The Evidence-Based Treatment Dissemination Center

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Other Involvement

- Jessica Mass Levitt, Ph.D. (Lowenstein Foundation Grant)
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- Erum Nadeem, Ph.D. (Hoagwood Center Grant)
- Scott Sawyer, MPH (Hoagwood Center Coordinator)

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  - Maura Crowe, BA
- OMH
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The EBTDC Mission

Aims:

- Decrease the research to practice gap in New York
- Provide specialized training in CBT for trauma and depression to NYS clinicians and supervisors
  - 3 Day Training
  - Ongoing year-long phone consultation
- Assess the feasibility of large scale treatment dissemination
- Identify barriers to sustainability
- Not a research project but program evaluation

Acknowledgements

- Formal collaboration with EBT treatment experts in field
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    - Judith Cohen, M.D., Tony Mannarino, Ph.D. (Allegheny General Hospital, Drexel University College of Medicine), and Esther Deblinger, Ph.D. (University of Medicine and Dentistry of New Jersey)
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    - Kevin Stark, Ph.D. (University of Texas) and John Curry, Ph.D. (Duke University)
  - Coping Power Individual Child Program: New York Version
    - John E. Lochman, Ph.D. (University of Alabama)
  - Parent Training for Disruptive Behavior Disorders
    - Karen C. Wells, Ph.D. (Duke University)

EBTDC Training Plan

Program Criteria

- Requirements for Clinician Completion and OMH Certificate of Completion:
  - Attend the three day training
  - Complete TF-CBT Web Course
    - Up to 10 hrs
  - 75% attendance on calls
  - 3 case presentations on the consultation calls
  - Completion of full manual treatment
    - either trauma or depression
  - Use of OMH-mandated assessment measures

The Trainings

	Year 1	Year 2	Combined
Trainings	9	8	17
Clinicians	333	294	627
Supervisors	94	66	160
Total Attendees	427	360	787

Clinician Demographics Combined Yrs 1 and 2

- Age
  - Mean: 41.0
- Gender
  - Male 18.0%
  - Female 82.0%
- Ethnicity
  - White 72.6%
  - Latino(a) 13.9%
  - African-American 7.4%
  - Asian 4.9%
  - Alaskan/AI 0.5%

Demographics

- Work Setting
  - 82.2% Outpatient
- Experience with CBT
  - 6% None, 24% Little, 51% Some, 19% A Lot, 1% Certified
  - Fully 81% Not CBT-Proficient
- Educational Background
  - 77.4% Social Workers

Consultation Calls

	Year 1	Year 2
Length	90 mins	60 mins
Supervisor Specific Calls	None	Avg of 11 (range 8-16 peo.)
Average # of participants on calls	12 (range 6-18 peo.)	8 (range 5-13 peo.)
# of call groups	35	42 clinician 8 supervisor
Total Calls Held	731	1007 Clinician 80 Supervisor

Consultation Call Findings

	Year 1	Year 2
Attendance-Clinicians	84.6%	83.4%
Attendance - Supervisor	39.0%	70.0%
Drop outs	28%-C, 23%-S	30.5%-C,17.3%-S
Call groups completed	35/36	42/42

-Attendance did not vary significantly over the course of the year

Non Program-Specific Drop Outs

	Year 1	Year 2	
	Clinician (%)	Clinician (%)	Supervisor (%)
Left Agency	19 (27.5%)	20 (24.4%)	3 (23.1%)
Maternity/Medical Leave	4 (5.8%)	6 (7.3%)	0 (0.0%)
	23 = 5.3% of Total 25% of Drop Outs	26 = 8.8% of Total 31.7% of Drop Outs	3 = 4.5% of Total 23.1% of Drop Outs

Program-Specific Drop Outs

	Year 1	Year 2	
	Clinician (%)	Clinician (%)	Supervisor (%)
Low Attendance	26 (28.3%)	26 (31.7%)	5 (38.5%)
Personal Issue/Time Conflict	15 (16.3%)	6 (7.3%)	1 (7.7%)
E3	n/a	4 (4.9%)	1 (7.7%)
Agency Drop	n/a	2 (2.4%)	2 (15.4%)
No clients	5 (5.4%)	n/a	n/a
Phone	3 (3.3%)	n/a	n/a
Unknown	20 (21.7%)	18 (22.0%)	1 (7.7%)
	69 = 16.2% of Total 75% of Drop Outs	56 = 19.0% of Total 68.3% of Drop Outs	10 = 15.2% of Total 76.9% of Drop Outs

Clinician Year-End Program Evaluation

- At the end of both years,
  - Participants were asked to evaluate aspects of the program
  - Surveys differed in Yrs 1 and 2
  - Yr 2 data is only partly analyzed
- Year 1
  - Data on Treatment Use, Assessment Use, and Consultation Calls
  - 44 year-end evaluations
- Year 2
  - 60 surveys to date

Depression Treatment Use

- Year 1
  - Completed a case
    - 48% saw at least 1
    - Average = 1.5 cases
    - 93% have portions
  - 78% will use in the future
- Year 2
  - 85% are continuing to use protocol

Trauma Treatment Use

- Year 1
  - Completed a Case
    - 46% saw at least one
    - Average = 2.2 cases
    - 80% have used portions
  - 80% will use in the future
- Year 2
  - 85% are continuing use of the protocol

Assessment Measure Use

- Year 1
  - 83% will continue to use the assessments
  - 73% say they were helpful in determining ***appropriateness*** (*M* = 4.09)
  - 54.6% say they were helpful in determining ***clinical change*** (*M* = 3.59)
- Year 2
  - 83% continue to use evidence-based assessment

Overall Ratings-Yr 2

- Ratings on 5-Point Likert Scale
  - Consultation Calls
    - 4.2 of 5
  - Program
    - 4.1 of 5
  - Future Participation
    - 4.3 of 5

Conclusions

- Large-scale training and consultation in EBTs on a statewide level is possible and impacts clinician use of treatment
- Clinicians were engaged
  - Attrition was relatively low
- Consultant factors are important
- Majority of clinicians were able to meet the completion criteria
- Case finding was most problematic
- Clinicians report gaining skills and planning to use the treatments in the future

Challenges

- Budget restrictions
  - Of the project
  - Of the participant clinics
- Complicated cases in real life
  - Diagnostic complexity
  - Demographic disadvantages
- Need for flexibly applied CBT protocols
- Sustainability –
  - Year 3 – 146 repeat customers of 429

Future Directions

- Consultants play a critical role
  - How much prior CBT training is sufficient?
  - More structure
- Monitoring
  - More quality assurance and supervision
- Supervisor involvement
  - Supervisor consultation
  - Train the trainer models for sustainability?
- Outcome and Fidelity
  - Are children getting better?
  - Are clinicians doing these treatments as developers intended?

Policy Implications

- Budget
  - High quality consultation costs
  - The issue of quality versus quantity
- Sustainability
  - Use of technology (website)
  - Regionalized specialty centers
    - Partner with clinical psychology departments of the major universities in the regions

Disseminating Evidence-Based Treatments for Children: A Microanalysis of Consultation Calls as an Ongoing Training Strategy

Sandra Pimentel, PhD, Kimberly Hoagwood, PhD,
Anne Marie Albano, PhD, & Jennifer Regan, BA

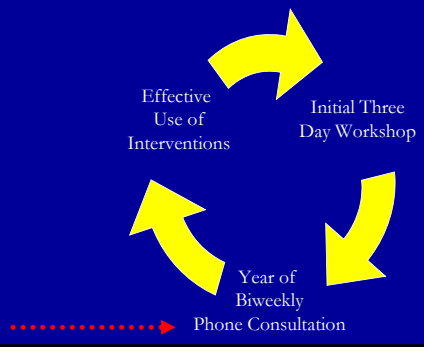
Columbia University/ New York State Psychiatric Institute

Research and Training Center for Children's Mental Health
March 2, 2009

New York State Office of Mental Health Policy Scholars Award

Columbia University Division of Child and Adolescent Psychiatry Advanced Center for Intervention and Services Research (ACISR)

EBTDC Training Plan



Project Aims: Understanding the consultation call hour

POLICY ⟷ IMPLEMENTATION ⟷ CLINICAL

What happens on these calls?

- Use of 60 minutes
- Who is speaking: Consultant? Clinicians?

- Structure of calls
- Understanding call content
- On-task vs. Off-task behaviors
- Educational Strategies

The Sample

Consultation Call = unit of analysis

- 40 calls randomly selected
  - 10 weeks (out of 173 calls)
- 4 Columbia-based EBTDC consultants
  - CBT experts
  - Blocked by consultant
- 2 trained & reliable coders
  - (ICCs > .85)

Coding Procedures

- Minute-to-Minute Coding
- Call Summary

Verbalization Source
- Consultant
- Clinician

On task vs. Off Task?

Content Area
- CBT Model
- CBT Techniques
- Assessment/Case Summary
- Case ID
- Parent/Family
- Motivation/Engagement
- Crisis
- Other

Educational Strategies
- Didactic
- Role play
- Case example

Agenda Set?
Agenda Followed?

Minute-to-Minute Coding

Minute	CONSULTANT							THERAPIST							Minute
	General CBT	Specific CBT	Assessment/Dx	Case ID/	Parent & Family	Patient Motivation	Crisis/ Emergent	Other	OFF TASK	General CBT	Specific CBT	Assessment/Dx	Case ID/	Parent & Family	Patient Motivation	Crisis/ Emergent	Other	OFF TASK	
1																			1
2																			2
3																			3
4																			4
5																			5

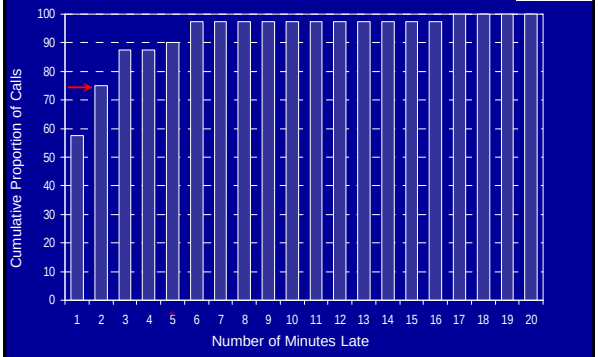
Outcomes: Procedural

- Call Duration
  - 28/40 calls lasted 57-63 minutes
- Consultants set an agenda **100%** of the time (40/40 calls)

Did Consultants follow agenda?

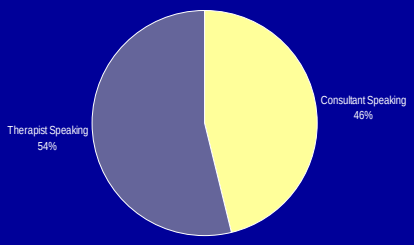
Completely followed	87.5%
"Mostly" followed	12.5%
Not followed	0%

How Late Did the Calls Begin?



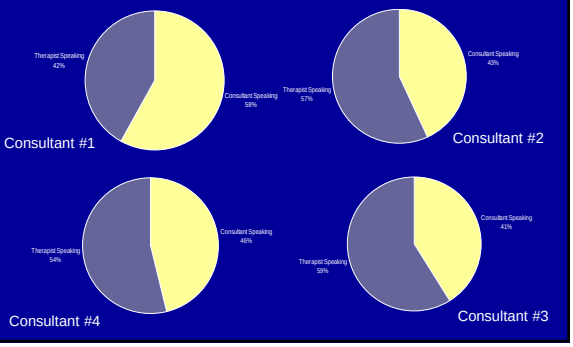
*75% of the calls began within the first 2 minutes of the call-hour

Percent of Call Hour Speaking: Consultant vs. Therapists

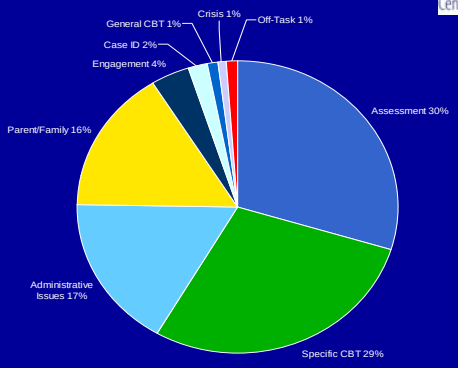


Average across consultants

Percent of Call Hour Speaking: By Consultant

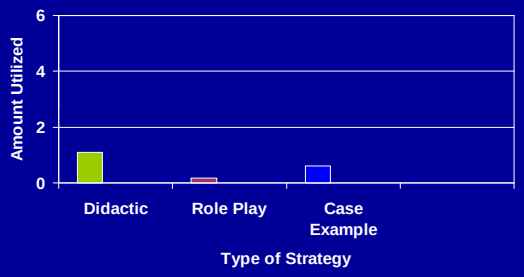


How was the call hour spent?



Small but statistically significant relationship between consultants and therapists discussing specific CBT techniques, $r = .33$, $p < .05$

Educational Strategies



Discussion & Implications

- Coding procedures feasible in large-scale dissemination project
- Consultants able to set and follow call agenda
  - General consistency of consultants
- Significantly on-task throughout
  - Full use of 60 minutes, start & end
- Calls cover broad content
  - Relationship between consultant discussing CBT specific techniques & therapist discussing
  - Proportion of "Other" category indicates need for different target for business-related issues
- Increase opportunities for educational strategies

Next Steps…

- More calls, more coding
- Longitudinal examination of calls
- Examine consultant strategies & broad indicators of therapist performance
  - Attendance on calls
  - Fidelity to protocols
  - Proficiency with CBT skills
  - Work samples
- Experimental variation of consultation & training strategies

Engagement, Empowerment, and Evidence-Based Treatment (E3): A Model for Enhancing Uptake of EBPs in Low Income Communities

James Rodriguez, Geraldine Burton, Marlene Penn, Alissa Gleacher, Serene Olin, Priscilla Shorter, Kimberly Hoagwood

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Research Findings on Parent Involvement

- Family participation in children's services leads to:
  - higher academic achievement and school competence (Kohl, Lengua, & McMahon, 2000),
  - better educational planning for children with autism (Moroz, 1989),
  - improvement in behavioral and academic outcomes for youth with behavior problems (Kumpfer & Alvarado, 2003; Aeby, Manning, Thyer, & Carpenter-Aeby, 1999).
  - Improvements in anxiety symptoms, compared to individual tx (e.g. Ginsburg & Schlossburg, 2002)
- Family to family support (F2F) reduces stigma and distrust by improving communication (Linhorst & Eckert, 2003)
- Improves activation in seeking care (Alegria et al., 2008)
- Improves self-efficacy-- active participation in decision-making (Heflinger & Bickman, 1997; Bickman et al., 1998)

Evidence-based Engagement strategies:

The First "E"

Steps to Engaging and Empowering Parents

1. Clarify your role
   Who are you and what do you do?
2. Clarify need
   What do you think you or your child needs?
   What do you expect to get out of treatment?
3. Increase parent investment and efficacy
   Give them credit for taking the step to come in.
   Strengthen their sense of self, by showing your belief that they can take the necessary next steps, one by one, and when the time is right take action
4. Identify potential obstacles (e.g. personal and concrete)
   How do you feel about this?
   Do you have any concerns?
   Will child care, time or transportation be a problem?
   Previous experience with systems of care?
   What do others think?
5. ADDRESS BARRIERS!!!

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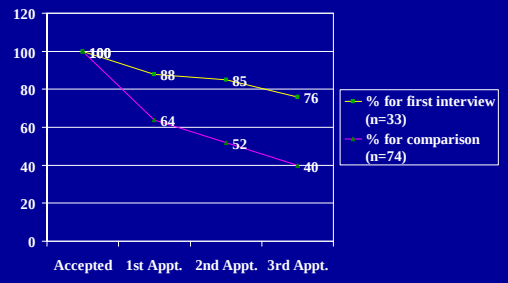
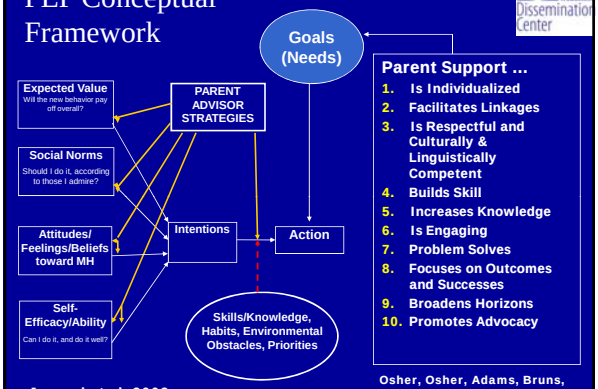
Engagement studies
(McKay et al., 1998; 2001; 2005)



Empowering parents as partners:

The Second "E"

PEP Conceptual Framework



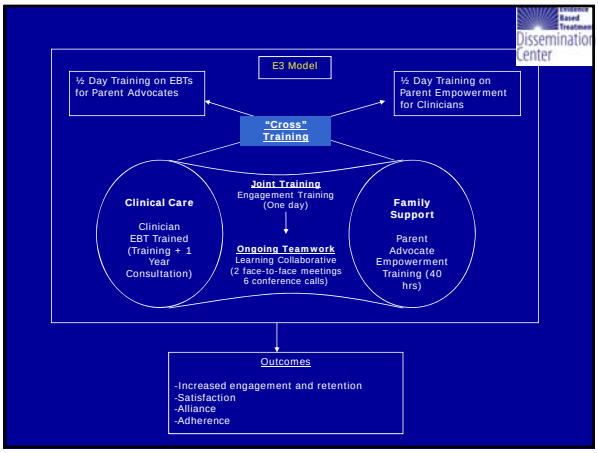
Parent Empowerment Project (PEP) Manual Content

Parent Advisor Manual

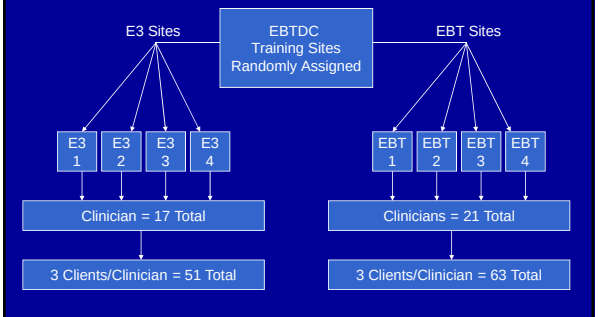
- Introduction
- Getting Ready
- Building Engagement, Listening, and Boundary Setting Skills
- Building Your Teaching and Group Management Skills
- Developing Priority Setting Skills
- Specific Disorders and Their Treatments
- The Mental Health System of Care: What to Expect and How to Prepare
- Services and Options Through the School System
- Teaching Tools for Parent Advocates

Parent Handbook

- Introduction
- Knowing Yourself
- Knowing Your Child
- Treatment Management Skills: How to be Your Child's Case Manager
- Specific Disorders and Their Treatments
- The Mental Health System of Care: What to Expect and How to Prepare
- Services and Options Through the School System
- Helpful Tools for Parents



E3 Study Design



Parent Interviews (BL, 2, 4,6 Months)

- Barriers (e.g. concrete)
- Parental Expectancies for Treatment (PETS; Kazdin) – Alpha=.83
- Caregiver Strain Questionnaire (CGSQ; Brannan, Heflinger, & Bickman, 1997) – Alpha=.88
- CESD (Depression) – Alpha=.92
- Strengths and Difficulties Questionnaire (SDQ)
- Helpfulness of service and provider

Summary/Challenges

- E3 model has been accepted by clinicians, administrators, and families in highly stressed MH clinics in NYC
- It is feasible to implement
- Integration of PA into clinical practice needs to be strategic and attend to organizational social context of agencies
- Parents continue to report elevated levels of depressive symptoms
- Fluency with EBPS is critical before implementing E3
- Communication between PAs and Clinicians is critical
- Implementation of E3 should include earlier integration of PA into clinical team

Transporting Evidence-Based Practice to School Settings: Examining Strategies for Consultation

Jessica Mass Levitt, PhD, Alissa Gleacher, PhD, Lindsay Greene, BS, Kimberly Hoagwood, PhD, Anne Marie Albano, PhD; Columbia University

Peter Jensen, REACH Institute

Presentation at the 22nd Annual Research Conference for the Research and Training Center for Children's Mental Health, Louis de la Parte Florida Mental Health Institute; March 2, 2009

Background

- Previous programs have shown that training seminars plus phone consultation are practical and effective means of disseminating evidence-based treatments
- However, significant obstacles to clinician use of these treatments have been found
  - Difficulty finding appropriate cases, maintaining patients in treatment, and sticking with the evidence-based treatment over time
- Need to address clinician obstacles and increase use of treatment for dissemination to be truly successful

Mental Contrasting – Implementation Intentions (MC/II)

- A motivational/problem-solving intervention developed from basic behavioral and cognitive research
- Theory of Reasoned Action (Fishbein & Ajzen, 1975; Ajzen & Fishbein, 1981)
- Theory of Planned Behavior (Ajzen & Madden, 1986; Ajzen, 1991)
- Applied in community settings to help physicians' follow guidelines for appropriate use of antipsychotic medications
- MC/II Goals:
- Strengthen behavioral intentions
  - Influence expected value of treatment, normative beliefs about treatment, self-efficacy beliefs
- Diminish any perceived obstacles
  - Challenge any irrational beliefs, problem-solve

MC/II (Mental Contrasting – Implementation Intentions)

- MC/II Procedure:
  - Mental Contrasting
  - (Oettingen, 1999; 2000; Oettingen, Pak, Schnetter, 2001)
    - If you did ____,what would be the best thing that would happen?
    - What obstacles might stop you from doing_____?
  - Implementation Intentions
  - (Gollwitzer, 1999)
    - How could you overcome those obstacles?
    - Make a statement:
      - If _____, then_____

The Current Study

- Goal: Test whether MC/II can improve clinician use of treatment compared to consultation as usual
- 28 Clinicians randomly assigned to consultation groups
  - MC/II (experimental) vs.
  - Consultation as usual (control)
- 3 Day Training Provided
- 20 biweekly calls held for each group, spanning 1 academic year

Case Finding & Use of Treatment

- Clinician case finding & use of treatment did not differ significantly between groups:
  - 91% (n=20) discussed potential cases
  - 64% (n=14) obtained consent/assent for 1+ case
  - 32% (n=9) completed treatment with 1+ case
  - MC/II clinicians obtained consent/assent 3 weeks faster on average (M = 14 vs. 17 wks, ns)
- Significant barriers in both groups:
  - Difficulty finding appropriate cases & maintaining them in treatment; Programmatic delays/systems issues; Clinician burn out; Research issues

Outcomes

- MC/II cases less depressed, more comorbidity
  - More challenging to fit into treatment model
- MC/II clinicians less engaged in consultation:
  - Lower attendance and possibly greater attrition
  - Fewer case pres/clinician (0.67 vs. 1.0, ns) & fewer calls with case pres (55% vs. 35%, ns)
- Consultation as usual clinicians:
  - more comfortable using certain CBT components
  - EBP attitudes more positive at end of study
    - More willing to adopt EBP if it is intuitively appealing, made sense to them, could use it correctly, and saw it being used by colleagues who were happy with it.

Implications

- Addressing clinician behavior is not enough to overcome barriers to using evidence based treatments in real world settings
  - Organizational/system level support needed
  - Treatments need to include engagement components and be adapted to work with complex, comorbid cases
- Case presentations were important
  - Listening to others present cases may
    - increase clinician comfort with treatment
    - make treatment more appealing (change attitudes)
    - provide a model of how to use treatment
    - increase clinician use of treatment

Future Directions

- Need strategies to specifically address obstacles to case finding and treatment completion
- Need more information on consultant strategies that lead to clinician engagement, learning, & fidelity to treatment
- Need to further explore application of basic behavioral and cognitive science to MH clinician behavior change

Extra EBTDC Slides

TF-CBT Techniques

(Yr-1 Means Based on a 5-point Likert Scale)

Technique	Use	Skill
Psychoeducation	4.27	4.29
Stress Management	4.24	4.09
Cognitive Coping Skills	4.08	4.09
Creating or Cognitive Processing of the trauma narrative	3.42	3.83
Sharing the trauma narrative with parents	2.94	3.57
Behavior Management Training	3.60	3.69
Stress Management Training with Parents	3.33	3.56
Affect Expression with Parents	3.31	3.49

Depression Techniques

(Yr-1 Means Based on a 5-point Likert Scale)

Technique	Use	Skill
Psychoeducation	4.28	4.30
Recognizing Emotion	4.35	4.25
Catch the Positive Activity	3.68	3.85
Coping Strategies: Teaching and Activities	4.16	4.10
Problem Solving	4.26	4.15
Identifying and Changing Negative Thoughts	4.07	3.90
Building Positive Self-Schema	3.84	3.76
Long Term Planning and Termination	3.61	3.88

Consultation Call Ratings-Yr 1

(Means Based on a 5-point Likert Scale)

Consultation assisted in or consultant	Rating
Developing and modifying case conceptualization	4.21
Using assessment data to define symptoms and goals	4.09
Constructing treatment plans	3.77
Instructed in use of specific CBT techniques	4.05
Used role-playing or made suggestions for improving my techniques	3.21
Followed up on specific issues raised before	3.86
Listened to my questions and was responsive	4.27
Managed time well	4.09
Demonstrated extensive knowledge of CBT	4.44
Overall quality of consultation calls	3.88

Year 3 Trainings

	Year 3
Trainings	9
Clinicians	353 (37 dropped so far)
Supervisors	71 (2 dropped so far)
Total Trainees	424

Attendance – Consultant Differences Year 1

Consultant	Clinician (%)	Supervisor (%)
1	88.5	60.0
2	84.8	38.5
3	84.0	49.1
4	**74.2***	**25.2***
Overall	83.3	39.6

Attendance – Consultant Differences Year 2

Consultant	Clinician (%)	Supervisor (%)
1	92.6	68.4
2	78.4	n/a
3	90.6	n/a
4	80.7	n/a
5	87.0	n/a
Overall	83.2	68.4

Certificate Criteria Completion Year 1

- Significant differences in completion rates across consultants

Consultant	Clinician (%)
1	**94.2***
2	68.4
3	82.5
4	68.6
Overall	79.6

Certificate Criteria Completion Year 2

- Significant differences in completion rates across consultants

Consultant	Clinician (%)
1	**71.4**
2	62.2
3	93.3
4	88.5
5	90.9
Overall	78.7

***Supervisor Completion Rate was 45.3%