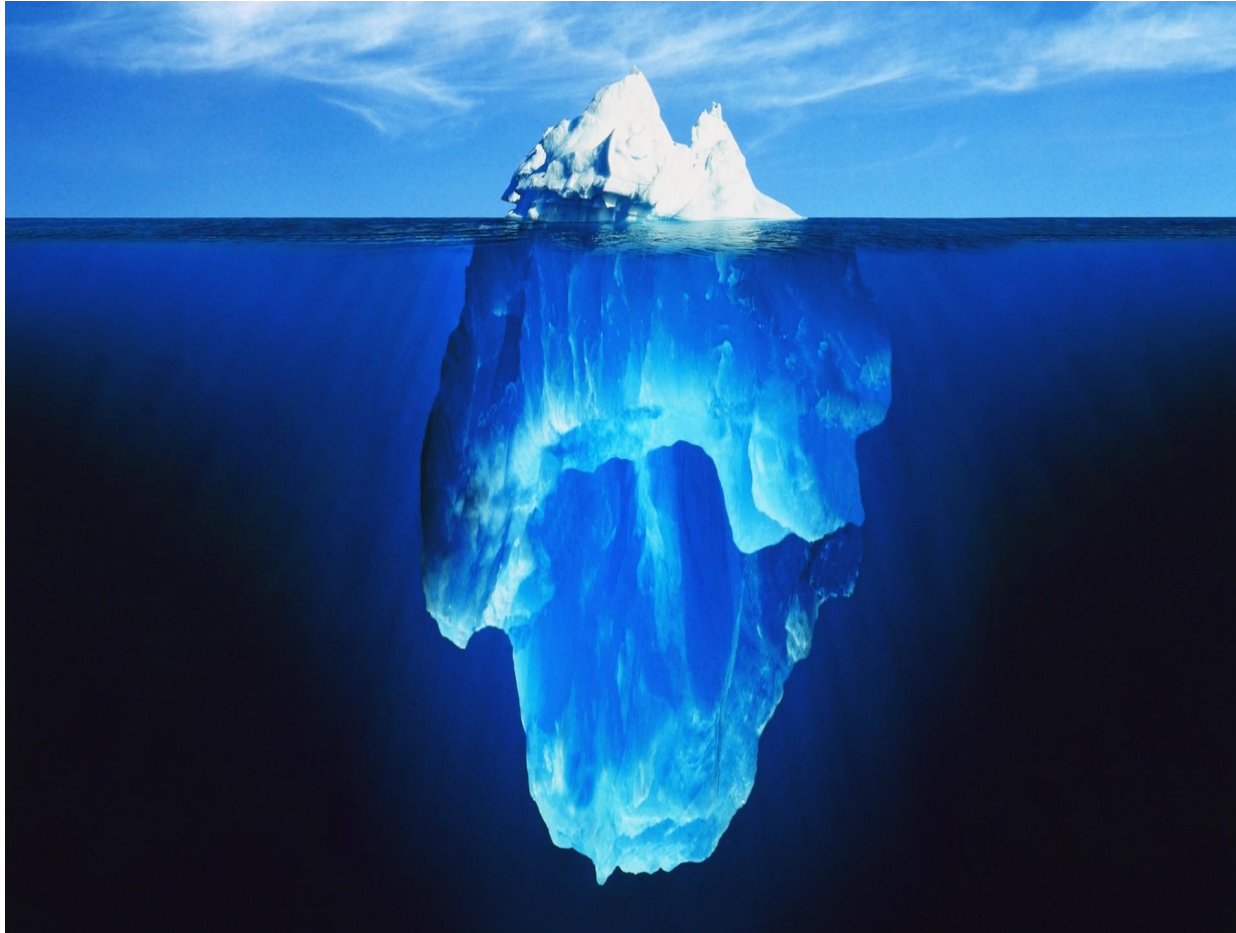
Very few receive services

- › Less than 1/3 of individuals with mental health problems are estimated to receive needed services
- › Significant disparities exist for mental health access for ethnic minorities

Even fewer complete services

- › High premature termination in community treatment
 - › Greater than 50%
- › Latinx and African American children are at greater risk for treatment dropout

The Bottom Line: We Only Serve The Tip of the Iceberg

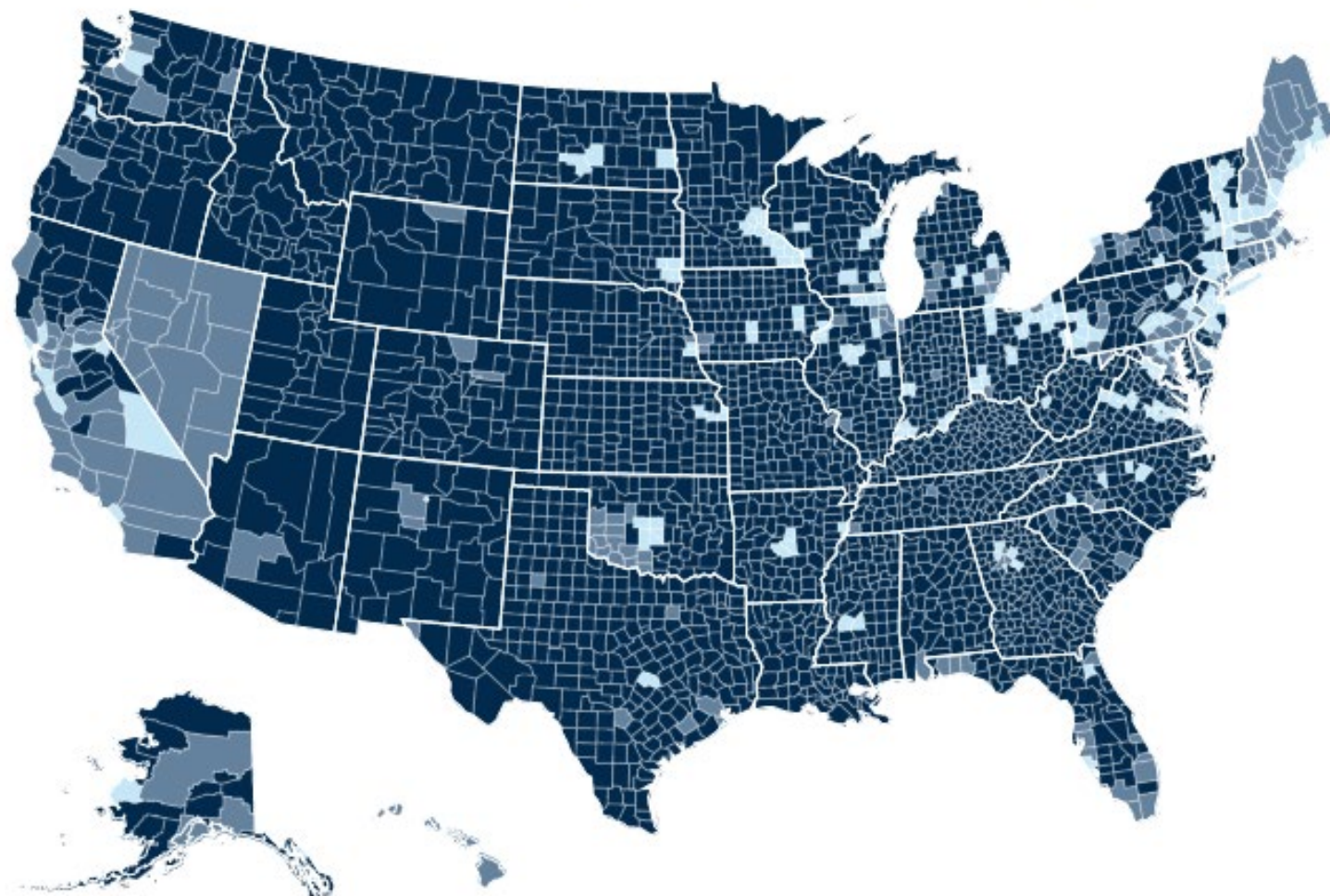


Barriers to Mental Health Services

- Only 20-30% of children in need of mental health care receive treatment services
- Situation even worse for underserved communities (e.g., rural and inner city)
- **Barriers to treatment**
 - › Limited availability of services
 - › Affordability (no health insurance)
 - › Lack of transportation
 - › Lack of childcare
 - › Employment barriers (scheduled work hours, leave restrictions)
 - › Limited availability of linguistically- and culturally-competent services



Health Professional Shortage Areas: Mental Health, by County, 2019

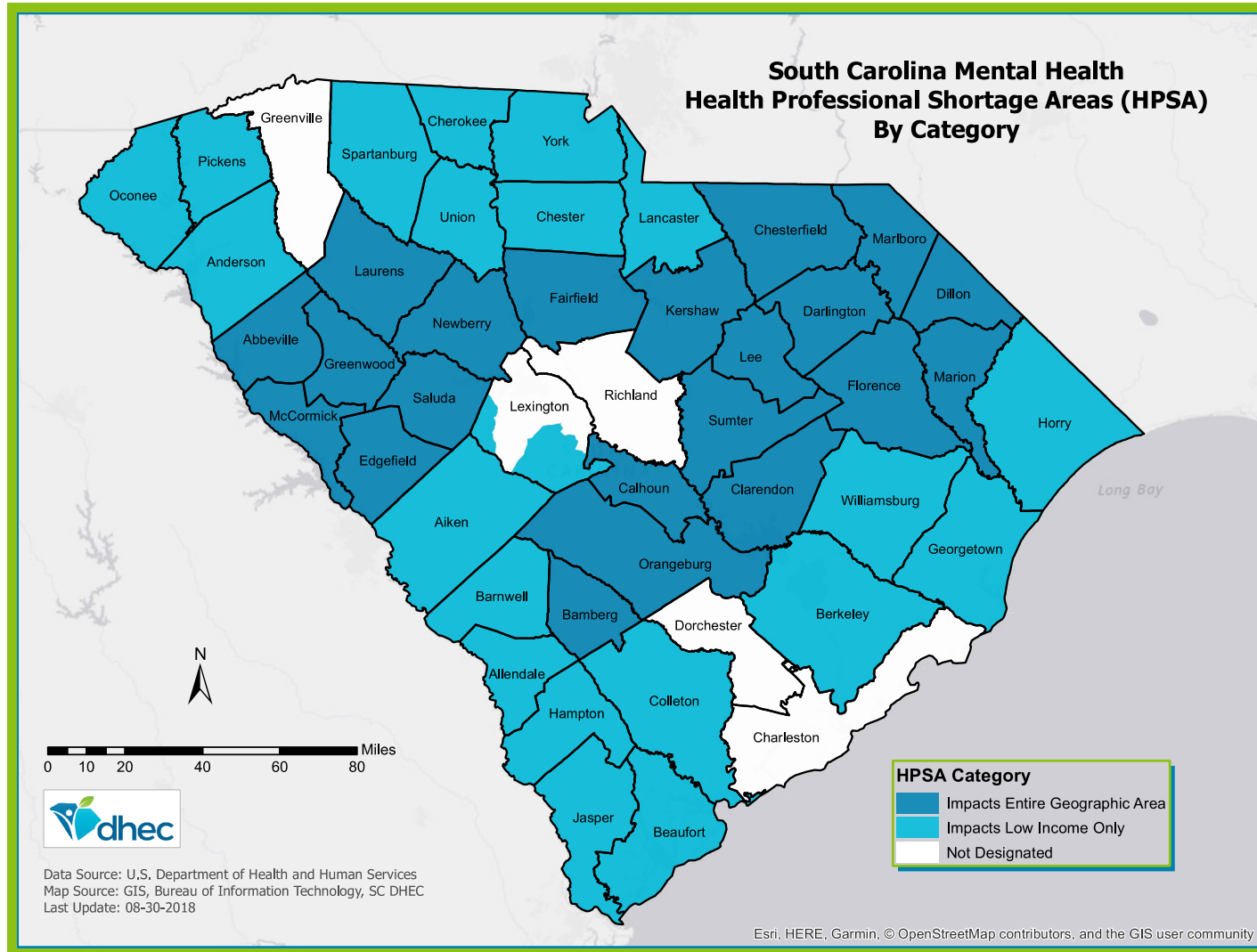


None of county is
shortage area

Part of county is
shortage area

Whole county is
shortage area

Source: data.HRSA.gov, July 2020.



**Telehealth is a promising
option for addressing
several of these barriers!**

TOP Program



Telehealth Outreach Program (TOP) in Schools

- Goal of improving access to evidence-based trauma-focused treatment for youth who are underserved by office-based mental health care programs
 - Rural populations
 - Racial/ethnic minorities
- Provides school-based mental health treatment for trauma-exposed children and adolescents using secure videoconferencing



Three-Pronged Approach



Telehealth



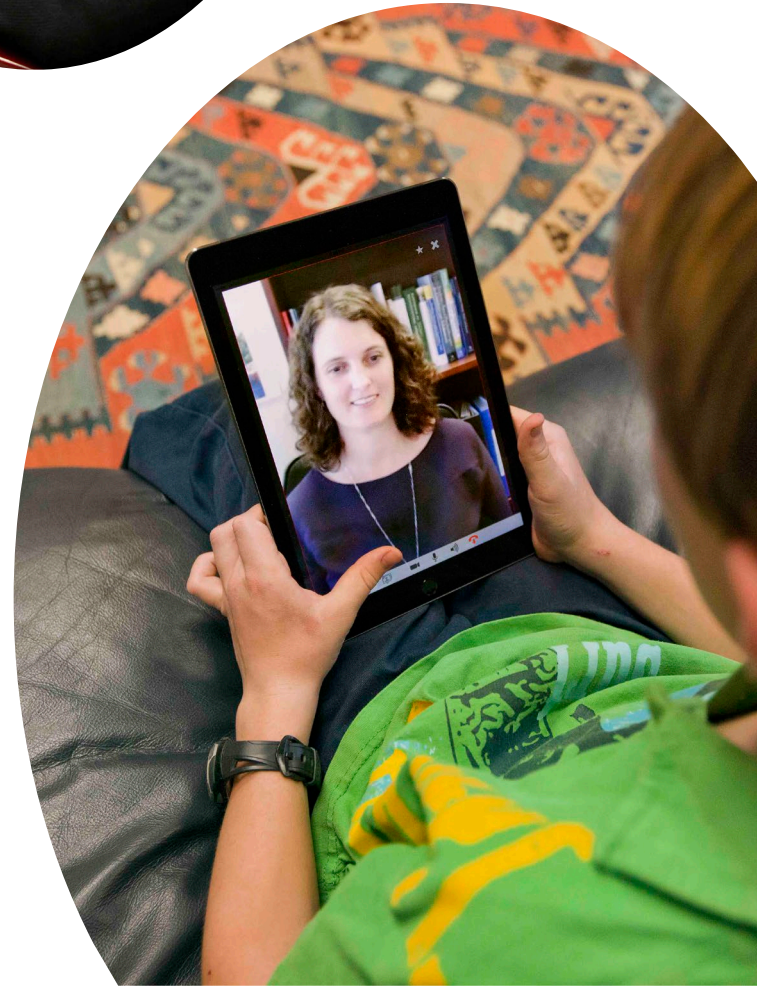
**Intensive Case Management
and Evidence-Based
Engagement Strategies**



**Evidence-based Trauma-
Focused Treatment**

How Does It Work?

- HIPAA compliant videoconferencing software (Vidyo, doxy.me)
- Use of a tablet, laptop, or desktop computer
- Private location at a school
- Referrals from school staff members, child advocacy centers, law enforcement, child welfare agencies, etc.
- Therapy and psychiatric medication management services (if needed)
- Interpreter services if needed

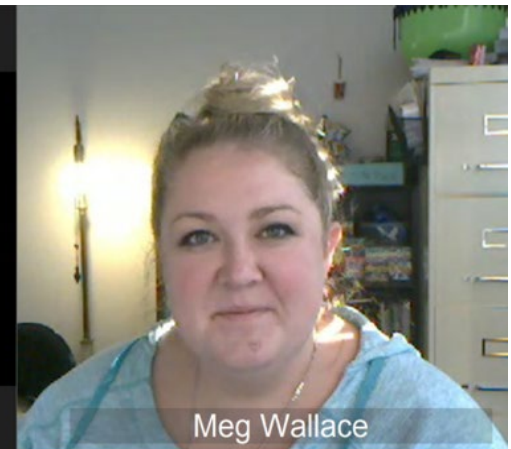
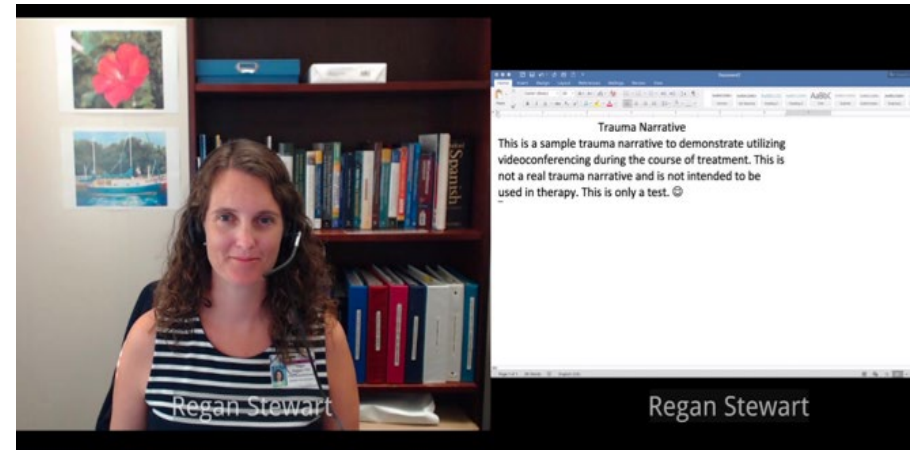
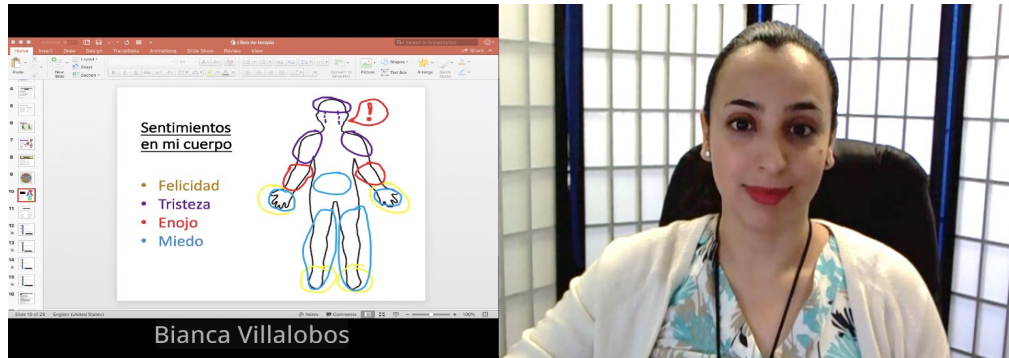


Tips for Telehealth Treatment with Youth

- Set ground rules
- Position camera to ensure you are looking at the child
- More animation and excitement
- Consider shorter sessions (especially for younger children)
- Build connection and engagement with interactive activities and props and creating opportunities for them to give input
- Preparation may take more time initially as you convert your worksheets/activities for telehealth
- If transitioning from in-person, allow for adjustment to new modality, but continue with treatment to maintain fidelity



Resources Used for Telehealth Treatment



Resources Used for Telehealth Treatment



MENU +

www.telehealthfortrauma.com

Assessment

Assessment Rating Scales [DOWNLOAD](#)

Psychoeducation & Parenting Skills

Therapy Trivia [DOWNLOAD](#)

Parenting Skills [DOWNLOAD](#)

- Resources
- Research
- Webinars

Intensive Case Management

- Based on Maslow's "Hierarchy of Needs"
 - Individual must first meet lower order needs before they can pursue higher order needs
 - Extremely important with trauma victims (SAFETY)
- Example:
 - *"I can't worry about my child having problems in school and my child not listening to me at home, while I am trying to make sure I can get him to school and making sure he has a home."*



Intensive Case Management

Goals:

- Help establish stability in the home
- Enhance engagement with family
- Connect family with community resources
- Teach family to problem solve and access services

Examples:

- Financial (food, clothing, shelter, health insurance)
- Victim Services (crime victims comp., shelter)
- Legal (orders of protection, immigration)
- Other mental health or medical (substance abuse, parenting)



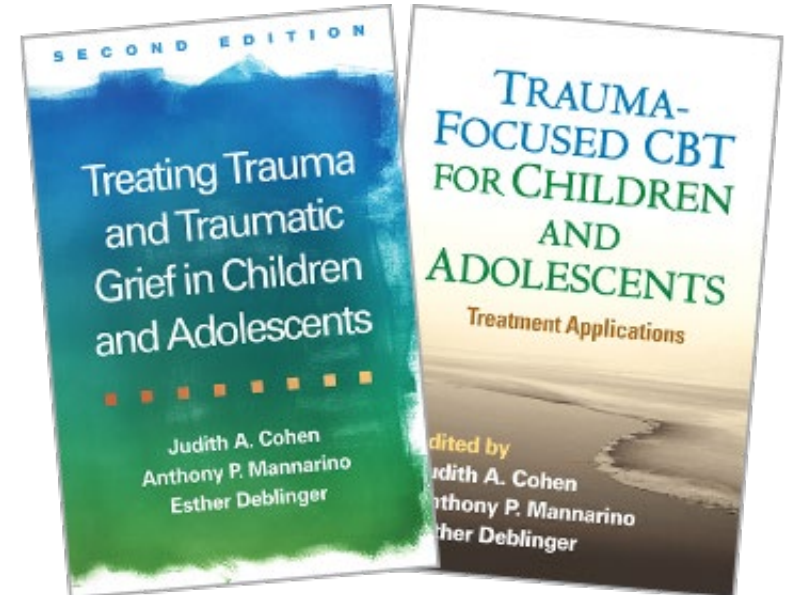
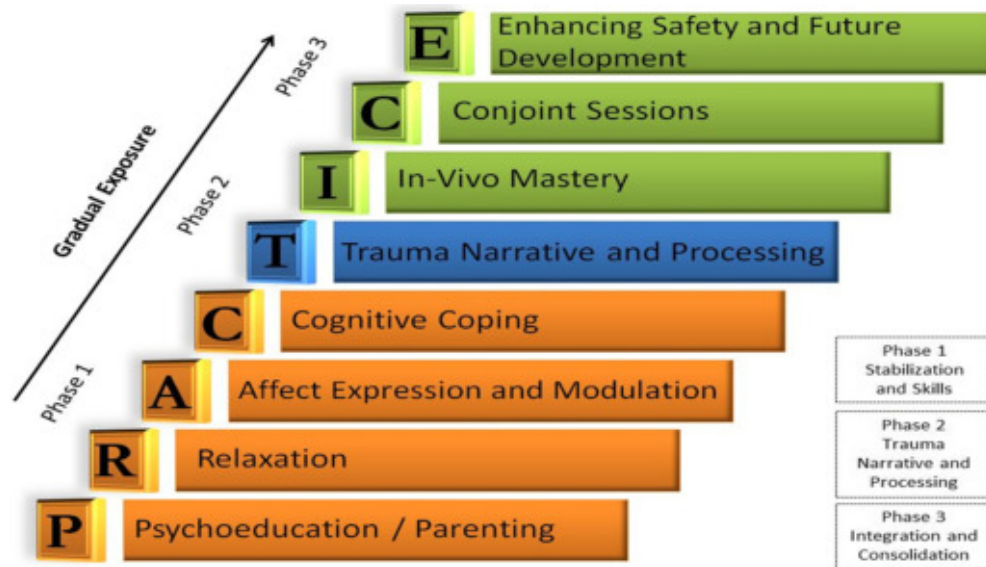
Evidence-Based Engagement Strategies

- **Why are evidence-based engagement strategies important?**
 - › Less than half of families attend the first scheduled visit
 - › Less than 10% remain in treatment after 3 months
- **What does this mean?**
 - › Clinicians address perceptual and concrete barriers during initial phone contacts with caregivers
 - › Caregiver goals are noted and addressed throughout treatment
 - › Reminder phone calls, texts, or emails
 - › Responsibility for completing treatment is shared between clinicians and patients



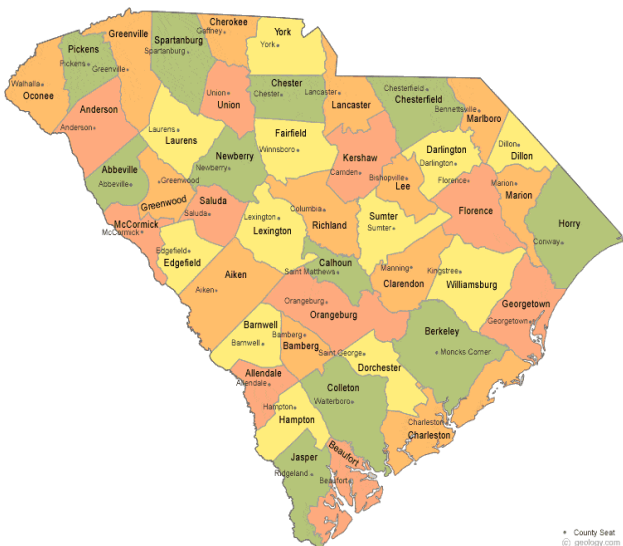
Evidence-Based Treatment

- The program provides Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
 - › Treatment completed with a supportive, non-offending caregiver
 - › Typically 12-16 sessions
 - › Child and therapist meet once per week



Demographic & Geographic Data

- Over 2,000 visits with over 300 patients in 8 counties (5 years)
- For children seen for individual therapy (n=70)
 - Ages 7-18
 - Common diagnoses: PTSD, Adjustment Disorder
 - 89% racial & ethnic minorities (59% Latinx, 30% African American)
 - 36% rural, 59% urban underserved
 - 63% school-based, 34% home-based, 3% combination



• County Seat
© geology.com



Barriers to Office-Based Care

- **Over 87%** of caregivers reported they experienced barriers that prevented them from accessing office-based mental health services
- Caregivers reported they would have had to travel between **5 and 89 miles** and between **15 and 90 minutes** to get to office-based mental health services

Caregiver Work schedule = **60%**

Distance = **58%**

Lack of transportation = **48%**

Not sure where to go = **40%**

Childcare = **33%**

Cost of services = **30%**

Lack of health insurance = **28%**

Stigma = **20%**

Treatment Outcomes

- **88.6%** completed all components of TF-CBT
- **96.8%** no longer had PTSD after TF-CBT



Vs. 25-60%
*Typical
 completion rate
 for TF-CBT in
 studies in the
 United States*



81% of caregivers
*Participated in TF-CBT
 with their child*

**Treatment effects similar to
 in-person TF-CBT**
Kids got better (effect size=2.42)

Metrics	Pre M (SD)		Post M (SD)	
	Child	Caregiver	Child	Caregiver
UCLA PTSD Reaction Index	36.96 (14.54)	31.59 (16.36)	9.29 (7.15)	9.27 (9.40)
	51.4% Above Clinical Cutoff	28.5% Above Clinical Cutoff	4.3% Above Clinical Cutoff	0% Above Clinical Cutoff

Stewart, R.W., Orenco-Aguayo, R., Young, J., Wallace, M., Cohen, J., Mannarino, T., & de Arellano, M.A. (2020). Feasibility and Effectiveness of a Telehealth Service Delivery Model for Treating Childhood Posttraumatic Stress: A Community-Based, Open Pilot Trial of Trauma-Focused Cognitive Behavioral Therapy. *Journal of Psychotherapy Integration*, 30(2), 274-289. <http://dx.doi.org/10.1037/int0000225>



Satisfaction with Services



100% satisfied with telehealth



86% said telehealth equipment was easy to use



100% said level of rapport with therapist was as good as in-person



100% would recommend telehealth to a family member or friend.

Villalobos, B.T., Dueweke, A., Orengo-Aguayo, R., & Stewart, R.W. (under review) Patient Perceptions of Trauma-Focused Telemental Health Services Using the Telehealth Satisfaction Questionnaire (TSQ).



Caregiver and Patient Satisfaction

What was the best part of the telehealth program?

Mother regarding home-based telehealth services for her 2 children:

“The convenience of not having to come to the clinic. I would have had to lose 4 hours between driving to the clinic, waiting for the therapy to end, and returning. Parking at MUSC is very difficult. They [the kids] liked doing [therapy] more on the tablet than in person. The therapist worked very well with them. Above all her therapist put herself at her level.”

Teenager regarding school-based services:

“I was able to overcome a lot of things. It was just as good as seeing my therapist in person.”

TF-CBT Via Telehealth Pilot Study

Conclusions

- **9.6 of every 10 children** (96.8%) no longer had PTSD after TF-CBT via Telehealth
- **8.8 out of every 10 children** (88.6%) completed a full course of TF-CBT via Telehealth
- **Very High Satisfaction** with the telehealth delivery format
- **Increase access** to trauma-focused treatment to underserved communities

**TF-CBT delivered via telehealth is feasible,
acceptable and effective!**

Adjustments during COVID



The Good News!

- TOP program was already set up to function remotely prior to the global pandemic.
- Due to the barriers faced by many patients in the TOP program, we already had access to loaner equipment and processes in place to use this.

So, we pivoted related to procedures, but overall, it's been an easy transition.



Adjustments during COVID Pandemic



- Changes to equipment distribution
- Changes to consent process
- Training patients and families on equipment use (increased use of tip sheets, etc.)
- Adjustments to sessions (shorter, more breaks)

Things to consider during a Pandemic

- Mailing system may be disrupted
 - Ex., Apartment complexes not receiving packages
- May need to be more creative in scheduling
 - More family members located in the home
 - Parents often have many demands (e.g. work, home, school) that are taking up their time
- Additional stressors impacting families
 - Safety concerns related to the pandemic (family members getting sick, deaths related to COVID, isolation from family)
 - Financial impact (loss of jobs, reduced income, etc).
 - Remote learning



Thank you!

Reflections, Comments, Questions?



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