Piloting Eye Movement Desensitization and Reprocessing (EMDR) Training in Foster Care

Annual Evaluation Report
Year 1: January 1, 2022 to December 31, 2022

SUBMITTED BY:
JUNE SIMON, MSW
EMILY RODRIGUEZ, MSW
DAISY LONGORIA, MA
TIMOTHY ROSS, PHD

ACTION RESEARCH PARTNERS
318th 5th STREET
BROOKLYN, NY 11215

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Acknowledgements

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Introduction

At the request of the New York City Department of Health and Mental Hygiene (DOHMH) and the Administration for Children's Services (ACS), Action Research studied the implementation of the Eye Movement Desensitization and Reprocessing (EMDR) pilot training program ("the Pilot") with funding provided by the Conrad N. Hilton Foundation.[1] This report covers the first year of the program, which aims to train clinicians working at foster care agencies to deliver EMDR to children and youth in foster care[2].

To inform this report, Action Research analyzed qualitative data obtained in 11 interviews and two focus groups conducted with clinician trainees, Pilot staff from ACS and DOHMH, and the Pilot EMDR trainer during September and October 2022. Action Research additionally reviewed program materials and drew on lessons learned from quarterly and supplemental meetings with Pilot staff and meetings with the EMDR trainer. Action Research analyzed quantitative data relating to EMDR sessions provided to 17 transition aged youth in foster care by 11 mental health clinicians trained in EMDR as part of this pilot. This report defines "transition aged youth" as young people aged 14 to 26 years. Due to the timing of data collection, all clinician-derived qualitative and quantitative data referenced in this report are restricted to the first group of clinicians trained, who began training in Spring 2022 and were scheduled to complete training in December 2022.

The findings in this report primarily reflect the experiences of the first group of clinicians trained (Spring 2022) and their clients. These clinicians, while almost a third of the first training group, may not represent the experiences of all Pilot-trained clinicians in year one. We expect that clinicians trained in the second group (Fall 2022) will have different experiences due to programmatic adjustments that Pilot staff implemented in response to trainees' feedback. The report addresses these changes using insights gleaned from interviews with Pilot staff. The report does not include an analysis of trauma symptom reductions among clients who received EMDR, as trainees had not had time to implement EMDR practice fully at the time of data collection, as was expected. Resources and confidentiality laws prohibited us from interviewing youth. Future reports will encompass a broader dataset, including greater numbers of clinicians trained and symptom change data concerning clients who have received EMDR. The report starts by providing status updates on project measures before describing successes of the Pilot during Year 1, identifying challenges, and presenting lessons learned to inform next steps.

[1] For more information on EMDR and the Pilot, see grant proposal for the *Conrad N. Hilton Foundation EMDR for Foster Youth Grant ("Hilton EMDR Grant")*. This report assumes the reader is familiar with EMDR and the structure of this grant.

[2] This report is a redacted version of the Year 1 grant report and is intended for public consumption. Names of individuals and specific foster care agency providers, as well as financial information related to the administration of the grant, have been withheld. This version of the report has been approved for public distribution by the NYC Department of Health and Mental Hygiene (DOHMH), the Administration for Children's Services (ACS), and the Conrad N. Hilton Foundation.

Project Measures

Project Measures Tables

Project Objective 1, Output 1.1, mental health providers trained in EMDR: Of the 29 clinicians who were expected to complete EMDR training in Year 1, 17 completed the training, one shy of the goal to train 18 mental health providers in EMDR (see Table 1). In addition, 36 clinicians are part way through the training as of December 31, 2022. The Pilot staff exceeded Year 1 recruiting expectations, enrolling 56 foster care staff from 16 agencies plus one ACS staff in EMDR training. As noted in Table 1 below, the first Group started in the Spring 2022 with a scheduled end date of December 2022. Hereon, this group is referred to as "Group 1." Ten trainees from Group 1 were unable to complete training during the expected period due to missed sessions but are on track to complete in early 2023. Group 2 started their training in the Fall 2023 and are on track to complete as scheduled in the Spring of 2023. Three clinicians started but did not complete the training. For information on the geographic locations of mental health providers trained in EMDR, see Appendix A, Table A1.

Table 1. Objective 1, Status at Year 1 End

Objective 1: To increase the number of Voluntary Foster Care Agency Mental Health staff trained in EMDR therapy.		
Output 1.1: Mental Health Providers Trained in EMDR *By 2024, the Department of Health and Mental Hygiene (DOHMH) in partnership with the Office of School Health (OSH) and ACS will identify and train a total of 90 mental health providers working in 10 NYC Voluntary Foster Care Agencies (VCFA) in EMDR, a specialized trauma treatment.*		
Timepoint	**Goal**	**Actual**
Baseline[3]	0	0
2022	18	17
2023	36	-
2024	36	-
Total	90	-

See Appendix A, Table A2 for a detailed breakdown of training outcomes by cohort.

[3] Baseline refers to providers who are newly trained in EMDR via the current Pilot. Five mental health providers in NYC VCFAs were trained previously in EMDR as part of a separate pilot program conducted by the Office of School Health (K. Celony, personal communication, January 4, 2023). For this report, we do not consider these providers as part of the baseline.

Table 2. Objective 2, Status at Year 1 End

Objective 2: To provide specialized EMDR trauma treatment therapy to transition aged foster youth in New York City		
Output 2.1: EMDR provided to transition aged youth in foster care *By 2024, the Administration for Children's Services, DOHMH, and VFCAs shall work in partnership to provide EMDR to 450 transition-aged foster youth, register them for services and provide access to trained EMDR trauma treatment clinicians.*		
Timepoint	**Goal**	**Actual**
Baseline	0	0
2022	0	17
2023	150	-
2024	300	-
Total	450	-
Outcome 2.2: Youth trauma symptoms reduced *By 2024, DOHMH anticipates 50% of the 450 total transition-aged foster youth receiving EMDR treatment will report a reduction in trauma symptoms.*		
Timepoint	**Goal**	**Actual**
Baseline	0	0
2022	0	Additional data required
2023	75/150 (50%)	-
2024	150/300 (50%)	-
Total	225/450 (50%	-

Project Objective 2, Output 2.1, EMDR provided to transition aged youth in foster care: the Year 1 goal, to provide EMDR to zero transition aged youth in foster care, was *exceeded* during the period (see Table 2). A total of 17 transition aged youth in foster care received EMDR from mental health providers trained in the Pilot. Youths' ages ranged from 14 to 22 years (Mean: 18.6 years). An additional nine youth 13 years or younger received EMDR during Year 1 (Range: 7 to 13 years; Mean: 10.2 years). See Appendix A, Tables A3 to A6 for more information.

Project Objective 2, Output 2.2, **youth trauma symptoms reduced:** the Year 1 goal, to reduce trauma symptoms in zero transition aged youth during the period, was *satisfied* during the period (see Table 2). Of the 17-transition aged youth in foster care who received EMDR during Year 1, quantitative trauma symptom data that spanned at least three sessions for a single target memory (i.e., the relevant unit of analysis) was available for only four youth.[4] While these data show promising results, we are reluctant to draw conclusions from such a small sample. For this reason, we do not report a numerator for the period in Outcome 2.2 in Table 2.

Project Objective 3, Output 3.1, **evaluation of EMDR youth intervention conducted:** the Year 1 goal, to finalize an evaluation plan and complete the first annual report, was *satisfied* during the evaluation period (see Table 3).

[4] Three sessions of EMDR (i.e., sessions including bilateral stimulation) is the appropriate minimum number of sessions to quantitatively assess change in trauma symptoms (Trainer, personal communication, January 18, 2023).

Table 3. Objective 3, Status at Year 1 End

Objective 3: To conduct an evaluation of the EMDR pilot project with New York City Foster Youth and Inform the field		
Output 3.1: Evaluation of EMDR youth intervention conducted Action Research will conduct an evaluation of the EMDR pilot project with New York City transition aged foster youth.		
Timepoint	**Goal**	**Actual**
Baseline	N/A	N/A
2022	Evaluation plan finalized; first annual report completed	Evaluation plan finalized; first annual report completed
2023	Evaluation implemented; second annual report completed	-
2024	Evaluation finalized, synthesized, and disseminated; final report completed	-
Total	Evaluation completed	-

Successes During the Reporting Period

Success 1: DOHMH and ACS are on pace to meet their training goal.

Context and conditions. Pilot staff initiated two training cycles, one in Spring 2022 and the other in Fall 2022. EMDR Basic training consists of three Parts. Part 1 and Part 2 consist of a total of seven sessions which include both didactic and practicum components. Part 3 of the training, which is required to complete and be deemed "eligible to practice," consists of 10 hours of consultation sessions provided in five, two-hour group sessions. The consultation sessions allow more flexibility for the trainer to adapt the content to include youth specific content and guidance. Of the 56 clinicians who started a training cycle, 17 completed the training, 36 remain in training, and three dropped out of training. Clinicians from 16 agencies in seven geographic locations plus one ACS staff participated in the training (see Appendix A, Table A1).

The Pilot design mitigated the barriers clinicians often encounter when seeking out EMDR Training. EMDR Training is expensive (~$2,000 per trainee) and time-consuming (20 hours of didactics, 20 hours of practicum, and 10 hours of consultation) for clinicians. This training is provided at no cost to participants during regular work hours. The timing of sessions was informed by agency leadership preferences, which Pilot staff surveyed. ACS staff additionally obtained signed letters of agreement from foster care agency leadership which outlined the time commitment expected of participating clinicians and secured commitments to support staff in implementing EMDR. Participating mental health clinicians from Group 1 reported feeling eager and grateful to access EMDR training at no cost, appreciated DOHMH and ACS efforts to ensure that agencies consider the training a part of their job responsibilities, and that the training enabled them to provide another well-supported, evidenced-based modality to their clients.

Potential for replication and scale. Cost, scheduling, and motivation issues often hinder training programs. The design of the Pilot fostered enthusiastic and sustained participation from the clinicians. Of the 56 clinicians who began the EMDR training in Year 1, only three clinicians withdrew from the training program prior to completion, and only five clinicians withdrew from the Pilot overall (two clinicians who completed the training later resigned from their agencies). Diligent recruitment efforts such as routine communication with provider leadership to promote participation, addressing concerns related to training time commitment, mental health staff member productivity, and billing procedures, contributed to success. This is easily replicable with appropriate staffing.

Success 2: Pilot program stakeholders collaborate well with one another, proactively seek feedback, and make appropriate adjustments.

Context and conditions. Many multi-agency pilot programs fail due to cross-agency collaboration issues. Pilot staff from ACS and DOHMH, however, worked with leadership at the foster care agencies from the start of the Pilot program, involved them in the planning of training logistics, and helped them to support clinicians throughout the training. Additionally, Group 1 trainees appreciated that Pilot stakeholders sought their feedback through a training evaluation form distributed by the trainer and follow-up outreach from ACS and DOHMH staff for discussions on how to incorporate their feedback into the program design and execution. Based on clinician feedback, Pilot staff worked with the trainer to make suggested adaptations to the training.

Potential for replication and scale. To replicate this success, government agency Pilot staff may aim to develop relationships with leadership at participating provider agencies as soon as possible. Ensuring that there is open communication between all parties, creating opportunities for trainees to provide feedback, and collaborating with trainers to ensure that feedback is incorporated is easily replicable with appropriate staffing.

Success 3: In cases where clinicians implemented EMDR with youth in foster care, clinicians noted client cognitive disturbances decreased.

Context and conditions. Clinician trainees who implemented EMDR into their practice reported observing clients process traumatic events and reductions in cognitive disturbance. One clinician reported that one client suddenly began discussing their trauma history after receiving EMDR, after years of avoiding the topic. Another clinician reported that EMDR helped a client to relax after undergoing sessions. Several clinicians noted that EMDR may be easier to implement than alternatives such as trauma-focused cognitive behavioral therapy (CBT). Unlike CBT, EMDR does not require caregiver participation and can be used with clients who are unable to express a trauma narrative.

Potential for replication and scale. As expected, few young people received EMDR treatment in the Pilot's first year (n=17 transition aged youth in foster care). Still, clinicians reported their belief in EMDR as a viable treatment option for reducing cognitive disturbances and reprocessing trauma among youth in foster care. As the Pilot program progresses, the study team expects to learn more from session-level quantitative data about clinicians' experience implementing EMDR with youth in foster care in line with benchmarks established in grant Objective 2.2.

Challenges During the Reporting Period

Challenge 1: Clinicians did not understand participation requirements in the first training cycle.

Context and conditions. Clinicians in training Group 1 reported feeling unprepared for the workload and emotional intensity of the training sessions. Both factors made it harder for clinicians to manage their regular workload outside of the training, such as meeting with clients, supervision, or paperwork. The training practicum sessions require trainees to utilize their own material and experiences. Many trainees underestimated the impact of this and how emotionally demanding EMDR training can be. Clinicians noted that discussing one's own traumatic experiences with colleagues in a professional setting could be stressful.

Potential for mitigation. Pilot program stakeholders at DOHMH and ACS have worked to mitigate the challenge of the unexpected time commitment experienced by Group 1 trainees by creating a syllabus that lays out the practice assignments and due dates. Before the second training cycle in Fall 2022, Pilot staff distributed this syllabus to potential trainees. Additionally, the trainer implemented a web-based course platform so that trainees would have access to course material, training dates, and assignment due dates, through an online course portal. To further ensure that trainees understood the expectations, the Pilot staff held a pre-training orientation session which included a discussion by the trainer that addressed the emotional drain that participants might experience. Orientation sessions prior to the start of each training cycle will become the standard in Y2 and Y3. Pilot staff plan to evaluate the efficacy of their adjustments in early 2023. We recommend that Pilot staff continue creating opportunities for trainees to voice their concerns and develop adaptations to address them.

Challenge 2: While clinicians understood the basic principles of EMDR treatment, many did not feel prepared to deliver the treatment to youth.

Context and conditions. The standard EMDR Basic training that all EMDR trainees are required to be trained in is an adult-focused protocol. The EMDR International Association (EMDRIA), a credentialing association that sets the standards and requirements for EMDR training, requires that this be the first step in EMDR training. Individuals interested in pursuing additional training in working with children and adolescents generally supplement their training after the initial basic training. Understanding that foster care trainees primarily work with youth, the trainer has adapted the training and added one half-day of training (about 3.5 hours) which covered EMDR use with youth specifically. The majority of available training videos and material are adult-focused as EMDR has been predominantly used with an adult private practice population. Therefore, much of the content and many examples in the training referred to adults, not children and youth. Many Group 1 clinicians reported feeling unprepared to adapt EMDR principles, particularly scripted prompts, to younger clients on their own. Factors that made delivering treatment challenging included the age, developmental challenges, and cognitive abilities of youth. Group 1 clinicians interviewed expressed feeling that the language taught in training often did not feel appropriate or relevant to youth.

While most clinicians we interviewed had been licensed mental health providers for more than five years and several had been for more than ten years, clinicians at foster care providers

tend to have less experience than the private practice clinicians who typically participate in EMDR training. Trainees with less clinical experience may face additional challenges in adapting language provided in EMDR training with youth clients.

Potential for mitigation. Understanding that there is a gap in youth-focused training material in the EMDR Basic training, the Pilot staff has explored additional trainers with expertise in using EMDR with children and adolescents to provide supplemental trainings. A co-trainer particularly experienced in implementing EMDR with youth will lead most trainees' consultation sessions in Year 2. While it is challenging to identify videos of youth receiving EMDR due to issues of confidentiality and consent to film, Pilot staff have researched and identified supplemental youth-focused resources. This material is routinely disseminated to trainees throughout the trainings since the Fall 2022 cycle and, in Y2, all trainees will be provided a supplemental text with a focus on EMDR with children and adolescents. Incorporating supplemental youth-focused materials, resources, and language adaptations into the training would help clinicians feel confident to implement EMDR with their clients.

Challenge 3: The foster care context poses unique challenges to providing EMDR treatment.

Context and conditions. Providing EMDR to youth in foster care settings presents unique challenges. Of the clinicians interviewed from Group 1, all expressed concerns about how to implement EMDR with youth in foster care, due to complex and ongoing trauma, placement instability, and a need for care coordination planning to support youth coping and self-regulation mechanisms after undergoing EMDR sessions. When identifying potential clients with whom to use EMDR, clinicians were trained to consider whether a client was, in an emotional sense, "safe enough"[5] to participate (e.g., whether the client had enough distance from a past traumatic experience to process memories of the event without re-traumatization) (Trainer, 2022). Current client experiences of new or ongoing trauma, which are likely more common among youth in foster care compared to EMDR clients in private practice settings, may inform clinicians' decision to implement EMDR. Training guidance provided to Pilot clinicians notes, "continuing exposure to traumatic reminders" may hinder EMDR implementation (Trainer, 2022).[6] Clinicians varied in their approaches to addressing these concerns, with some reporting that they considered almost any client to be eligible for EMDR, and others reporting difficulty identifying appropriate clients. Group 1 clinicians working in residential treatment centers reported greater difficulty identifying appropriate clients due to EMDR's contraindication with acute dysregulation compared to clinicians working with children in family foster care.

Group 1 clinicians noted that EMDR training emphasizes the importance of consistency and client support systems. Clinicians cited two related challenges: placement moves and educating foster caregivers. If youth receiving EMDR treatment move to a new placement, clinical care of all types can be disrupted and behavioral health issues usually worsen (Rubin et al., 2007).[7] When youth move to new provider agencies or to residential care, they may not be able to see the same clinician. As of this writing, there are not enough data to determine the scope of this issue.

[5]Trainer. (2022). *EMDR Therapy Training*.
[6] Ibid.
[7] Rubin, D. M., O'Reilly, A. L., Luan, X., & Localio, A. R. (2007). The impact of placement stability on behavioral well-being for children in foster care. *Pediatrics*, 119(2), 336-344.

One clinician reported that a client replaced to a different borough was unable to continue attending appointments in-person. Changes in caregivers, locations, and schedules raise concerns for clinicians attempting to guide clients through emotionally intensive reprocessing.

As EMDR requires clients to revisit past traumatic events, challenging experiences, and current triggers, all youth who receive EMDR require emotional support and assistance especially after treatment sessions. Parents or guardians usually provide this support for youth not in foster care. Clinicians reported that, for youth in foster care, this type of support may be difficult to find. One clinician stressed the importance of providing psychoeducation to foster parents as clients' symptoms may appear to "worsen temporarily" when involved in intensive reprocessing. Therapeutic training and knowledge vary among foster caregivers, and caregiver education is not part of the Pilot. One clinician described pro-actively engaging agency staff, such as case planners and socio-emotional therapists, in a coordinated plan to ensure support for youth outside of EMDR therapy. Instructions on ways to build the appropriate supports within foster care, however, are not part of the Pilot's training.

Group 1 clinicians in residential settings identified additional barriers. These included working with clients who experience acute dysregulation, scheduling concerns, and clients who only have direct care staff as supports. Clinicians considered many clients ineligible for EMDR due to current experiences of behavioral or emotional issues at levels residential settings are intended to treat (e.g., self-injurious behavior, aggressive outbursts, dissociation, or substance use). Highly structured and inflexible schedules made identifying time to implement EMDR challenging, and one clinician felt that youth who immediately resume scheduled activities after EMDR may be more likely to experience crises. Two clinicians in a residential setting felt it is necessary to educate direct care staff on EMDR and how to support youth who may struggle or become dysregulated as they reprocess trauma. ACS encourages agencies to ensure staff practice is trauma-informed and has invested in offering trauma-informed trainings in recent years, but clinical experience or training on trauma treatment among residential direct care staff varies. Staff turnover, high workloads and shift changes could limit the availability and consistency of support available to youth. Reports indicate high turnover in these positions.[8] As a result, youth in residential care may not have the emotional supports needed to participate in EMDR. We intend to explore this issue further in Y2 and Y3.

Potential for mitigation. To gain better understanding of the complexities of working with youth in foster care, the trainer met with key foster care stakeholders from ACS in August of Y1 with the goal of further enhancing and adapting the trainings. Additionally, Pilot staff met with leadership from each agency with participating staff, as well as staff who provided feedback either via email or through the formal written training evaluation mechanism. Many Group 1 clinicians who participated in the qualitative interviews recognized a disconnect between the eligibility guidance of "safe enough" emotionally that was mentioned in training and the experiences of their clients with respect to recent trauma, which caused some to feel uncomfortable with implementation. The EMDR manual provided to clinicians notes that "continuing exposure to traumatic reminders" is a client factor that may hinder EMDR treatment. Pilot staff have made multiple adaptations based on feedback gleaned from meetings with Group 1 trainees attempting to address the concerns trainees

[8] In 2018, residential care case workers in New York City had a turnover rate of 39.5%, according to the Council of Family and Child Caring Agencies' (COFCCA) 2018 Workforce Compensation Report, as cited in ACS' Fiscal 2021 Preliminary Financial Plan.

raised. Additionally, the trainer has revised the EMDR Manual to include exercises and guidance, also discussed in the Fall 2022 trainings, to address the unique challenges foster care clinicians encounter. Adaptations addressing the unique challenges of youth in foster care are constantly being discussed and adaptations are being made in "real time" to the training content. A significant component of this evaluation will be to determine if these ongoing adaptations are sufficient to mitigate provider concerns and barriers to implementation.

Key Learnings and Potential for Future Application

Learning 1: Clinicians may need more guidance on implementing EMDR with children and with youth in foster care

Context and conditions. Group 1 trainees expected that the training would focus on working with youth in foster care settings. With few exceptions, clinicians identified the training's lack of content related to implementing EMDR with children generally and youth in foster care specifically as a significant challenge. Constraints contributing to this challenge included the EMDRIA requirement that clinicians be trained in the standard adult-focused protocol prior to receiving supplemental training, the limited public availability of youth-focused training material, and the dearth of material focused on implementing EMDR with youth in foster care specifically. As the Pilot program intends to make EMDR accessible to youth in foster care, the training should incorporate a stronger focus on using EMDR to treat young people.

Potential for application. Pilot staff engaged in numerous efforts to address training gaps and trainees' requests for more guidance on working with youth. Pilot staff established weekly check-in meetings with the trainer to provide feedback and ensure adaptations are made in "real time;" conducted extensive research to identify resources (primarily supplemental reading material) and disseminated these to trainees; and identified EMDR trainers with expertise in working with youth to provide supplemental trainings in Y2 and Y3. Using feedback from Group 1, Pilot staff also incorporated into the orientation messaging that the training is in the adult protocol. The Pilot team worked with the trainer to weave into the training more youth-focused content, including adding a child-focused session that clinicians found helpful. Still, many expressed a need for more extensive training and assistance on the topic. Clinicians also requested more direction on how to adapt the scripted language for children and for teens with developmental delays. Because youth in foster care tend to experience multiple and complex traumatic events, trainers may give additional focus to how that changes EMDR treatment focused on a singular traumatic event. Some clinicians also suggested that subsequent training on attachment-focused EMDR[9] could be important for implementation with the population of youth in foster care.

How learning will support progress in reaching grant objectives. Additional guidance for clinicians on implementing EMDR with children and with youth in foster care may facilitate treatment delivery and aid the Pilot in reaching target goals for grant Objective 2.

[9] See, e.g., Parnell, L. (2013). *Attachment-focused EMDR: Healing relational trauma*. WW Norton & Company.

Learning 2: Provider agencies and Pilot staff should consider adding post-training implementation support.

Context and conditions. As clinicians have moved through the training process of the Pilot program, many have encountered interpersonal and organizational challenges to implementation outlined above in the challenges section. After clinician trainees complete the training, they are eligible to attend trainings in Y2 that are supplemental but have otherwise limited access to continued implementation supports. There is an opportunity for Pilot staff to develop a technical assistance plan to facilitate EMDR application as clinicians translate what they have learned from the training into practice. Research has found that technical assistance is linked to changes or improvements in the use of targeted practices, and more intensive technical assistance is associated with larger effect sizes (Dunst, et al., 2019).[10]

Potential for application. Technical assistance planning is a frequent practice in implementation programs that feature a professional development component. Establishing a regular technical assistance meeting would require additional planning, coordination, and communication between Pilot staff, program stakeholders, and clinician trainees. Pilot staff and provider agencies may also explore the possibility of identifying within each agency a leader, who is experienced clinically and in EMDR, to provide ongoing practice support and feedback to clinicians on-site and post-training. Pilot staff and provider agencies may similarly consider the establishment of regularly occurring (e.g., quarterly or monthly) inter-agency group sessions for trainees to share strategies and lessons learned from implementing EMDR with youth in foster care. Implementation support increases the chances of a high return on the training investment.

How learning will support progress in reaching grant objectives. Regular technical assistance meetings or more formalized intra-agency or inter-agency EMDR support would allow clinician trainees to access targeted and customized implementation support for their practice. Mitigating the interpersonal and organizational challenges outlined above would allow clinicians to achieve a greater breadth and depth of practice with their clients facilitating grant Objectives 2.1 and 2.2.

Learning 3: A targeted trainee recruitment plan that considers clinician practice experience and the level of care and placement type of the clinicians' clientele may facilitate EMDR use.

Context and conditions. In the first evaluation year, Pilot staff described the varied and diligent recruitment efforts used to attract foster care agencies and clinicians resulting in training cohorts of 29 clinicians in cycle one and 27 clinicians in cycle two. Recruitment efforts in Y1 involved a multi-pronged approach. The Hilton-funded training project was initially introduced at two ACS hosted quarterly Voluntary Agency Group meetings coordinated by the Medical Directors office in November 2021 and February 2022. Additional recruitment efforts included emails, announcements, and individual meetings with agency leadership and staff. Recruitment communications to leadership included outlining eligibility requirements that encouraged leadership to prioritize staff who had demonstrated a commitment to the agency, worked clinically with youth in foster care, and worked with youth who were likely to benefit from the intervention.

[10] Dunst, C. J., Annas, K., Wilkie, H., & Hamby, D. W. (2019). Review of the Effects of Technical Assistance on Program, Organization and System Change. *International Journal of Evaluation and Research in Education*, 8(2), 330-343,

While robust, Group 1 featured several clinicians who completed the training but who were unable to implement EMDR with transition aged youth. Several clinicians reported experiencing challenges to implementation as their clientele is primarily comprised of young children in residential treatment centers (i.e., at a high level of care) and another clinician we spoke with practices via telehealth. While EMDR has been adapted to be suitable for virtual delivery, it is not recommended for newly trained EMDR clinicians. Additionally, because it is critical that youth receiving the intervention be "emotionally safe," providing a treatment intervention remotely for youth in foster care who have experienced trauma may not be suitable.

Potential for application. Based on feedback from Group 1 clinicians, Pilot project staff should consider including enrollment prioritization that considers clinicians' client characteristics and clinicians' potential to implement EMDR to implement EMDR with transition aged youth. An application process that includes targeted questions around clinicians' practice experience and clientele (e.g., the number of clients they currently have, how many currently experience acute dysregulation, or what their placement and therapy settings are) may inform enrollment prioritization.

How learning will support progress in reaching grant objectives. Developing a targeted recruitment plan could help narrow the clinician trainee pool to those who most frequently work with transition aged youth who are viable candidates for EMDR. As many of the grant objectives are oriented around implementing EMDR with this age range, this strategy may facilitate grant objective achievement.

Appendix A. Project Measures Tables, Detailed

Table A1. Project Output 1.1, Mental Health Providers Trained in EMDR, by Agency and Geography

Agency and Geography of Clinicians Trained during Hilton EMDR Pilot, Y1									
Agency	Agency Location							Total	Percent
	Bronx	Brooklyn	Manhattan	Queens	Staten Island	Long Island	Westchester County		
Agency 1	1	0	0	0	0	0	1	**2**	**3.6%**
Agency 2	1	0	0	0	0	0	0	**1**	**1.8%**
Agency 3	5	0	0	0	0	0	0	**5**	**8.9%**
Agency 4	0	0	0	2	0	0	0	**2**	**3.6%**
Agency 5	0	0	1	0	0	0	0	**1**	**1.8%**
Agency 6	0	2	0	0	0	0	0	**2**	**3.6%**
Agency 7	1	3	0	0	0	0	3	**7**	**12.5%**
Agency 8	0	5	0	1	0	2	0	**8**	**14.3%**
Agency 9	0	0	0	1	0	0	0	**1**	**1.8%**
Agency 10	0	0	3	0	0	0	0	**3**	**5.4%**
Agency 11	0	0	0	0	0	3	0	**3**	**5.4%**
Agency 12	0	0	0	0	0	0	1	**1**	**1.8%**
Agency 13	0	1	0	1	0	3	0	**5**	**8.9%**
Agency 14	4	0	2	0	0	0	0	**6**	**10.7%**
Agency 15	3	0	1	0	0	0	0	**4**	**7.1%**
Agency 16	1	0	1	2	1	0	0	**5**	**8.9%**
Total	**16**	**11**	**8**	**7**	**1**	**8**	**5**	**56**	
Percent	**28.6%**	**19.6%**	**14.3%**	**12.5%**	**1.8%**	**14.3%**	**8.9%**		

*Note: Percentages do not total 100% due to rounding.
*Note: Two providers withdrew from the Fall 2022 training cycle.

Table A2. Project Output 1.1, Mental Health Providers Trained in EMDR, by Training Outcome and Training Cohort

Training Outcomes and Training Cohorts among Number of Clinicians Trained during Hilton EMDR Pilot, Y1			
Training Outcome (in # of trainees)	**Training Cohort**		**Total 2022**
	Spring 2022 Group #1	**Fall 2022** Group #2	
Completed all training hours	17	0	17
Scheduled to Complete in 2023	10[a]	26	36
Total Completed or Scheduled to Complete	**27**	**26**	**53**
Withdrew from training	0	1	1
Resigned from agency	4[b]	0	4[b]
Total Did Not Complete and Not Scheduled to Complete	**2**	**1**	**3**
Total # Trainees	**29**	**27**	**56**

[a] Trainees who missed sessions due to FMLA (Family and Medical Leave Act), illness, or personal reasons and need to "make-up" sessions.

[b] Of the four trainees who resigned from their agency, two completed the 50 hours training and are also included in the group of 17 listed above.

Table A3. Project Output 2.1, EMDR Provided to Transition Aged Youth in Foster Care, by Agency and Geography

Agency and Geography of Transition Aged Youth in Foster Care who Received EMDR during Hilton EMDR Pilot, Y1									
Agency	Agency Location							Total	Percent
	Bronx	Brooklyn	Manhattan	Queens	Staten Island	Long Island	Westchester County		
Agency 3	1	0	0	0	0	0	0	**1**	**5.9%**
Agency 15	2	0	0	0	0	0	0	**2**	**11.8%**
Agency 4	0	0	0	1	0	0	0	**1**	**5.9%**
Agency 7	0	0	0	0	0	0	1	**1**	**5.9%**
Agency 8	0	3	1	0	0	0	0	**4**	**23.5%**
Agency 10	0	0	2	0	0	0	0	**2**	**11.8%**
Agency 11	0	0	0	0	0	1	0	**1**	**5.9%**
Agency 16	0	1	0	2	0	0	0	**3**	**17.6%**
Agency 14	0	0	2	0	0	0	0	**2**	**11.8%**
Total	**3**	**4**	**5**	**3**	**0**	**1**	**1**	**17**	
Percent	**17.6%**	**23.5%**	**29.4%**	**17.6%**	**0%**	**5.9%**	**5.9%**		

*Note: Percentages do not total 100% due to rounding.

Table A4. Project Output 2.1, EMDR Provided to Transition Aged Youth in Foster Care, by Youth Age

Age of Transition Aged Youth in Foster Care who Received EMDR during Hilton EMDR Pilot, Y1		
Age (in Years)	**Total**	**Percent**
14	1	5.9%
15	1	5.9%
16	2	11.8%
17	0	0%
18	2	11.8%
19	5	29.4%
20	2	11.8%
21	3	17.6%
22	1	5.9%
23	0	0%
24	0	0%
25	0	0%
26	0	0%
Total	**17**	**100%**

*Note: Percentages do not total 100% due to rounding.

Table A5. Project Output 2.1, EMDR Provided to Transition Aged Youth in Foster Care, by Youth Gender

Gender of Transition Aged Youth in Foster Care who Received EMDR during Hilton EMDR Pilot, Y1		
Gender	**Total**	**Percent**
Female	11	64.7%
Male	5	29.4%
Trans Female (Male to Female)	0	0%
Trans Male (Female to Male)	0	0%
Non-binary	0	0%
Other gender identity	1	5.9%
Total	**17**	**100%**

*Note: Percentages do not total 100% due to rounding.
*Note: Clinicians were asked *"What is the youth's self-reported gender identity?"* at the youth's first EMDR session and prompted to select from the response options shown here.

Table A6. Project Output 2.1, EMDR Provided to Transition Aged Youth in Foster Care, by Youth Race and Ethnicity (Hispanic or Latinx)

Race and Ethnicity (Hispanic or Latinx) of Transition Aged Youth in Foster Care who Received EMDR during Hilton EMDR Pilot, Y1								
Youth's Race	**Youth's Ethnicity: Hispanic or Latinx?**						**Total**	**Percent**
	No, Not Hispanic or Latinx	**Yes, Dominican**	**Yes, Mexican, Mexican American, Chicano or Chicana**	**Yes, Multi-ethnic Hispanic, Latinx**	**Yes, Puerto Rican**	**Yes, Other Hispanic, Latinx**		
American Indian or Alaska Native	0	0	0	0	0	0	**0**	**0%**
Asian	1	0	0	0	0	0	**1**	**5.9%**
Black or African American	11	0	0	0	0	0	**11**	**64.7%**
Multi-racial or Biracial	0	0	0	1	0	0	**1**	**5.9%**
Native Hawaiian or Other Pacific Islander	0	0	0	0	0	0	**0**	**0%**
White	0	0	0	0	0	0	**0**	**0%**
Other	3	0	0	0	1	0	**4**	**23.5%**
Total	**15**	**0**	**0**	**1**	**1**	**0**	**17**	
Percent	**88.2%**	**0%**	**0%**	**6.7%**	**6.7%**	**0%**		

*Note: Percentages do not total 100% due to rounding.

*Note: Clinicians were separately asked *"What is the youth's self-reported race?"* and *"What is the youth's self-reported ethnicity?"* at the youth's first EMDR session and prompted to select from the response options shown here.

Appendix B. Supplemental Youth Tables, All Ages

Table B1. EMDR Provided to Youth in Foster Care, All Ages, by Agency and Geography

Agency and Geography of All Youth in Foster Care who Received EMDR during Hilton EMDR Pilot, Y1									
Agency	Agency Location							Total	Percent
	Bronx	Brooklyn	Manhattan	Queens	Staten Island	Long Island	Westchester County		
Agency 3	1	0	0	0	0	0	0	**1**	**3.8%**
Agency 15	2	0	0	0	0	0	0	**2**	**7.7%**
Agency 4	0	0	0	1	0	0	0	**1**	**3.8%**
Agency 7	0	0	0	0	0	0	1	**1**	**3.8%**
Agency 3	0	3	2	0	0	0	0	**5**	**19.2%**
Agency 10	0	0	6	0	0	0	0	**6**	**23.1%**
Agency 11	0	0	0	0	0	1	0	**1**	**3.8%**
Agency 16	0	1	0	4	0	0	0	**5**	**19.2%**
Agency 14	1	0	3	0	0	0	0	**4**	**15.4%**
Total	**4**	**4**	**11**	**5**	**0**	**1**	**1**	**26**	
Percent	**15.4%**	**15.4%**	**42.3%**	**19.2%**	**0%**	**3.8%**	**3.8%**		

*Note: Percentages do not total 100% due to rounding.

Table B2. EMDR Provided to Youth in Foster Care, All Ages, by Youth Age

Age of All Youth in Foster Care who Received EMDR during Hilton EMDR Pilot, Y1		
Age (in Years)	**Total**	**Percent**
7	1	3.8%
8	0	0%
9	1	3.8%
10	3	11.5%
11	3	11.5%
12	0	0%
13	1	3.8%
14	1	3.8%
15	1	3.8%
16	2	7.7%
17	0	0%
18	2	7.7%
19	5	19.2%
20	2	7.7%
21	3	11.5%
22	1	3.8%
23	0	0%
24	0	0%
25	0	0%
26	0	0%
Total	**26**	**100%**

*Note: Percentages do not total 100% due to rounding.

Table B3. EMDR Provided to Youth in Foster Care, All Ages, by Youth Gender

Gender of All Youth in Foster Care who Received EMDR during Hilton EMDR Pilot, Y1		
Gender	**Total**	**Percent**
Female	17	65.4%
Male	8	30.8%
Trans Female (Male to Female)	0	0%
Trans Male (Female to Male)	0	0%
Non-binary	0	0%
Other gender identity	1	3.8%
Total	**26**	**100%**

*Note: Percentages do not total 100% due to rounding.

*Note: Clinicians were asked *"What is the youth's self-reported gender identity?"* at the youth's first EMDR session and prompted to select from the response options shown here.

Table B4. EMDR Provided to Youth in Foster Care, All Ages,
by Youth Race and Ethnicity (Hispanic or Latinx)

Race and Ethnicity (Hispanic or Latinx) of All Youth in Foster Care who Received EMDR during Hilton EMDR Pilot, Y1								
Youth's Race	**Youth's Ethnicity: Hispanic or Latinx?**						**Total**	**Percent**
	No, Not Hispanic or Latinx	**Yes, Dominican**	**Yes, Mexican, Mexican American, Chicano or Chicana**	**Yes, Multi-ethnic Hispanic, Latinx**	**Yes, Puerto Rican**	**Yes, Other Hispanic, Latinx**		
American Indian or Alaska Native	0	0	0	0	0	0	**0**	**0%**
Asian	1	0	0	0	0	0	**1**	**3.8%**
Black or African American	17	0	0	1	0	0	**18**	**69.2%**
Multi-racial or Biracial	0	0	0	1	0	0	**1**	**3.8%**
Native Hawaiian or Other Pacific Islander	0	0	0	0	0	0	**0**	**0%**
White	0	0	0	0	0	0	**0**	**0%**
Other	4	0	0	1	1	0	**6**	**23.1%**
Total	**22**	**0**	**0**	**3**	**1**	**0**	**26**	
Percent	**84.6%**	**0%**	**0%**	**11.5%**	**3.8%**	**0%**		

*Note: Percentages do not total 100% due to rounding.

*Note: Clinicians were separately asked *"What is the youth's self-reported race?"* and *"What is the youth's self-reported ethnicity?"* at the youth's first EMDR session and prompted to select from the response options shown here.