

State-Wide CBT Training and Consultation for Trauma: Linking Engagement Strategies to Clinical Care

March 7, 2007

Kimberly Eaton Hoagwood
New York State Office of Mental Health
Columbia University

Core Team

- Jim Rodriguez, New York State Psychiatric Institute (NYSPI)
- Mary McKay, Mount Sinai School of Medicine
- Marleen Radigan, NYS Office of Mental Health
- Sue Marcus, Mount Sinai School of Medicine
- Jamie Foster, NYS Office of Mental Health
- Jessica Levitt, NYSPI
- Jamie Weaver, Mount Sinai School of Medicine
- Jennifer Sawaya, NYSPI

Background

- CATS: Child and Adolescent Trauma Treatments and Services Consortium
- Begun in 2002 with funding from SAMHSA to NY State Office of Mental Health (OMH) to provide trauma treatments for school age children in the aftermath of Sept. 11
- Commissioner's commitment to EBPs
- OMH issued RFA for community-academic partnerships
- Stipulated training of child clinicians on EBP trauma treatments for children ages 5-21, and an evaluation of the implementation

Awardees

Jewish Board of Family and Children's Services
Mount Sinai Medical Center
NYU/Bellevue Hospital Center
North Shore – Long Island Jewish Health System
Lutheran Medical Center
New York/Columbia-Presbyterian
Alianza Dominicana
Safe Horizon
St. Vincent's Medical Center

CATS Consortium Collaborators

The CATS Consortium is a cooperative multi site treatment study performed by nine independent teams in collaboration with the New York State Office of Mental Health. The New York State collaborators are Kimberly Eaton Hoagwood, Ph.D., Chip Felton, M.S.W., Sheila Donahue, Ph.D., Amita Appel, M.S.W., James Rodriguez, Ph.D., (NYSPI), Laura Murray, Ph.D., (NYSPI), David Fernandez, M.A., (NYSPI), Joanna Legerski, B.S., (NYSPI), Michelle Chung, B.A., Jacob Gisis, B.S., Jennifer Sawaya, B.A., Sudha Mehta, M.P.H., (OMH), Jessica Mass Levitt, Ph.D., (NYSPI), Marleen Radigan, Dr. P.H., (OMH), Jameson Foster, M.P.H., (OMH). The Principal investigators and co-investigators from the nine sites are Robert Abramovitz, M.D., (JBFCS), Reese Abright, M.D., (St. Vincent's Hospital), Peter D'Amico, (North Shore/Long Island Jewish), Giuseppe Constantino, Ph.D., (Lutheran Hospital), Carrie Epstein, C.S.W.-R., (Safe Horizon), Jennifer Havens, M.D., (Columbia University), Sandra Kaplan, M.D., (North Shore/LLJ), Jeffrey Newcorn, M.D., (Mt. Sinai), Moises Perez, Ph.D., (Alianza Dominicana), Raul Silva, M.D., (NYU/Bellevue), Heike Thiel de Bocanegra, Ph.D., (Safe Horizon), Juliet Vogel, Ph.D., (North Shore/LLJ). The Scientific Advisors to the project are: Leonard Bickman, Ph.D., (Vanderbilt University), Peter S. Jensen, M.D., (Columbia University), Mary McKay, Ph.D., (Mount Sinai Medical School), Susan Essex, Ph.D., (Mount Sinai Medical School), Sue Marcus, Ph.D., (Mount Sinai Medical School), Wendy Silverman, Ph.D., (Florida International University), Robert Pynoos, M.D., (University of California, Los Angeles); Allan Steinberg, Ph.D., (University of California, Los Angeles); Lawrence Palinkas, Ph.D., (University of California at San Diego); and Joseph Cappelleri, Ph.D., (Pfizer Corporation). The Treatment Developers and Scientific Consultants to the project are: Judy Cohen, M.D., (Allegheny General Hospital), Anthony Mannarino, Ph.D., (Allegheny General Hospital), Christopher Layne, Ph.D., (Brigham Young University), William Saltzman, Ph.D., (UCLA).

Description

- Trauma-focused CBT training provided to 173 front-line clinicians in NYC after September 11 by expert treatment developers (Cohen, Mannarino, Layne, Saltzman)
- Clinical case consultation provided by phone with 2 in person booster sessions for 18 months post-training
- Bi-weekly site visits + weekly steering committee calls + weekly site coordination meetings. INTENSIVE!
- 700 children/adolescents 5-21 received either TF-CBT (N=445), a briefer version (Project Liberty) (N=112), or TAU (N=143)
- 2/3rd Latino children; 46% very low income (less than 15K/yr)
- Clinical assessments provided at baseline, 3, 6 and 12 months. Included UCLA PTSD-RI, CDI/BDI (depression), MASC (anxiety), BASC (behavior problems), BERS, CGAS (functioning)
- Additional training provided on McKay's engagement strategies to boost recruitment/retention

Selection of Treatment Models

- Two treatment models identified
 - Children (5-12)
 - Cohen, Judith; Mannarino, A; Deblinger, E. (2002; 2006) Child and Parent Trauma-Focused Cognitive Behavioral Therapy Treatment Manual.
 - Adolescents (13-21)
 - Layne, Christopher M.; Saltzman, William R.; Pynoos, Robert S.; (2002) Trauma/Grief-Focused Group Intervention for Adolescents.
- Core Components
- Psychoeducation, Feeling identification/Emotional Regulation, Stress Inoculation/Relaxation, Thoughts-Feelings-Behaviors Connection, Trauma Narrative, Cognitive Restructuring, Skills

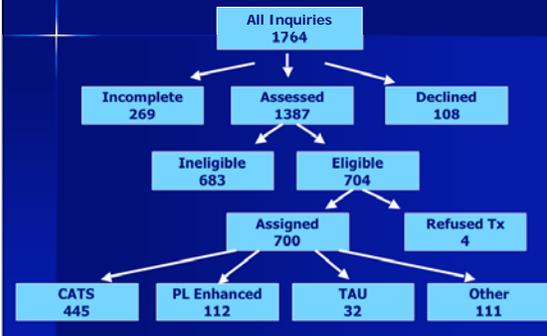
Clinician Demographics

Age	Avg. Age = 33.3
Gender	Females = 86.7% Males = 13.3%
Ethnicity	White = 56.7% Latino = 36.7% African American = 6.7%
Educational Background	Ph.D./Psy.D. = 23.3% MSW = 26.7% MA/MS = 43.3% BA = 6.7%
CBT Training	CBT Training = 36.7% Other = 63.3%

Study Design

- Study Design** : Cutoff-based randomization procedure to enable comparisons of outcomes to be made across two groups: youth receiving the CATS trauma treatments (the experimental group) and comparison group (youth receiving treatment as usual)
- Sample Selection**: The specific cutoff-based procedure used in the study is referred to as a regression discontinuity design (RD),- based on the baseline score on PTSD RI Score
 - CATS = PTSD score greater than or equal to 24
 - Comparison=PTSD score less than 24
 - Conferenced in children= clinical consultation process to include low scoring children in CATS group

Flow Diagram



Measures

Symptoms and Functioning, (CATS and Comparison Groups)*

- PTSD- PTSD RI,
- Depression- CDI, BDI,
- Anxiety- MASC
- WTC Exposure
- Behavioral Functioning- BASC, SDQ
- Social Functioning- BERS
- *Collected at Baseline, 3 month, 6 month and 12 month time points

Clinician Measures (CATS Only):

- Dose
- Alliance
- Adherence
- Therapeutic Orientation
- Attitudes about EBTS

Organizational Measures:

- Organizational Climate Questionnaire (OCQ) &
- Organizational Culture Inventory (OCI)

Sample Socio-Demographics

- | | |
|---|--|
| CATS | Comparison |
| <ul style="list-style-type: none"> N = 445 56% female 62% Latino, 16% Black, 13% White 64% ages 5-12 36% ages 13-19 46% below 15K | <ul style="list-style-type: none"> N = 144 52% male 67% Latino, 16% White, 9% Black 73% ages 5-12 27% ages 13-19 44% below 15K |

Other Traumatic Events

Exposure Type	CATS		Comparison	
	%Yes	Index*	%Yes	Index*
Witnessing Community Violence	43.8	4.7	26.2	7.9
Witnessing Domestic Violence	33.9	9.2	20.1	15.8
Painful medical treatment	31.9	6.5	19.5	5.3
Victimized in community**	32.8	6.1	15.4	6.6
Victimized at home	30.6	3.6	12.8	5.3
Touched by adult**	17.5	8.1	4.7	2.6
Bad Accident	23.6	3.6	6.7	2.6
Violent death/injury of loved one	52.8	18.7	41.6	22.4
Other	74.6	26.3	46.2	19.7
Disaster	25.4	1.6	16.8	5.3
Seeing a dead body**	30.3	0.9	9.5	5.3
War	14.4	0.9	4.0	1.3
Earthquake	6.7	--	1.3	--

*Index event endorsed is "most bothersome."

** p<.05

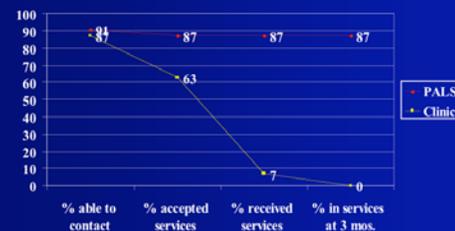
Outreach, Recruitment, Retention

- Despite free treatments, outreach and recruitment required major efforts

Barriers for Urban Youth and Families

- Triple threat:** poverty, single parent status and stress
- Concrete Obstacles for Parents of Youth**
 - lack of time
 - Transportation
 - child care
 - presence of community violence
 - long agency wait-lists
- Psychological Factors/Perceptual Barriers**
 - Parental perceptions of the therapeutic relationship
 - Degree to which families are involved in service planning
 - Stigma of mental illness
 - Prior bad experiences with mental health service systems
 - Negative socio-cultural attitudes about mental illness

McKay et al., 2003: Family service involvement - PALS vs. Clinic

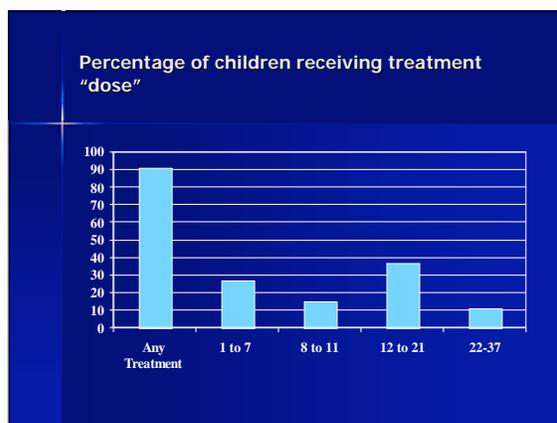
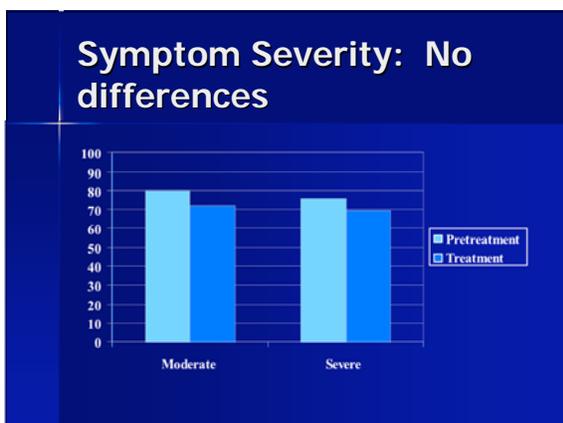
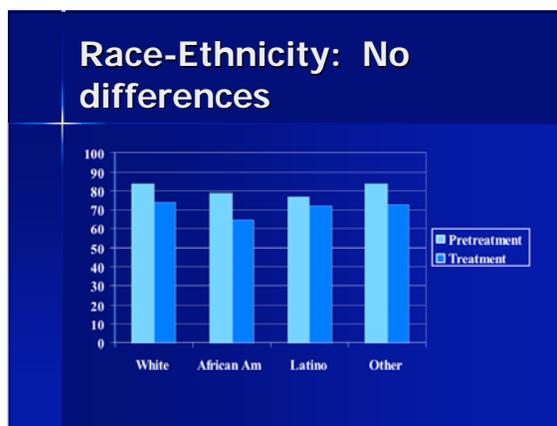
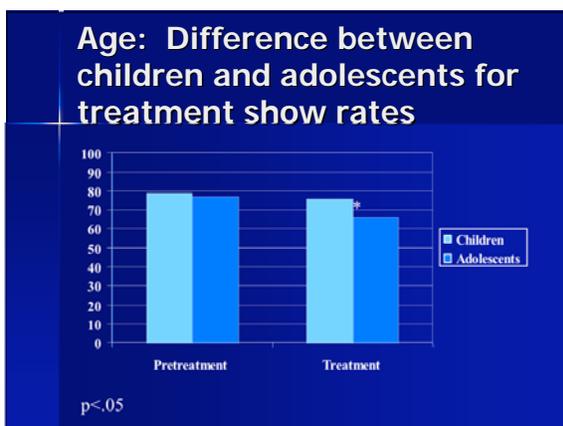
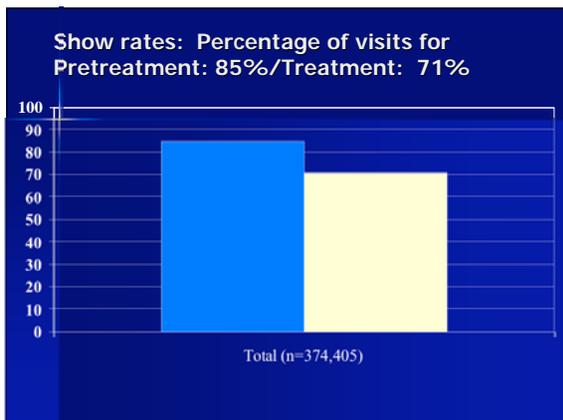


Evidence-based engagement interventions

- Reminders reduced missed appointments by as much as 32% (Kourany et al., 1990; McLean et al., 1989; Shivack et al., 1989; & Sullivan)
- Intensive family-focused telephone engagement intervention associated with 50% decrease in initial show rates and a 24% decrease in premature terminations (Szapocznik, 1988; 1997)
- Combined telephone and first interview engagement interventions associated with attendance rates of 74%, representing a 16 to 25% increase above the clinic comparison families (McKay et al., 1998).

Components of Engagement Interventions

- Clarify role of worker, agency, intake process and possible service options
- Set foundation for collaborative working relationship
- Identify concrete, practical concerns that can be immediately addressed
- Problem solve regarding barriers to ongoing involvement with agency



Major findings

- Engagement strategies can improve access and retention in services
- Linking engagement to clinically effective services may improve outcomes for more children
- At the 6-month follow-up time point, 64% of children in the TF-CBT no longer met study inclusion criteria.
- Over 40% of the TF-CBT group had a reliable decrease in PTSD scores compared to only 9% of the comparison group.
- Through training and delivery of an evidence-based engagement strategy, 91% of children and youth were retained in treatment and 63% of children received a "dose" of at least 8 treatment sessions.
- Training well-received by clinicians

Major Implementation Challenges

- Training insufficient without ongoing consultation and support
- Research team needed to provide program support, treatment implementation, budget management, and data collection
- Part-time vs. full time clinical workforce led to differing levels of commitment to the project
- Adaptation and tailoring needed
- IRB layers and delays extensive
- Intermittent funding led to staff turnover
- Model bleeding challenged the evaluation design (Project Liberty Enhanced)

Lessons Learned for Post-Disaster Evaluation

- Role differentiation: research staff support vs. program implementers: both needed but must be separate
- Data: On site data collection should be performed by staff other than clinical staff
- Assessment simplification and links to accountability
- IRB: IRB disaster protocols should be prepared in advance
- Contagion: Control for model bleeding
- Funding: Plan the study based on actual not promised funding
- Connect to existing community networks

Policy and practice implications

- Translation from research to policy to practice has been accelerated
- Training model has been incorporated into NYS OMH's EBP Treatment Dissemination Center for children
- PTSD-RI has been incorporated into OMH data tracking and accountability monitoring system for children