New York State's Evidence Based Treatment Dissemination Center for Children, Adolescents and Families:

Measurement and Implementation Challenges

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Core Team for EBTDC

Formal collaboration between NYS Office of Mental Health and Columbia University
- NYS OMH: Oversight & Evaluation
- Columbia University: Training & Consultation

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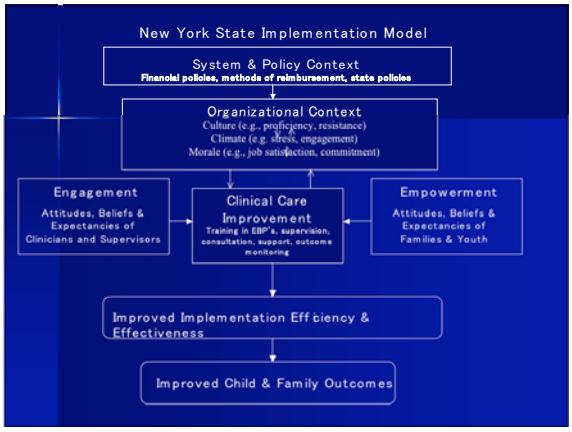
NYS: Evolution of EBP Implementation for Children

- 2002-04: Commissioner mandate to improve services through EBPs
  - Functional Family Therapy (Sexton & Alexander)
  - CBT trauma after Sept. 11th (CATS Project)
  - School mh treatments (CBT, IPT)
  - Guidelines for medication management of atypical antipsychotics (TRAAY)
- 2005: Evidence-based Treatment Dissemination Center (EBTDC) established as core State function
- 2005: Learning Collaboratives established to focus on improving retention through use of EBP engagement strategies (McKay)
- 2005: Parent Empowerment Training and Support (OMH, DOE and NIMH to develop family-driven empowerment strategies)
- 2006: $30M expansion of State funding for screening, assessment, and expansion of home-based services for children and families
- 2006: NIMH Developing Center grant to experimentally examine alternative implementation strategies to improve uptake of EBPs

New York State's Evolving System Change Model

- **Train** clinicians and supervisors using expert treatment developers and provide intensive consultation for 1 year
- **Engage** families in services by removing barriers to access: Target clinician outreach
- **Empower** families with tools, skills, and support: Target families and advocates
- **Monitor** using EBP assessments
- **Target** core social-organizational processes
- **Incentivize** change through fiscal re-alignment



The Evidence Based Treatment Dissemination Center Aims

Broad Aims:
- Improve the effectiveness of clinical services for children and families
- Decrease the research to practice gap
- Provide specialized training and year-long consultation in CBT for trauma and depression to approximately 400 practicing clinicians and supervisors throughout NYS
- Assess the feasibility of large scale treatment dissemination and identify barriers to sustainability

EBTDC Structure

- Two-year cycle. New EBPs selected each cycle.
- First effort: 417 clinician/supervisors trained on CBT for childhood trauma and depression (Cohen, Mannarino, Deblinger, 2006; Stark & Curry, 2006).
- Ongoing 1 year consultation bi-weekly by phone
- Cost: Approximately $1,400 per clinician per year

Treatment Developers

- Formal collaboration with EBT treatment experts in field
  - Trauma Focused-CBT
    - Judith Cohen, Tony Mannarino (Allegheny General Hospital, Drexel University College of Medicine), and Esther Deblinger (University of Medicine and Dentistry of New Jersey)
  - Depression Symptoms Intervention
    - Kevin Stark (University of Texas) and John Curry (Duke University)

Training and Consultation

- Workshop
  - Day 1
    - Overview of Project
    - Basic CBT Principles
    - Clinical Assessment
  - Day 2
    - CBT for depressive symptoms
  - Day 3
    - Trauma-Focused CBT
- Consultation Calls:
  - Bi-weekly 90 min telephone consultation for 1 year in groups of 8-12
  - Consultation provided by 4 trained part-time psychologist consultants
  - Monthly supervision for the consultants provided by a CBT expert (Albano)

Measurement

- Clinical assessment battery
  - UCLA PTSD Reaction Index (PTSD-RI)
  - Children's Depression Rating Scale (CDRS)
  - Strengths & Difficulties Questionnaire (SDQ)
  - Clinical interview
  - Suicide questions
- Evaluation
  - Training Satisfaction Rating Scale
  - Pre/post knowledge of CBT for trauma (with treatment developers)
  - Pre/post knowledge of CBT for depression (with treatment developers)
  - Attitudes & Beliefs about CBT (adapted from Kolko, Weersing)
  - Therapist Adherence Scale (with treatment developers)
  - Tracking of attendance on calls
  - Tracking of case presentations

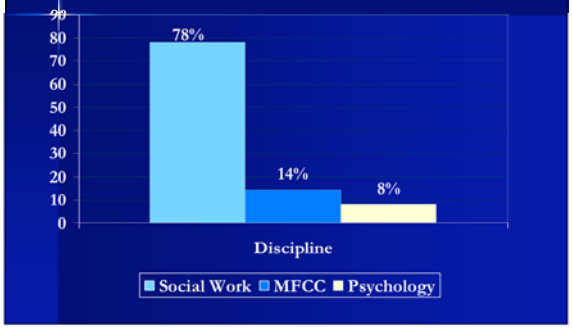
The Trainings

- 9 Trainings
  - Held between June and October 2006
  - 417 completed the training and are participating in the bi-weekly consultation calls
  - The 10th to be held in April for school mental health clinics

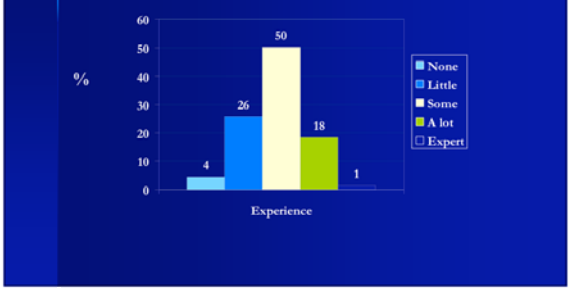
Clinician Demographics

- Age
  - Mean: 41.2 years old
- Gender
  - Male 18%
  - Female 82%
- Ethnicity
  - White 76.1%
  - Latino(a) 13.7%
  - African-American 5.7%
  - Asian 2.7%
  - Alaskan/AI 1%

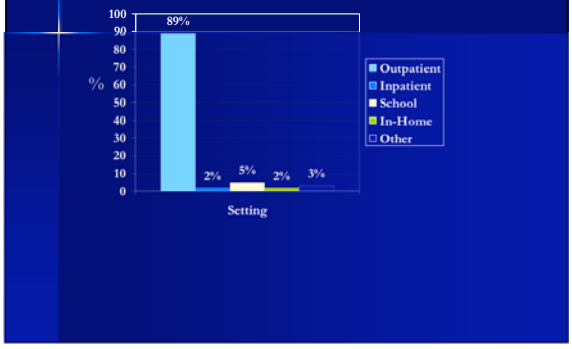
Clinician Educational Background



Experience with CBT before Training

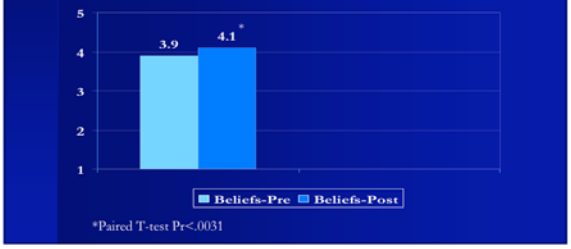


Clinician Work Setting



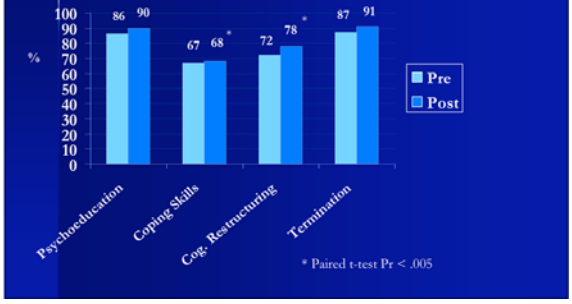
Clinician Attitudes about CBT Pre-Post Training

- Ratings on a 5-point scale from 1(strongly disagree) to 5 (strongly agree) on attitudes and beliefs about using CBT



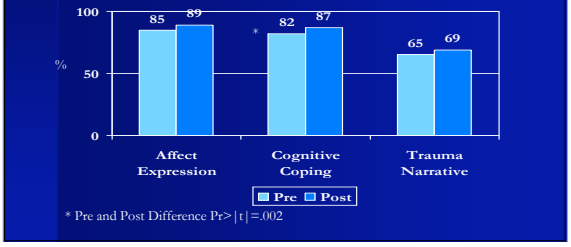
*Paired T-test Pr<.0031

Clinician Knowledge about CBT for Depression



* Paired t-test Pr < .005

Clinician Knowledge about CBT for Trauma



* Pre and Post Difference Pr>|t|=.002

Consultation Calls

- Requirements for completion:
  - 80% call attendance
  - 3 case presentations
- Call Format
  - Attendance
  - Presentations
  - Check-in on cases
  - Focus on specific EBT techniques

Consultation Calls

- 36 scheduled biweekly consultation calls
- 8-12 clinicians on each consultation call
- 231 consultation calls held to date
- Each consultant manages 11 groups of clinicians with an average of 5 calls per week

Attendance

- Of 417 trained, 8% have dropped out of the consultation program
- 73% have attended at least 75% of the consultation calls to date (through 6 months)
- Primary reason for dropping out: job change, maternity leave, medical illness

Clinician Feedback

- What is working
  - Consultation calls assist in applying the protocols to real clients.
  - Improve accountability in use of protocols.
  - Focus on specific techniques helpful in applying CBT with actual clients.
  - Focus on assessment and how to use ratings is helpful in conceptualizing cases
  - Helpfulness of calls rating (N=63 clinicians) (scale of 1-10)
    - Average rating 8.5

Clinician Feedback

- What needs work:
  - Consultation Calls
    - Shorter calls with fewer clinicians on them
    - More direct instruction on protocol techniques
    - More role plays
    - More engagement training and support for working with challenging parents
    - Shorter assessments—especially for depression

Major Challenges

- Assessments: length, usefulness
- Engagement of families after intake
- Treatment dropouts
- Limited # of depression and trauma cases
- Disruptive behavior problems
- Balancing clinic productivity demands with use of the protocols.

Next Steps

- 10 new trainings/consultations planned for 2007-08
- 400 new clinicians/supervisors to be trained
- Consultation to include special group for supervisors to meet monthly
- Limit of 7 clinicians/call
- Evaluation of length of consultation process (6, 9, 12 months)
- Therapist Competence Scale will be added
- Engagement-Empowerment Program to be added and evaluated through NIMH Center study

Lessons Learned

- Consultation call participation is more difficult than training participation but essential to create practice change
- Maintaining engagement in consultation calls past 6 months is challenging
- Integration of clinical assessments into practice is as important as knowledge of therapy techniques
  - Creating a feasible and practical EBT assessment process is critical
- Clinic issues (e.g., staff turnover, retention, norms and expectations, leadership) affect uptake of EBPs