Child Health and Development Institute of Connecticut, Inc.

ISSUE BRIEF

NO. 71 · SEPTEMBER 5, 2019

Better than Usual (Care):

Evidence-Based Treatments Improve Outcomes and Reduce Disparities for Children of Color

Behavioral health problems are common, with 13-20% of all youth experiencing a diagnosable mental illness in the past year, and as many as half of all children experiencing mental illness at some point by the age of 18[1]. Child and family-focused psychotherapy ("talk therapy") is generally the first treatment indicated for most childhood mental illness, with outpatient and school-based therapy being the most frequent treatment settings. While psychotherapy is generally effective overall, rates of improvement are modest[2] and treatment completion rates are low. Behavioral health disparities also exist, particularly for children of color, who access services at lower rates and are less likely to complete treatment than White children. Research is less clear about whether racial/ethnic disparities in outcomes exist for children who do receive treatment within large systems of care.[3,4]

Recent data from Connecticut suggest that evidence-based treatments (EBTs) can result in greater improvement than usual care treatments while also reducing disparities for children of color.

EBTs Remain an Underutilized Resource for Improving Outcomes and Reducing Disparities

EBTs are treatments that have been rigorously evaluated to show that they are effective for the behavioral health conditions they were intended to treat, and that they work better than usual care interventions *(i.e., generic talk therapy most commonly provided in the community).* While hundreds of EBTs have been developed and despite their benefits for improving outcomes for children, access to EBTs in "real world" community mental health settings remains limited. Estimates suggest only 1-3% of children receiving treatment nationally get an EBT.[5] The primary challenges to improving access include the added time and cost to train staff in EBTs and participate in the quality assurance and consultation needed to sustain them. Questions have also been raised about the applicability and effectiveness of EBTs to diverse populations, including whether, when, and how cultural adaptations to EBTs should be made. However, EBTs have generally been found effective for children regardless of race/ethnicity[2,3] and cultural considerations are increasingly included in training for many EBTs.

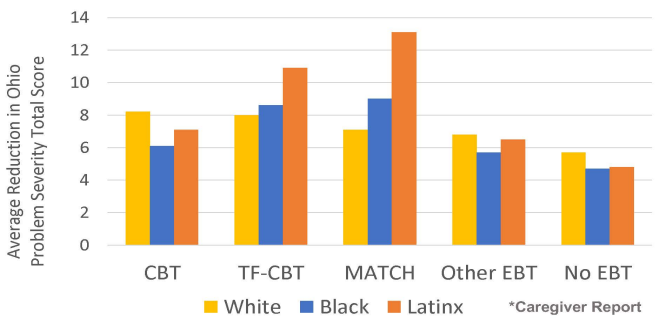
Connecticut is a Leader in Improving Access to EBTs

Connecticut, led by the Department of Children and Families (DCF) and the Court Support Services Division of the Judicial Branch, has been a national leader in improving access to EBTs for children with behavioral health conditions over the past 15+ years. DCF has partnered with CHDI to support dissemination of several EBTs in outpatient behavioral health clinics and schools as a key component of improving access to high-quality children's behavioral health services statewide. Since 2007, more than 1,500 clinicians have been trained and more than 14,000 children have received one of these EBTs. Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems (MATCH-ADTC) are two of several models being widely implemented in Connecticut's outpatient clinics. Recent data indicate approximately one third of children receiving outpatient treatment received a specific EBT, while another third received cognitive behavioral therapy (CBT), a more general EBT.

Children Receiving EBTs in Connecticut Have Better Outcomes

CHDI analyzed administrative data from 46,729 children (mostly between 3 and 17 years old) who received treatment at 25 DCF-contracted outpatient children's behavioral health clinics in Connecticut between 2013 and 2017 to examine the use of EBTs and their effects on child outcomes. Outcomes were measured using the Ohio Scales problem severity scale, which is a general measure of children's behavioral and emotional health that is reported separately by caregiver and clinician. Clinicians also reported the type of EBT or other treatment(s) provided to each child. **Results from this preliminary analysis show that the use of EBTs resulted in improved outcomes and reduced or eliminated disparities in outcomes compared to usual care** (Figure 1).

Figure 1: Improvement in Child Problem Severity by Treatment Type and Race/Ethnicity



Overall, children receiving any type of treatment (including usual care and EBTs) showed modest improvements but the results suggested racial/ethnic disparities in outcomes.

- Children who received any treatment showed a 26%-28%[6] reduction in symptoms, consistent with existing research on outpatient therapy. Approximately half of all children did not show meaningful improvement.
- Children who received any treatment had disparities in outcomes by race/ethnicity. Black children improved at a 20% lower rate and Latinx children improved at a 6-11% lower rate than White children.

Children who did not receive an EBT (e.g. received usual care) showed the lowest rates of improvement and greatest disparities:

- Children who did not receive an EBT showed a 21%-24% reduction in symptoms.
- Children who did not receive an EBT had greater racial/ethnic disparities. Black children improved at an 18-30% lower rate and Latinx children improved at a 12-15% lower rate than White children.

EBT use was high, and children receiving an EBT showed greater improvement with fewer racial/ethnic disparities:

- Clinicians reported using at least one specific EBT with approximately one third of children and CBT with another third, much higher than national EBT estimates of 1-3%. In Connecticut, 6% of children received TF-CBT and 1% received MATCH-ADTC, and many received other EBTs.
- Children who received an EBT showed greater improvement than those who didn't, particularly for TF-CBT and MATCH-ADTC. For example, children showed 46%-76% (TF-CBT) and 68%-75% (MATCH-ADTC) greater improvement in problem severity than children who did not receive an EBT. Children receiving generic CBT showed the smallest improvements among EBTs, but still improved more than children receiving no EBT.
- Racial/ethnic **disparities in outcomes were reduced or eliminated** for children receiving most EBTs.

- For children receiving TF-CBT and MATCH-ADTC, disparities were reversed such that Latinx and Black children showed **more improvement** than White children (35% more for Latinx, 8% more for Black) based on caregiver report.

Next Steps Toward Equitable and Effective Children's Behavioral Health Services

In summary, these results suggest a complex picture of outpatient children's behavioral health treatment outcomes in Connecticut. Children showed overall improvement at rates consistent with the limited national research on community-based behavioral health. On the other hand, approximately half of all children do not show meaningful improvement, also consistent with national research, and outcomes are also worse for children of color. While rates of EBT use in Connecticut are much higher than national estimates, too many children still do not receive an EBT.

More children are receiving EBTs in Connecticut each year, and Connecticut is one of the first states where EBTs have been effectively scaled up statewide while demonstrating better outcomes than usual care. Data show that the increasing availability of EBTs is both improving outcomes for all children and appears to reduce or eliminate disparities in outcomes for Black and Latinx children. This indicates that continuing to expand access to EBTs is a promising strategy for improving outcomes and closing the gap in disparities.

The following recommendations are made:

- The state and other stakeholders should continue to improve access to EBTs in settings that are most accessible to youth and families (e.g. schools, homes, primary care, and community settings), including evidence-informed application of EBTs with culturally and linguistically diverse families.
- The state should support continued collection of high-quality data on children's behavioral health treatment, including type of treatment provided and outcomes, in order to better understand and improve program quality and outcomes.
- Information about the benefits of EBTs, including for reducing disparities, and where to access EBTs should be shared with families, treatment providers, community leaders, service directories, and referrers to behavioral health services.
- The state and other stakeholders should examine whether there are disparities in treatment access, initiation, and completion, as well as identification of factors that contribute to improved outcomes and reductions in disparities.
- Public and private behavioral health reimbursement strategies should favor performance- or value-based payments and innovative training and dissemination approaches to support further spread of EBTs and improved outcomes for children.

REFERENCES

1. Perou, R., Bitsko, R. H., Blumberg, S. J., Pastor, P., Ghandour, R. M., Gfroerer, J. C., . . . Schieve, L. A. (2013). Mental health surveillance among children—United States, 2005–2011. MMWR Surveill Summ, 62(Suppl 2), 1-35.
2. Weisz, J. R., Kuppens, S., Ng, M. Y., Eckshtain, D., Ugueto, A. M., Vaughn-Coaxum, R., . . . Fordwood, S. R. (2017). What five decades of research tells us about the effects of youth psychological therapy: A multilevel meta-analysis and implications for science and practice. Am Psychol, 72(2), 79-117.
3. Huey, S. J. J., Tilley, J. L., Jones, E. O., & Smith, C. A. (2014). The contribution of cultural competence to evidence-based care for ethnically diverse populations. Annu Rev Clin Psychol, 10, 305-338.
4. Alegria, M., Vallas, M., & Pumariega, A. J. (2010). Racial and ethnic disparities in pediatric mental health. Child and Adolescent Psychiatric Clinics, 19(4), 759-774. doi:10.1016/j.chc.2010.07.001
5. Bruns, E. J., Kerns, S. E., Pullmann, M. D., Hensley, S. W., Lutterman, T., & Hoagwood, K. E. (2015). Research, data, and evidence-based treatment use in state behavioral health systems, 2001 to 2012. Psychiatric Services, 67(5), 496-503.
6. Note: Outcomes are listed as a range because measures include separate caregiver and clinician reports.

This Issue Brief was prepared by Jason M. Lang, Ph.D., Vice President for Mental Health Initiatives at CHDI, and Phyllis Lee, Ph.D., Assistant Professor, Eastern Connecticut State University. For more information, contact Dr. Lang at jalang@uchc.edu or visit www.chdi.org.