

# **Serving the Underserved: Preparing Psychologists for Effective Practice in the Public Sector**

Plenary 2: Speaker 1

## **Evidence Based Practices: Los Angeles County Evidence Based Practice & Psychology Training Issues**

LaTonya Wood, PhD

Linda asked me to talk about Los Angeles County Evidence Based Practices, and the impact of them on training. And my response to her was you know I work for DMH right? So I'm going to, in an effort to temper the conversation and discuss the challenges and the opportunities presented in DMH. I do want to introduce you to DMH, yay, I see there are some supporters here in the front row. I will talk about LA county Evidence Based Practices in the context of why we're here for the next two days, and what opportunities and challenges are presented to training programs within DMH. I was fortunate to sit at a table of lively people during the discussion that we had after the last session. So since we've already started this discussion, so I'm just going to continue it all for us this afternoon and I want to.

For purposes of the conversation I want to give a little bit of background information because I'm not sure that everybody is aware of what's happening in DMH. Some people are like yeah we are, but especially in L.A. County, so I want to speak to what's going on. Actually a few years ago, even before MHSA and the PEI-- Prevention Early Intervention--there was some implementation of evidence based programs in the child welfare section across the state. CIMH actually endorsed and set up what they call Community Development Teams which were small teams that were put in place to try to increase accessibility and sustainability of evidenced based programs throughout the state, and L.A. County had their contingent. These are some of those initial evidence based programs that were implemented in L.A. County. They were implemented in intensive in-home services predominantly for children and child welfare and here is the slide so you can see the list of names.

...And then came the MHSA. Earlier this morning Melody talked about the WET, Workforce Education and Training, phase of MHSA which funded this symposium. However what has been taking place in the last couple years is the next phase of MHSA which is Prevention and Early Intervention. Part of PEI mandated evidenced based practices, which is a great idea. It's wonderful to bring quality and effective services and treatment to those who need it the most. However there have been some challenges in the implementation of that and I'm going to talk about those challenges. But I also want to go back to this slide to tell you what this all means when the rubber hits the road, okay.

In L.A. County we have different programs that were implemented via PEI, meaning they would be funded through MHSA. So not to give too many of the boring details, but of MHSA, as you heard earlier, there were Requests for Proposals people sent out, saying yes, yes we'll take your money. And then they were trained on how to do those specific interventions, which they could then bill for and be reimbursed. They were like okay well we need these programs, and

they were defined, sort of, and had to fit into one of three categories. Evidenced based programs are those that sort of meet the gold standard of having randomized controlled trials that show positive outcomes and replications. Then there are promising practices, those are programs or services or interventions that have shown positive outcomes yet maybe not necessarily in a variety of settings and maybe they have not been replicated, so they don't meet yet the gold standard of what we consider to be evidenced based treatments but they're promising. So you could have submitted a RFP for funding to have this listed as one of those reimbursable services in the county. Or it could have been a community defined evidence based practice which is specific to L.A. County. These are some practices and intervention services in the communities that again have shown positive outcomes with that specific population. So, if you could demonstrate that your program was effective in L.A. County with certain populations then you could have submitted a request to say we want our program also listed for reimbursement.

The result was that 23 different programs are on the list of approved programs for reimbursement in PEI-- Prevention Early Intervention. A lot of acronyms, a lot of language but it's about the money right? So again, when Linda emailed me and we were discoursing back and forth and she said DMH has adopted one treatment program that people have to do. Oh, if we only had one! We have 23! So we already had these five, we had a leg up because we already had these five going but then we added all the additional ones. In just the last year there are seven other programs that clinicians from agencies in L.A. County have been trained on. Many of the approved programs you may, like me, haven't heard of a particular one because it may be one of the promising practices, or it may be one of the community defined evidence practices. This doesn't hit all 23 I know, but just in the last year we have reached 23 which is kind of astounding.

I'm talking a bit about the context of PEI--Prevention Early Intervention, because that then explains the impact on training. It's unfortunate that actually it came after WET, because even again listening to Melody this morning, it's one of the mandates and the objectives of WET to increase diversity in our workforce, to prepare the workforce to go out into community agencies, and it came behind the different services we were going to have to train those people in. So we've already missed each other in our own initiative of how we were going to raise funds to increase access to services.

So let's talk about the scope and size of implementation. In the last year, and I mean the last year, and anybody who is in community mental health or has tried to send their students to community mental health recognizes that it has literally been in the last year, programs have said no, these are the services that we're offering. Let me read some of these numbers for you. For Triple P we've had 40 different agencies and 595 clinicians trained. For Seeking Safety we've had 55 agencies, 666 clinicians trained. I believe I may not be right, but I think CBITS is one of those community defined interventions. It was, I think, a developed in collaboration between USC and LAUSD, and is an intervention that was implemented in the schools. I think it's one of the more promising practices, and I believe it's one of those community defined interventions. We've had 123 people trained in CBITS.

Trauma focused CBT, that's the hot ticket right now. We've had 68 agencies trained, with 1029 clinicians, and this is in L.A. County alone. Now that's great news because that

means these are the number of staff persons who are being prepared to provide effective quality services to those who need it the most. The bad news is it has happened within six months and it has changed the way services are provided in just six months. So the size and the scope of the implementation has been one of the challenges that we've encountered. Along with that is staff resistance of people being told "Now I know that you've been doing play therapy for several years but now you're going to the "TFCBT" and people saying "You can have this job, I'll leave."

Now staff resistance, I think, has changed. I think people are more open to taking on different trainings and learning different models but it has been a shift. And aside from any money that is needed, the county has said that "If you're a provider, and you want to receive our funds, then you're going to have to do one of these 23 treatments and you're going to get your people trained by the people that we're endorsing." You need to pony up the money for this training. These are not necessarily inexpensive trainings, and even if the agencies come up with the funds for the trainings, there are few providers who can actually provide the training. In TFCBT for example, the training providers are very specific, and they are the only ones who can provide the training. There is no "train the trainer" model for this. In my agency we've had to wait until there are training openings. We must compete with the other 1000 people in L.A. County who are trying to get the training. We want the training so we can have our staff ready to bill for services and get money to continue our work.

We haven't even talked about students yet. So now you guys understand why I'm talking about how this movement toward using EBPs is affecting the county in general. There's no room yet for discussion of training students because we can't even get our staff trained, much less train students in EBPs.

There is a lot of staff turnover which doesn't help the problem, and there are many administrative and bureaucratic issues. So along with this move to EBPs, and other sorts of system issues and challenges public mental health is facing as it navigates multiple systems, there are tons of barriers to accessing treatment for our clients.

I work in what is known as service area six, to those of you who speak DMH talk. For those of you who don't, service area six is called South LA, and which formerly was called South Central LA. We changed the name to South LA a few years ago as a marketing strategy to change our reputation. And it worked, because people know what South Central is.

Our staff have to get credentialed in these approved treatment models, which usually requires attending the training, receiving the supervision, ongoing monitoring, submission of video tapes and audio tapes, etcetera. We need the technical support and equipment in order to provide the audio and video tapes so we can send the tapes to the training provider who's going to give us our credentialing. The credentialing, and the administrative issues, will lead to the billing. And again I speak to this to give you the overarching context of just the impact of the implementation on public mental health before I even begin to introduce how it could be affecting training and interns. For some of you this is new, but I know at our discussion table we already started talking about this because I was sitting with some DCTs who talked about just the huge number of practicum sites that have been lost in response to this issue.

If you're an agency that's looking at paying for your staff to go to a training that costs \$2500 a person, and you are hoping to sustain this staff over time, the investment that's required to train a student who's going to be with you for just one year is not even an option, much less a consideration. It's just not even an option, especially considering all the other things that are needed to actually support students when they are training with us.

So I have some personal experience with this, I did leave the jail. My bio says that I worked with LA County on the Adult Justice Bureau, because I was working in the jails. But I broke free! I left and I went to foster care, so some say I left one prison for another. But the program that I work in now is called Specialized Foster Care. Some of you may have heard of it as a result of a lawsuit, Katie A - which is the child's name. This was a class action lawsuit filed on behalf of children in foster care which created a mandate for the Department of Children and Family Services (DCFS) and DMH to collaborate and insure that kids at risk for needing mental health services, would be screened, and assessed, and receive appropriate mental health services.

We are an inter-disciplinary team--we have psychologists, social workers, marriage and family therapists, psychiatrists, and medical case workers. My team is a multi-racial multi-ethnic staff. We have five different offices in service area six now, and again I'm sorry I'm speaking DMH language, but geographically we're the smallest portion of the county, however we also have the largest population. It is a very dense population. I don't have a map to show you but to just to give you a sense of the borders, probably the area that we cover is as far south and east as Compton, as far west as maybe Inglewood, and as far north as maybe just due south of the USC campus. So that's the geographic area that we cover, but we're intensely dense so we have a great, great overrepresentation of children in child welfare. One of my five offices, or I shouldn't say my, but one of THE five offices, generates 20% of the revenue for foster care for the entire county, just to give you a sense of the number of kids in foster care in our system. We have about 80 staff total, so at each office we get many of these referrals. Any child that enters into DCFS we screen and assess for the need for mental health services, we get about 100 referrals at each office each month, and these are the different services we provide.

I'm one of the lucky ones. I work in a system with a supervisor who values training and supervision. So I'm one of the lucky ones. I actually know that what I'm talking about is even more than other DMH sites get to experience regarding the exposure to training because I actually have a supervisor who supports it and encourages it.

So this is what we have, we have TFCBT-Trauma Focused CBT. What we've done at a system level and a local level is just to support the staff. We have a monthly administrative call where we talk with each other about different issues that we're having, and that's across the county. We have a monthly supervisor's meeting, again across the county, so all the supervisors can get together and problem-solve the challenges they're enduring. But at the local level in my service area we also provide weekly group supervision, two hours for clinicians that are doing trauma focused CBT. Twice monthly we have consultation calls with a provider who trained us in TFCBT, but those calls just ended. Also monthly we have an administration meeting so we get together the managers, myself and a couple other people, to talk about the billing issues, the

legal issues, and the ethical issues that come up. I can tell you what all those are if you really want to know, but just know that I'm going to get to it, it's a challenge, it's a challenge.

So training--there are huge wonderful opportunities that are presented by what we're doing in DMH. For me it's a privilege to work in the community that I work in. It's a privilege to serve the underserved. It's a privilege and an honor. I love where I work, I would not work anywhere else. It is my choice to be in service area six. And for those who know service area six, you choose to be in service area six. I love it. And I think the opportunity it provides for students to gain experience and exposure is wonderful. The opportunity to give them exposure to evidenced based practices is great. We have 23, it's quite a lot but it's 23, its 23 different programs that we could, in real life, have students exposed to. The diversity of culture, race, social-economic status, religion, sexual orientation—it's all there embedded within DMH. The diversity of clinical settings in which services can be provided is there. One thing I didn't say about our program, is that it's predominantly field based. I have two of my offices co-located in DCFS--meaning my DMH staff are located in the Department of Children and Family Services office. We have cubicles. All of our clinical services are provided in the field. We are at school, we're at group homes, we are in the homes. I actually had a supervisor who went out to Walmart to meet the parent there. We are out in the field. We are providing services in a multitude of settings.

Beyond that there are also all the other systems that we interact with—probation, juvenile hall, health care, all of the things that have been mentioned earlier today. There is a convergence of all these different possibilities of where evidenced based practices could be implemented with this huge expansive population. Just the experience and exposure to public mental health, that's a lesson in and of itself. That's a training experience in and of itself. Come to public mental health, not have a fax machine that works, not have a desk to sit at, not have a voicemail number to leave for clients to call you, have clients who don't have phones, that is training all in itself, as well as have all the different public systems we interact with. So it's a wonderful, unique, excellent, and needed training site.

But, here are the challenges. On so many levels supervision is an issue. First of all it's having the number of people to do the supervision, then it's assuring that those people have the time available to do the supervision. Much of what we do is driven by money, if I haven't said that enough yet. The services that are provided, which services are indicated, which are delivered, what staff can do, is determined by money. It is really tough to convince a program manager to release their staff person, who can be billing two to three hours a week, to instead provide clinical supervision during that time.

Again I'm lucky. I'm one of the lucky ones, but that is not true across the board. So the challenge is having an adequate number of staff to provide supervision, the administrative support to allow for supervision, as well as the time to do supervision. We're talking about EBPs today. Those first two comments were relevant just to supervision itself. Now let's talk about supervisors who themselves have the competency, the knowledge, and the skills to supervise an EBP when they've just been trained themselves six months ago in a two day workshop. The research support says a two day workshop doesn't necessarily change behavior, that it isn't sufficient, and that you need more ongoing long term exposure to training to actually

be effective with a new treatment model. So do we even have the supervisors who have the skills themselves, and knowledge base to provide the supervision?

Next let's consider internship regulations versus what DMH practices, we talked about this at our table today. APA accreditation, our board, our regulations, specify and dictate what kind of clinical services and practices a psychologist needs to train in. Come work with me and it will be tough to see what a psychologist is doing that would meet those regulations. Now, we are assessing, we are intervening, we are doing all the things that are at the core of being a psychologist, but they don't fit exactly into a description that looks like what the Board of Psychology, or maybe APA, wants; what they seem to want is very, very different. And that difference is a challenge, because and I was the internship training director of eight interns, six of which worked in the jails, two of which worked in foster care. Then my manager said we are now following a recovery and resiliency model. Now we have peers—clients who are going to assist in running peer run groups--and your psychology students need to sit in those groups with them and co-lead a group with a peer. I'm thinking APA doesn't allow for that. There's no room for it, but that was what my administration was wanting from me. It is very difficult to merge those two different sets of expectations and have them converge in a way that can support the internship as well as the needs of the DMH programs.

Providing adequate exposure and experience to students—students who need to get a certain number of cases, a certain number of assessment batteries, and a certain type of case—is a challenge because we just don't always have the flexibility to manage that in DMH. Even when we have the flexibility, we need the person who's trained in doing TFCBT to go see this client because that's what DMH is paying for right now. We need this, this, and this. I know that you were really hoping to get a humanistic experience, but we can't get reimbursed for that. So, and I'm being very frank, perhaps we don't have the capacity for adequate exposure and experiences for our students that will guarantee that they can, at the end, feel like they've had a well rounded thorough experience that really meets their training needs and the needs of any board regulations that we have.

The expense, and actually more the funding sources, and I again hope I've made this clear, but what it comes down to is not so much just the money. We have the money. MHSA gave us money. It is where the money is spent. I think earlier today the MHSA priorities were described. The priorities dictate how we manage our funds in DMH. Money drives the services, unfortunately. I guess I'm taking on the spirit of Dr. Deleon because he was very frank, and I was like, okay we're going to have one of those kinds of sessions today. Money drives the services. And what is the funding source? Remember at the beginning of my talk I said that unfortunately PEI has become synonymous with EBP. If you are working in a DMH agency, the county will say which PEI--Prevention Early Intervention—programs I can use. That really means what treatments can I provide that will be reimbursed with PEI funds.

The people who are trained in the PEI programs are those 600-1000 clinicians that I just talked about, not our interns, not our practicum students. So, the interns and practicum students are not going to be providing those services because the agency won't get paid—this is the bottom line. The impact of this reimbursement limitation has been a great decline in the number of practicum and internships available in Los Angeles.

I'm running out of time here, so I'm going to go to strategies. I don't want to paint a completely dour picture of what we're dealing with, but a realistic picture of what we're dealing with. These are just my thoughts, and actually they're shared by people I know at my table, so it made me feel good. These comments are not unique thoughts, but just my own reflections as a person working in DMH who is committed to the vision, committed to education and training, and wants to fulfill the mission of WET. WET wants to grow a crew of students who want to come into Community Mental Health, and who will have jobs there for them when they leave us. So I want to see that mission fulfilled. We need more partnerships. I said academic and community partnerships, but after our discussion earlier I'm going to add business partnerships to that. We need business partnerships, we maybe need legal partnerships, we need political partnerships, and we need to think more broadly about who our partners are.

When I was thinking about partnership in the context of this talk, I was thinking more about ways to build in the supervision. If there is one complaint that we have at DMH it is that we don't have enough supervisors. I get calls all the time from clinical training directors asking if I can place a student. It's like, well I have one licensed psychologist and she's doing this, and I have a licensed marriage and family therapist if you're okay with that because I actually have a lot more of them than I have of psychologists. Will that work for you. But what if we actually built in supervisors? I've actually done this a couple times with schools. I say, we'll take care of the case supervision, can you supervise the clinical work? I have lots of work psychology students can do, so we negotiate a relationship where clinical supervision is provided by someone at the school.

We also need some way of providing onsite education, since DMH is not going to be able to send our students out to get specific training. Can we have educators from the schools come to our DMH sites? Can we have the educators come and lead a seminar on CDT weekly or monthly to the students on site? I think we need to build academic partnerships that really blend the two needs together. I also think we maybe need multi-year and multi-site placements that build upon themselves. What I see happening too often with students is that they go one place for their assessment practicum, another place for their clerkship, and yet another place for their intervention training, and none of these experiences are connected. But if perhaps there was a more planful, intentional strategy at the start here, letting us develop training here in a similar setting, similar context. This could then build upon itself. Students would have the opportunity to gain the breadth and depth that would help them feel more prepared for working with this population. But right now it's a bit fragmented.

An organized training trajectory might also endear the program to DMH, and then encourage more investment on part of DMH and some of the agencies. Take Pacific Clinics for example, I'm thinking of my partners here from Pacific Clinics who have different sites across the county and are very invested in the students. But what if the potential was there to say we have a two year commitment to you. And so at the beginning of the first year if we train you in TFCBT we know that you're going to be doing this. Or we train you in PCIT, they have a great mobile PCIT van, because we know we're going to have you for the next two or three years across the county with our agency.

We need maybe, perhaps maybe, a broader orientation to evidenced based practices as far as a concept and a notion separate from the treatments because again it remains fragmented. We have the treatments that people are receiving, and my staff and DMH providers are victims of this because we have people--those 1000 and 666 people who went through all those trainings are the same people--so in one week they're doing Seeking Safety and another week they're doing trauma focused CBT and then another week they're doing Incredible Years. So they're just kind of inundated with all these as opposed to maybe a more broad approach when you're doing an assessment--are you teasing out the elements of the behaviors and symptoms that will be impacted by evidenced based treatment? Are you able to evaluate and synthesize what the evidence is to know what will be applicable in this setting and in this environment and with this population? In your intervention are you able to tease apart and have a more general and broad understanding of what the elements are that are effective with this population?

One of the treatment models that DMH did adopt is the modifying and adapting practices which was developed by Bruce Chorpita in Hawaii which sort of looks at the issue of specific elements of treatment needed by specific people. It's a more treatment as components module approach.

What do we know, what does the research tell us? So we're looking at the data, we're looking at the research and exposure is the thing that's going to best treat anxiety. So let's train my clinicians on exposure therapy to treat most of the anxiety. This is good, because only the people who were trained on Trama Focused CBT--which for me is five, and I have a staff of 80--can do TFCBT. I can much more easily teach 80 people how to do exposure than to teach the same number to do TFCBT, which will cost me \$10,000.

Blended learning, which means using different types of systems, or methods, or strategies to support learning will be most useful in our dispersed program. So we have distance learning, web based learning, virtual classrooms, face to face supervision, workshops, and a library full of learning resources. Let's blend all of these together and update our training models.

GARCIA-SHELTON

I think if Latonya played chess she would be a grand master. Thank you for that Master Lecture!

Now Dr. Beutler, Dr. Larry Beutler is going to talk about choosing interventions that work.