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

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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 EBPs trauma treatments for children ages 5-21, and an evaluation of the implementation

CATS Consortium Collaborators

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

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=145), a briefer version (Project Liberty) (N=112), or TAU (N=143)
- 23% Latino children; 45% very low income (less than 15K/year)
- Clinical assessments provided at baseline, 3, 6 and 12 months. Included UCLA PTSD-R, CDI/BDI (depression), MASC (anxiety), BASIT (behavior problems), BPRS, CGAS (functioning)
- Additional training provided on McKay’s engagement strategies to boost recruitment/retention

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

Additional training provided on McKay’s engagement strategies to boost recruitment/retention

- Commerative training on McKay’s engagement strategies to boost recruitment/retention

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Selection of Treatment Models

- Two treatment models identified

Core Components
- Psychoeducation, Feeling identification/Emotional Regulation,
- Stress Inoculation/Relaxation, Thoughts-Feelings-Behaviors
- Connection, Trauma Narrative, Cognitive Restructuring, Skills

Clinician Demographics

<table>
<thead>
<tr>
<th>Age</th>
<th>Avg. Age = 33.3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>Females = 86.7%</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>White = 36.7%</td>
</tr>
<tr>
<td>Educational Background</td>
<td>Ph.D./Psy.D. = 23.3%</td>
</tr>
</tbody>
</table>

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
- Conferred in children= clinical consultation process to include low scoring children in CATS group

Sample Socio-Demographics

<table>
<thead>
<tr>
<th>CATS</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>N = 445</td>
<td>N = 144</td>
</tr>
<tr>
<td>56% female</td>
<td>52% male</td>
</tr>
<tr>
<td>62% Latino, 16% Black, 13% White</td>
<td>67% Latino, 16% White, 9% Black</td>
</tr>
<tr>
<td>64% ages 5-12</td>
<td>73% ages 5-12</td>
</tr>
<tr>
<td>36% ages 13-19</td>
<td>27% ages 13-19</td>
</tr>
<tr>
<td>46% below 15K</td>
<td>44% below 15K</td>
</tr>
</tbody>
</table>

Measures

- Symptoms and Functioning (CATS and Comparison Groups)*
  - PTSD: PTSD RI,
  - Depression: 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)

Flow Diagram

- All inquiries 1764
- Incomplete 269
- Assessed 1387
- Declined 108
- Eligible 1279
- Assigned 700
- Refused Tx 4
- CATS 445
- PL Enhanced 112
- TAU 32
- Other 111
**Other Traumatic Events**

<table>
<thead>
<tr>
<th>Exposure Type</th>
<th>CATS %Yes</th>
<th>Index*</th>
<th>Comparison %Yes</th>
<th>Index*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Witnessing Community Violence</td>
<td>41.8</td>
<td>4.7</td>
<td>29.2</td>
<td>5.9</td>
</tr>
<tr>
<td>Witnessing Domestic Violence</td>
<td>33.9</td>
<td>9.2</td>
<td>20.1</td>
<td>18.8</td>
</tr>
<tr>
<td>Parental medical treatment</td>
<td>31.9</td>
<td>6.3</td>
<td>19.5</td>
<td>3.3</td>
</tr>
<tr>
<td>Victimized in community**</td>
<td>32.8</td>
<td>4.1</td>
<td>15.4</td>
<td>4.6</td>
</tr>
<tr>
<td>Victimized at home</td>
<td>18.6</td>
<td>3.6</td>
<td>12.8</td>
<td>5.3</td>
</tr>
<tr>
<td>Reach by adult**</td>
<td>17.2</td>
<td>4.5</td>
<td>9.5</td>
<td>2.6</td>
</tr>
<tr>
<td>Bad Accident</td>
<td>23.4</td>
<td>3.6</td>
<td>6.7</td>
<td>2.6</td>
</tr>
<tr>
<td>Violent death/injury of loved one</td>
<td>52.8</td>
<td>18.7</td>
<td>41.6</td>
<td>22.4</td>
</tr>
<tr>
<td>Other</td>
<td>74.6</td>
<td>7.9</td>
<td>44.2</td>
<td>19.7</td>
</tr>
<tr>
<td>Disaster</td>
<td>23.4</td>
<td>1.6</td>
<td>16.8</td>
<td>5.3</td>
</tr>
<tr>
<td>Seeing a dead body**</td>
<td>80.5</td>
<td>0.9</td>
<td>9.5</td>
<td>2.5</td>
</tr>
<tr>
<td>War</td>
<td>14.4</td>
<td>0.9</td>
<td>4.0</td>
<td>1.3</td>
</tr>
<tr>
<td>Earthquake</td>
<td>6.7</td>
<td>–</td>
<td>1.3</td>
<td>–</td>
</tr>
</tbody>
</table>

*Index event endorsed is “most bothersome.”

**Evidence-based engagement interventions**

- Reminders reduced missed appointments by as much as 32% (Kourany et al., 1990; McLean et al., 1989; Shwack 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).

**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**

**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
Show rates: Percentage of visits for Pretreatment: 85% / Treatment: 71%

Gender: No differences in show rates

Age: Difference between children and adolescents for treatment show rates

Race-Ethnicity: No differences

Symptom Severity: No differences

Percentage of children receiving treatment "dose"
**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.

**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.

**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).

**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.