The Role of Evidence-Based Treatments in the Reduction of Racial/Ethnic Disparities in Treatment Outcomes

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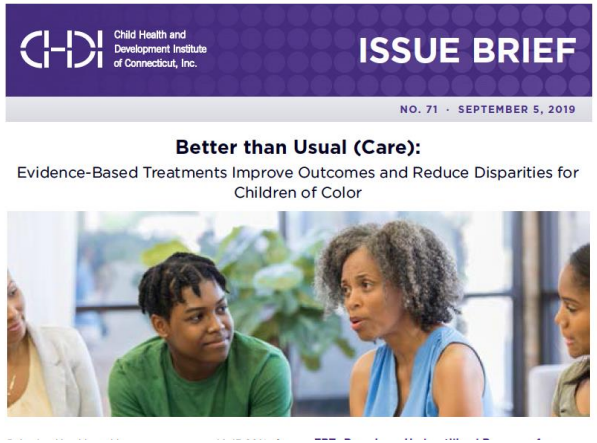

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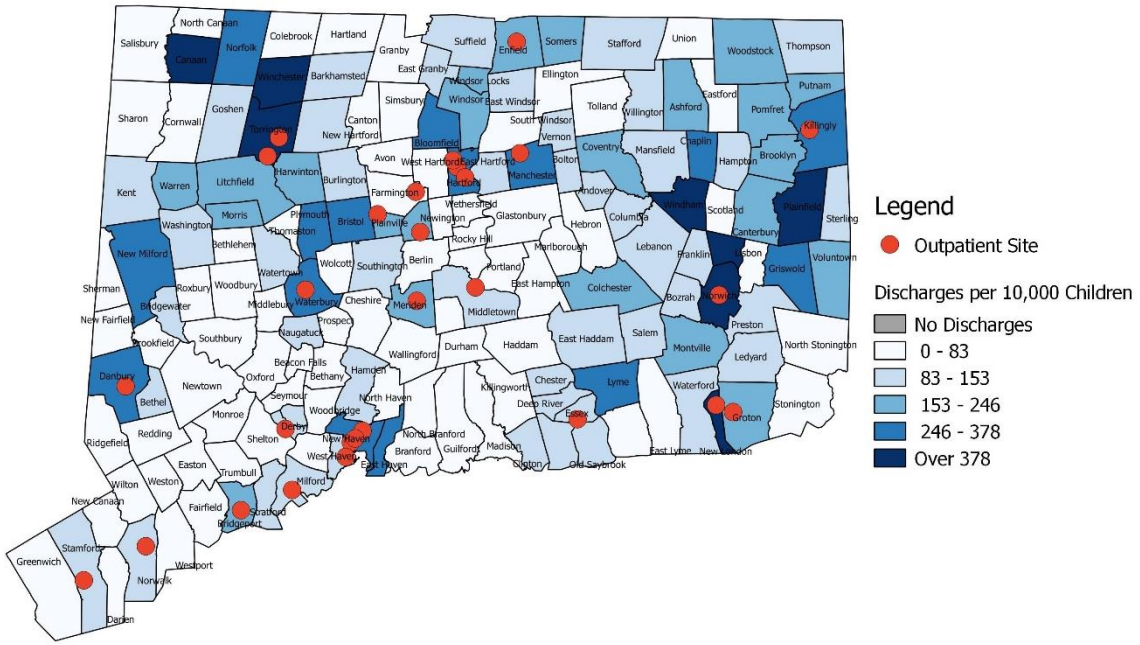
Data

- CT DCF's Provider Interface Exchange (PIE) data system
- Children discharged from 25 DCF-funded outpatient clinics from July 1, 2013 – June 30, 2017
- Some children had multiple episodes at the clinic in a year (~3.7%)
  - only the first episode was used in analyses



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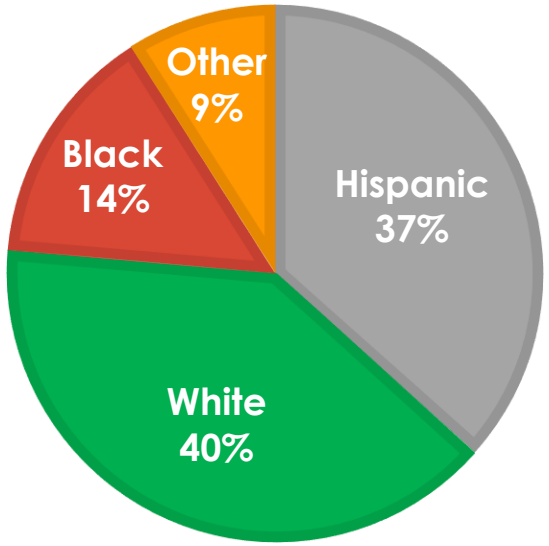
Measures

- Clinicians, caretakers, & children 12 yrs. and older rated Problem Severity at intake and discharge
  - *Ohio Scales* (Ogles, Melendez, Davis, & Lunnen, 2000)
  - Change score = discharge score – intake score
- Clinicians reported which EBPs they used for each case
- Demographics collected from families at intake

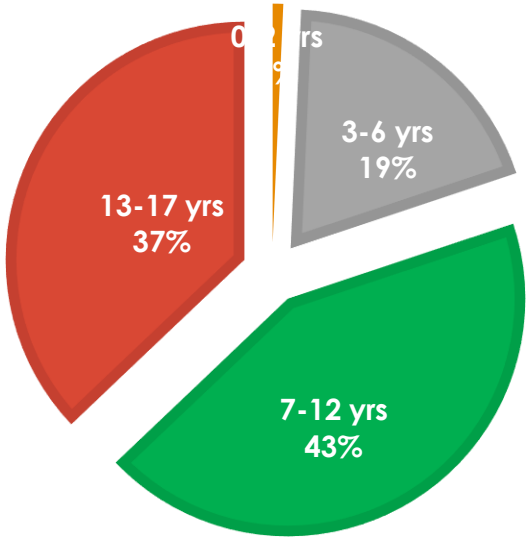
Description of children served

- 46,729 children discharged July 1, 2013 – June 30, 2017
- 55% male, 45% female

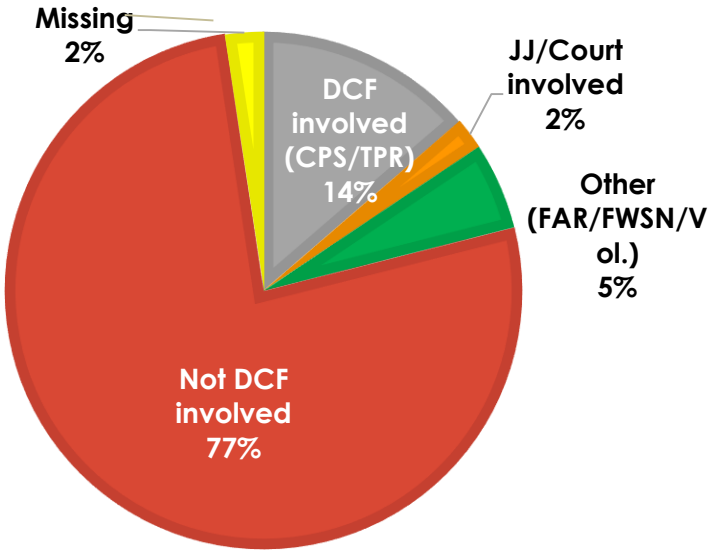
Race



Age



System Involvement



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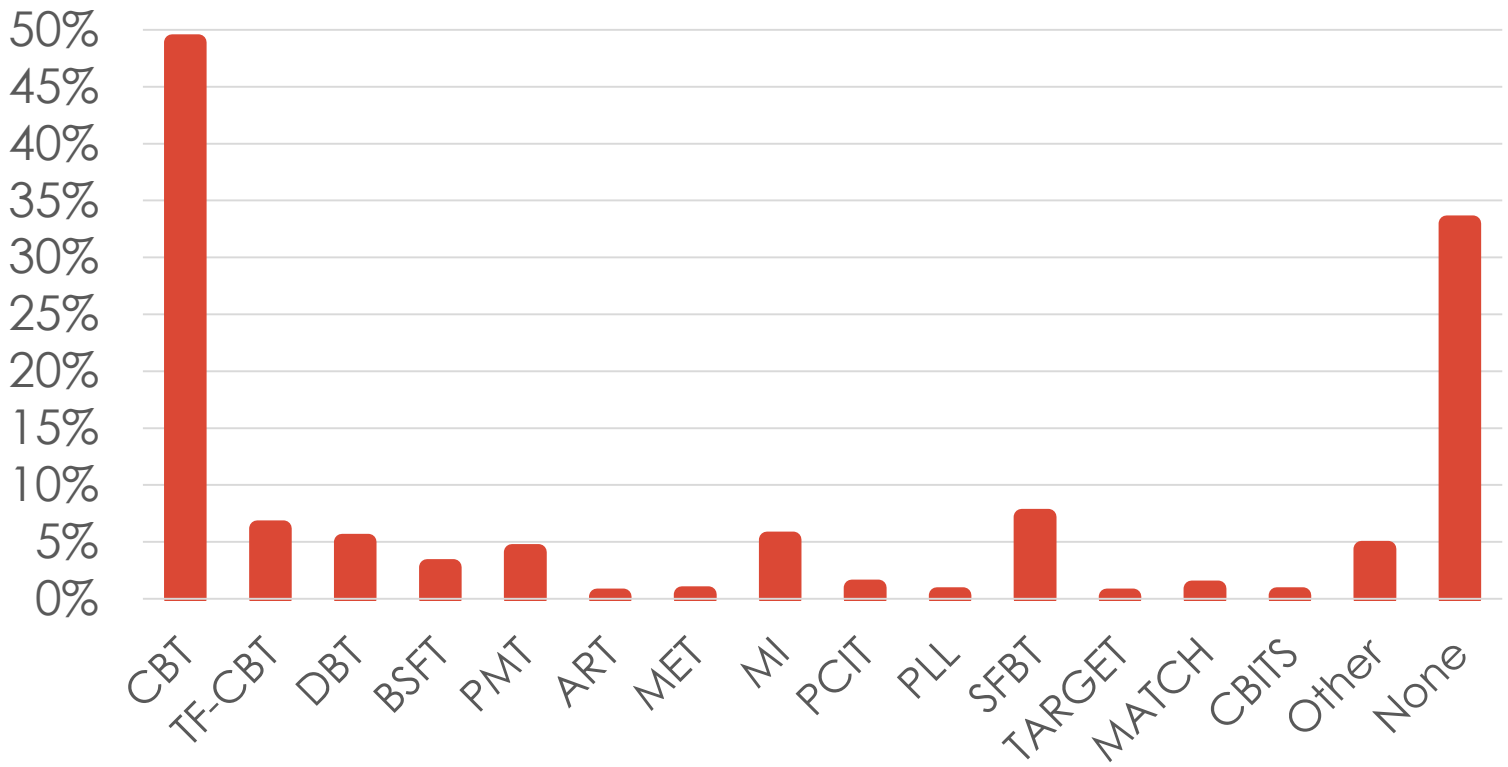
Use of EBPs at Outpatient Clinics



# of EBPs selected M(SD) = 1.41(.69), Range 1-7

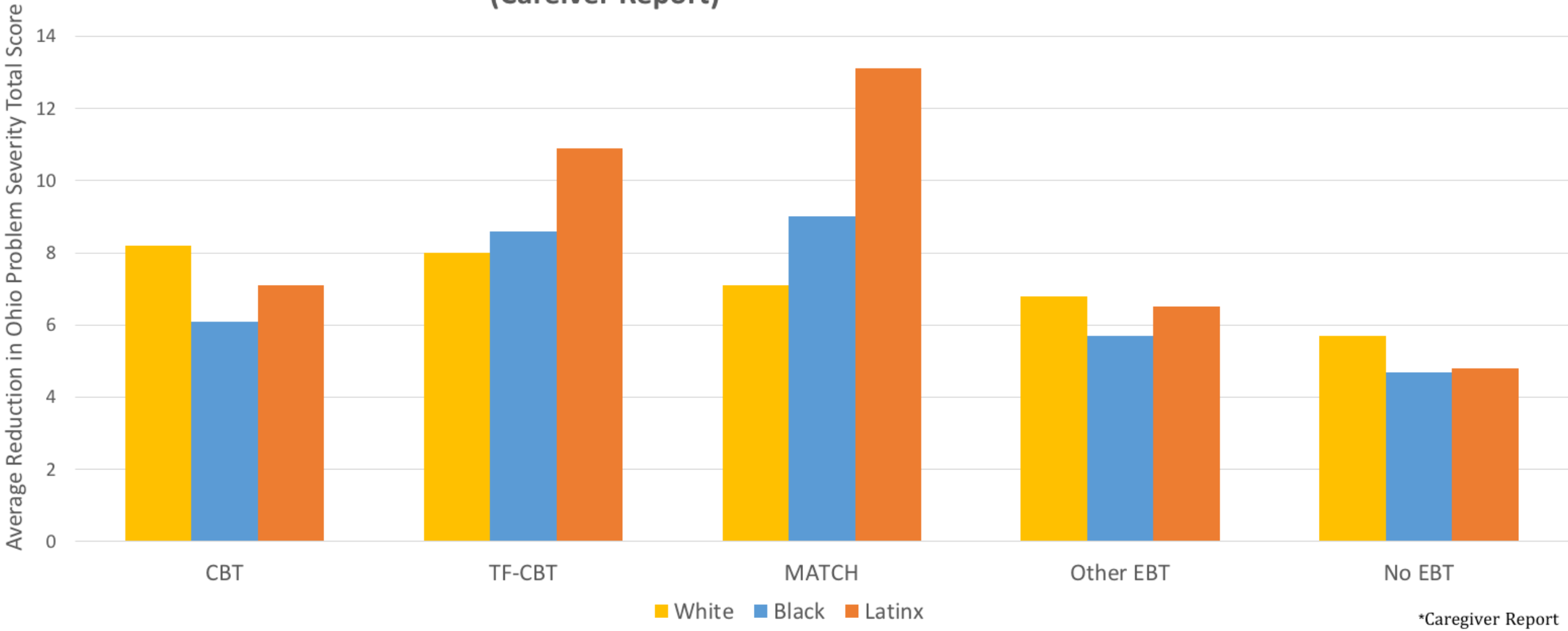
Overall Outcomes

- Children receiving treatment in outpatient clinics demonstrated some improvements, across racial/ethnic groups, and across all treatment types
  - Average 26-28% reduction in symptoms overall across all treatment types
  - About half of children did not show meaningful improvement

- Treatment outcomes showed disparities by race/ethnicity when aggregating across treatment types
  - Black children improved at **20% lower rate** than White children
  - Latinx children improved at **6-11% lower rate** than White children

DISPARITIES IN OUTCOMES BY EBP

Figure 1: Improvement in Child Problem Severity by Treatment Type and Race/Ethnicity (Careiver Report)



*Caregiver Report

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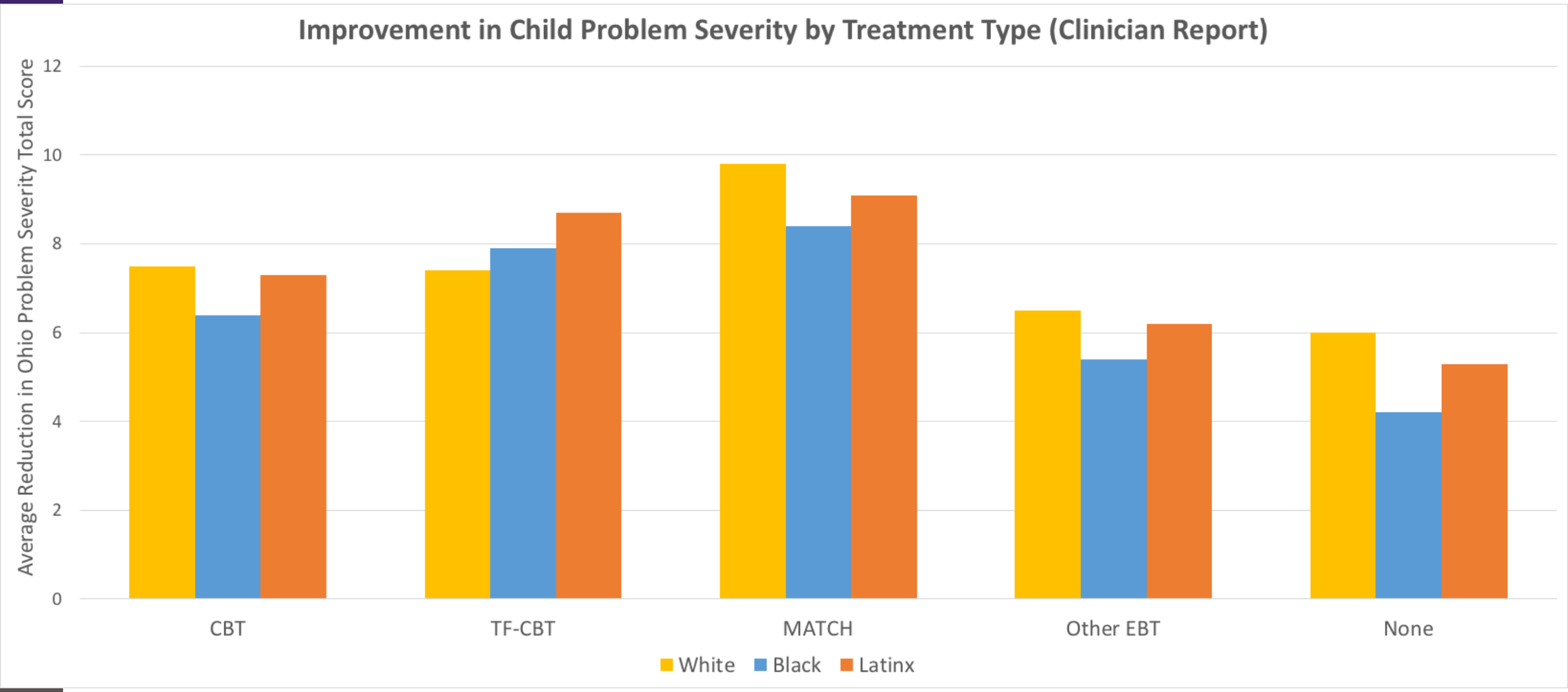

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Summary

- Overall, outpatient treatment is associated with improvements, across all treatment types, and across all racial/ethnic groups:
  - However, the effects are modest, and disparities exist
  - Only ~50% of children show meaningful improvement on problem severity
- There are several types of EBTs used in community clinics
  - Most common: CBT (1/3) and no EBT (1/3)
  - Another 1/3 of children participated in a number of different EBTs
  - 1-3% of children nationally receive an EBT

- **EBTs show greater symptom reduction than usual care** (especially TF-CBT & MATCH--the models with a full suite of implementation supports)
- EBTs are associated with **reduction/elimination of disparities in outcomes** by race/ethnicity

Limitations

- Preliminary analysis
- Administrative data, for outpatient clinics only
  - Missing data, especially at discharge
- Data collected from clinician & caretaker varies
- Cannot account for treatment dosage; cultural adaptation of EBTs unknown
- Other factors can influence treatment outcomes
  - Child clinical characteristics
  - Clinician factors
  - Organizational climate/other differences

- These data can't address questions about access to treatment/EBTs, including for children of color

Implications and Recommendations

- Similar analytic approaches to examine outcomes by race/ethnicity must be undertaken for all behavioral health programs and services
  - Other community-based models (e.g., Mobile Crisis, Care Coordination), intensive in-home EBTs (e.g., MST, MDFT, FFT), school-based models (e.g., CBITS, BounceBack)
    - Many RBA report cards are doing this already
  - JJ system interventions (e.g., traditional service delivery vs. evidence-based models)
  - EBTs should also examine other cross-system outcomes (e.g., education, out-of-home placement, JJ involvement and recidivism)
- Ensure equitable access to EBTs; equivalent access across racial/ethnic groups
  - We know EBTs are working for children of color, but do we know they are getting equitably referred?
  - Availability/location (e.g., home, school, primary care), referral rates, engagement, completion
  - Publicize outcomes, make it easier to locate providers delivering EBTs (e.g., expand searchable director at www.kidsmentalhealthinfo.com)
- Examine cultural adaptations of EBTs for impact on outcomes
- Make EBTs the "standard of care" in children's mental health in CT; address scaling issues
  - Establish differential reimbursement rates for EBTs to incentivize providers to train and deliver EBTs
  - Incorporate EBTs into emerging value-based payment models

Questions

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