SUSTAINABILITY OF CBT FOR YOUTH ANXIETY IN COMMUNITY SETTINGS FOLLOWING IMPLEMENTATION

RINAD S. BEIDAS, PHD
DEPARTMENT OF PSYCHIATRY
UNIVERSITY OF PENNSYLVANIA

SUPPORTED BY K23 MH099179; F31 MH083333

Perelman School of Medicine
University of Pennsylvania

May 16th, 2013

Sustainability

"Sustainability is the continued use of program components and activities for the continued achievement of desirable program and population outcomes" Scheirer & Dearing, 2011

"There is a near absence of studies focusing primarily on the sustainability of complex service innovations" Greenhalgh et al., 2004

"With prospective studies of implementation efforts underway, investigators could make a substantial contribution to the field by planning follow-up studies that assess the degree to which the programs or practices are maintained and the nature and implications of changes that are made once implemented" Wiltsey Stirman et al., 2012

Training and Consultation to Promote Implementation of an Empirically Supported Treatment: A Randomized Trial

Rinad S. Beidas, Ph.D.
Julie M. Edmunds, M.A.
Steven C. Marcus, Ph.D.
Philip C. Kendall, Ph.D., A.B.P.P.

Training and Consultation Trial

- 115 clinicians
- Randomized to one of three training conditions plus 3 months consultation
- Training method did not impact fidelity
- Number of consultation hours predicted fidelity
- Last follow-up was at 3 months

What about sustainability?

- Follow-up study two-years after training and consultation

Sample

- N = 50
- Age M = 35.09
- 92% female

- Master's degree (64%); Doctoral degree (18%); Graduate student (18%)

Procedure – Quantitative

- Completion of self-report measures
  - Identification and Treatment of Anxious Youth – Revised (Benjamin et al., 2010)
  - Knowledge Test (Beidas et al., 2009)
  - Evidence Based Practices Attitude Scale (Aarons, 2005)

Procedure - Qualitative

- Semi-structured interviews (Wiltsey Stirman et al., 2012)
  - 45-60 minutes
  - Elicited information about experiences implementing cognitive-behavioral therapy for child anxiety in the 2-years following training

Qualitative data analytic plan

- Transcribed
- Used grounded theory
  - Inductive process of iterative coding to identify recurrent themes, categories, and relationships in qualitative data
- Generated the following themes
  - Attitudes, Practice Change, Facilitators, Barriers, Adaptation, Organizational Factors, Self-efficacy, Eclecticism, Client Factors, Treatment Factors, EBP Language , Consultation
- Trained 2 bachelors level raters to reliably code
- Interpret each theme and subcode

Quantitative Results

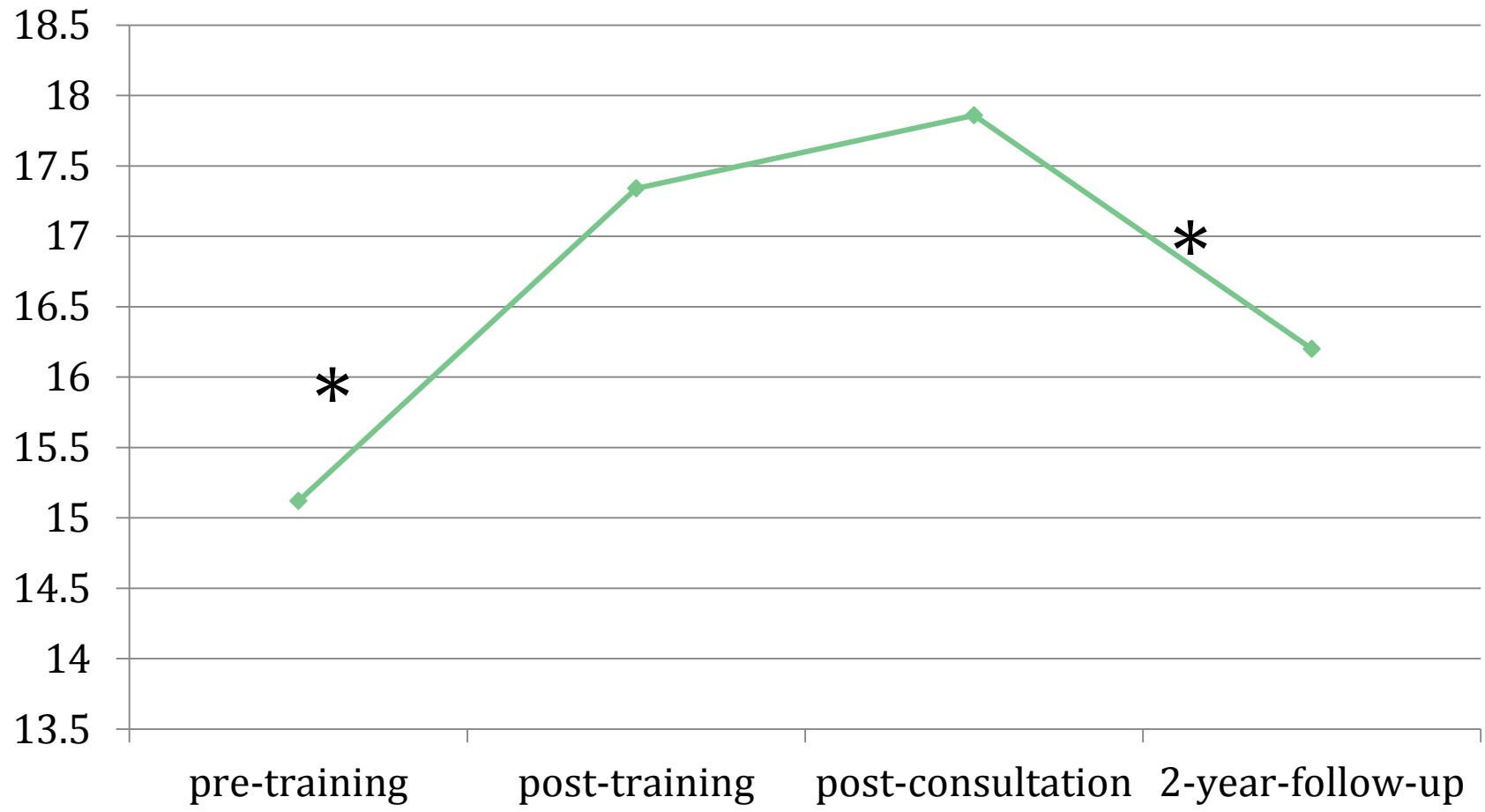
Sustainability Outcomes

- Implementation
- Knowledge
- Attitudes

Implementation

- t (28) = -.11, *NS*
- Percentage of anxious youth treated with CBT
  - Post-consultation (n = 29)
    - M = 84.41, SD = 28.14
  - 2-year-follow-up (n = 29)
    - M = 85.17, SD = 29.26

Knowledge

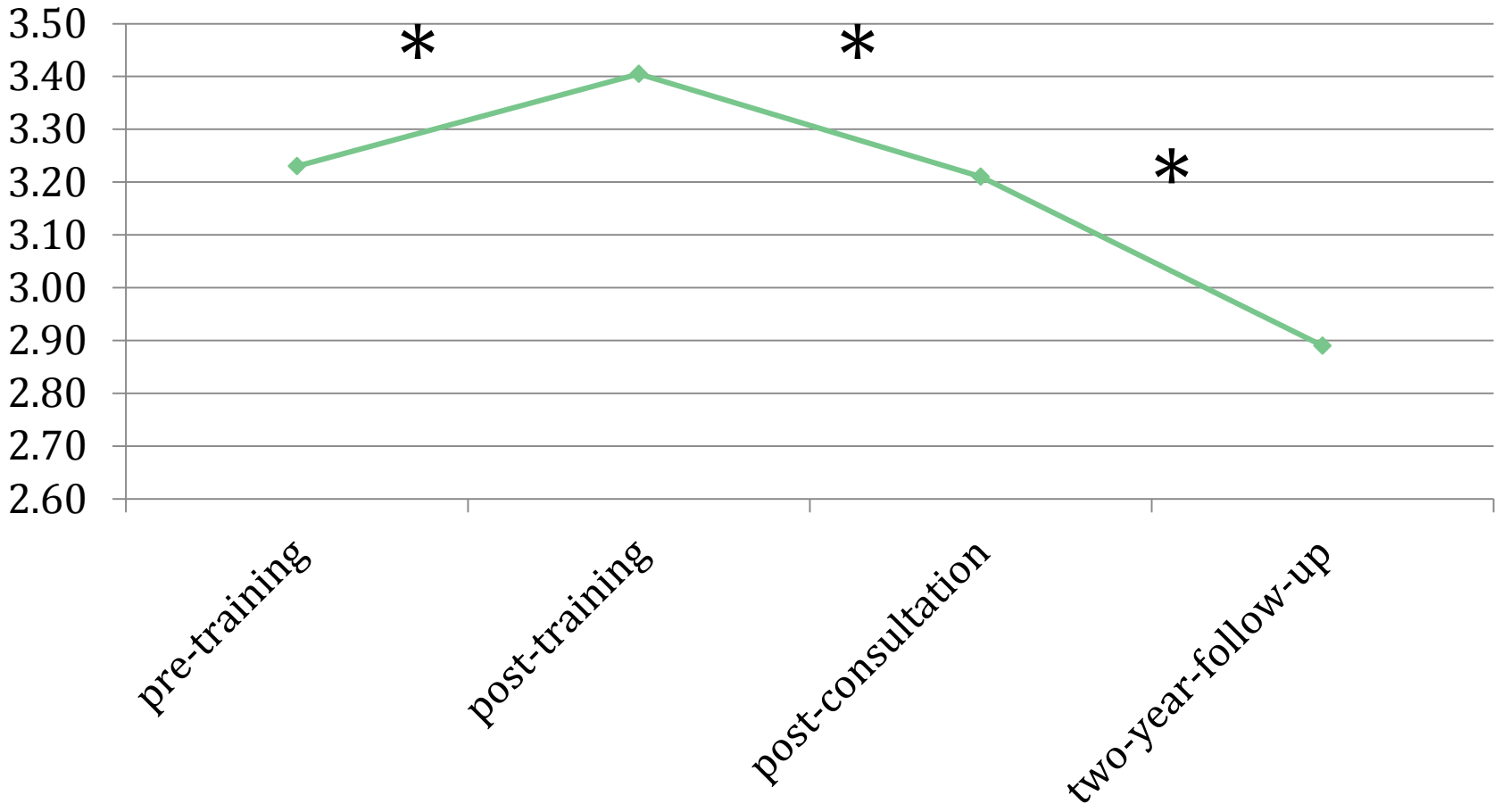


F (3, 147) = 26.86, p <.00

Attitudes

- EBPAS requirements (NS)
- EBPAS appeal (NS)
- EBPAS openness: $F(3, 147) = 13.29$, $p = .000$
- EBPAS divergence (NS)
- EBPAS total (NS)

EBPAS openness

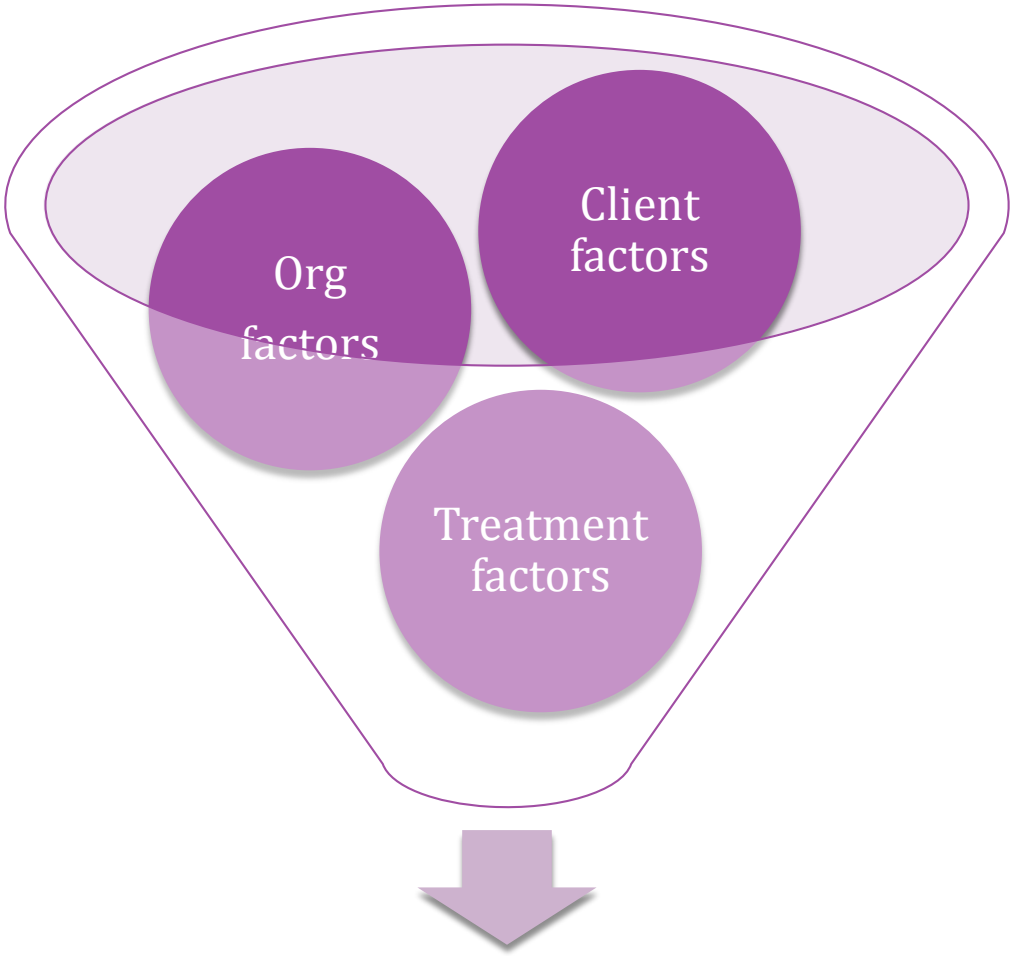


Qualitative Results

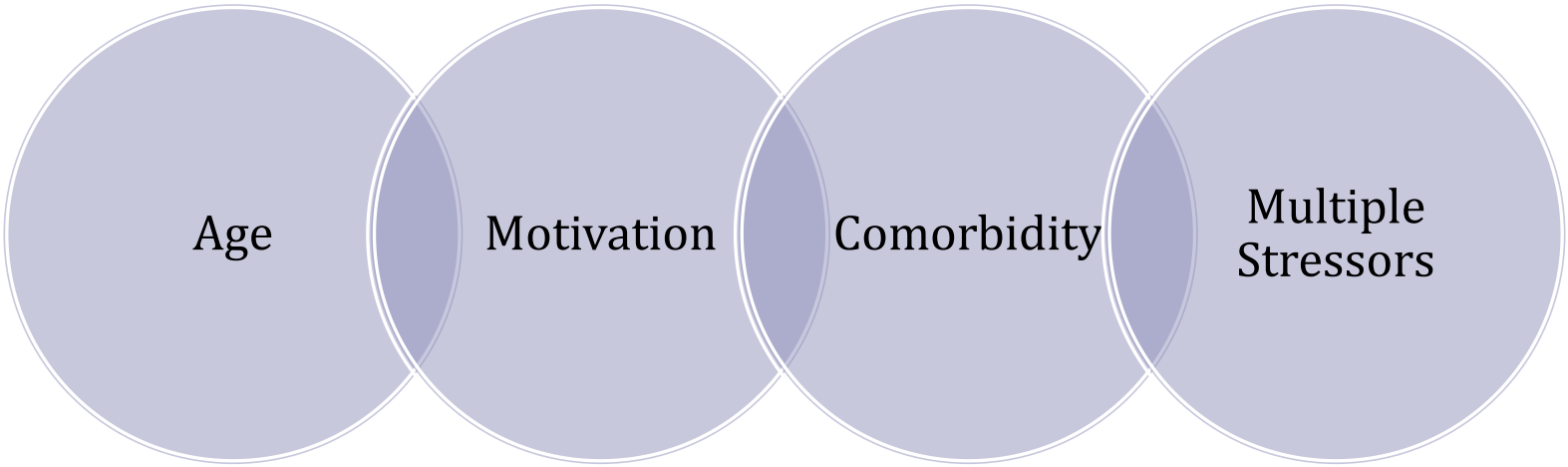
Qualitative Outcomes

- Barriers to sustainability

Themes



Client factors



Age – too young…too old….sweet spot?

"..you know it's just it's hard to get it across young children. I find that really hard."

"..you know just concern, with the older youth kinda being more urban and hip-hop-ish. They don't wanna do stuff that's corny or you know or its considered childish or, you know, not cool. Granted the sessions are private so that has an effect. But I try to give it to them in such a way that they can implement it on their own and they don't look weird doing it."

Coping Cat/CBT for child anxiety specific - intended for 7-13 year olds

Motivation

"..well certainly you know patient willingness…to participate...we also treat a number of adolescents and as those kids get older they seem less willing to kind of try to practice especially the physical stuff like the breathing exercises or progressive muscle relaxation. I don't know if they just felt awkward but they seem less willing to that so…just my trying to explain what we were doing and them kind of accepting the modality was the most difficult thing.

Motivation…an issue for any modality

Comorbidity

"But at the same time, with some of the student I work with they are special education students, so it just doesn't fit. I think you really have to have a certain level of intelligence and, you know, functioning at a certain level. So I think some of my students just are not good candidates for it."

Clients with multiple comorbidities or poor fit for CBT for child anxiety

"…a lot of clients that I see, their main diagnoses are ODD and ADHD. And some of them are diagnosed with PTSD, some of them are diagnosed with anxiety, some of them are diagnosed with depression, but the majority of the clients I see are ODD and ADHD. So I would say the ones that are diagnosed with ODD, oppositional defiant disorder, it's—it's quite difficult because they don't want to do any type of work in school. So when I try to use CBT and do these different activities with them, they don't have the patience or the compliance to really be able to sit through an entire session, I feel like.

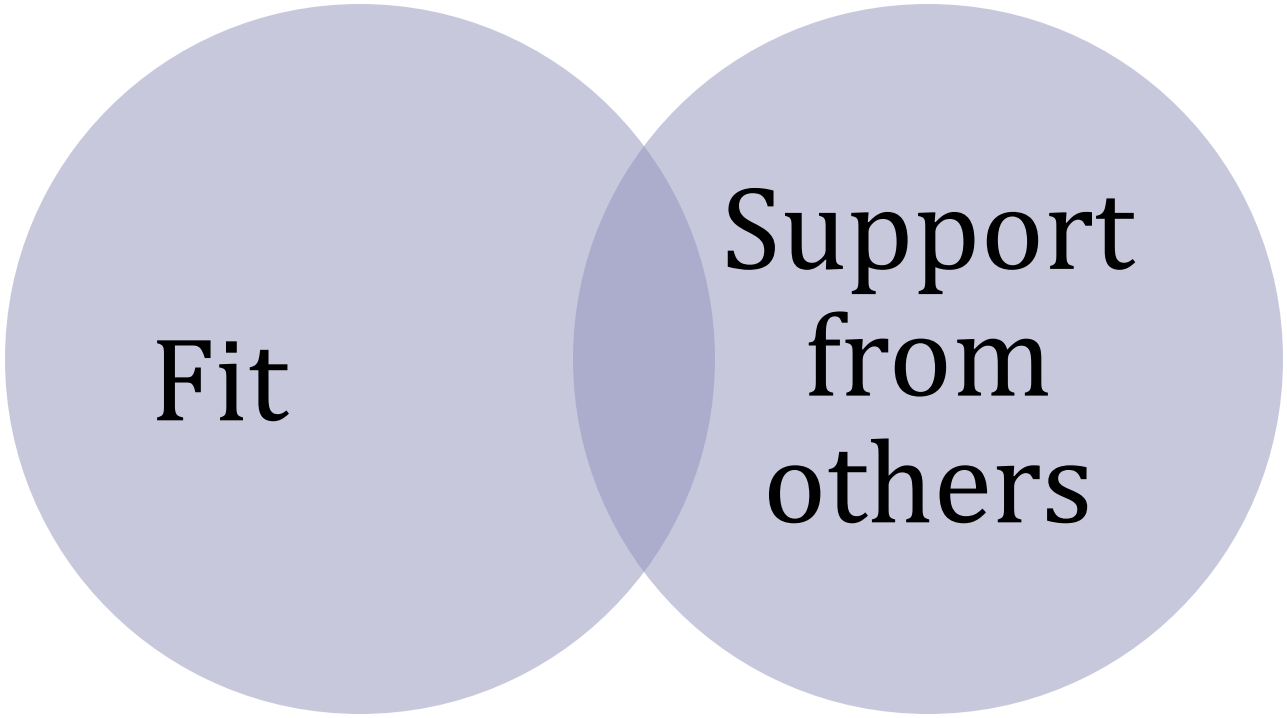
Multiple stressors

"I'd say its probably less effective because there's just constant crisis to the family. So it's hard to and it's a slower process because the crisis need to be worked on as they happen so you can't get to what your plan is every session you know… lots of parents just aren't invested cause they have their own stressors and the responsibility is on the child"

I don't really think that CBT works well with people that have multiple stressors because there [are] so many aspects going on that it's really hard to pin point one or two goals to work on. And I feel like even if you identify a goal if there are so many stressors by the next week there's another goal. So I don't feel like it works that well.

Stressors get in the way of being goal-oriented

Organizational factors



Fit – community mental health clinics

"I think the only thing is that the population that I have been working with my career is primarily is low-income, you know, Medicaid population and the intensity their acuity of some of their issues, the anxiety, doesn't always seem to be the biggest, most salient issues to treat, the other trauma and other issues that seem to come first. So I don't come across it as often in my practice, as I would like to utilize it more. So like maybe folks that work in an effective, different type of setting, you know, more, you know, different type of population might have a better use for this technique."

"I had a very hard time imagining the in-vivo exposures. Mostly due to the population I was working with, like I didn't really have the option to take them to places or do things- it wasn't legally something I could do. (laughs) So to take them somewhere and expose them was like kind of almost unthinkable in the type of practice I was working."

CBT for child anxiety doesn't fit the population or setting for some community mental health clinics

Fit - schools

"well my job in the school setting technically I wasn't supposed to be seeing kids weekly, like it wasn't supposed to be a regular therapy session it was supposed to be more for situational problems that arose...so it was a little bit hard just because I had to be in charge of 600 kids"

Doesn't fit the school setting and the role of a school counselor

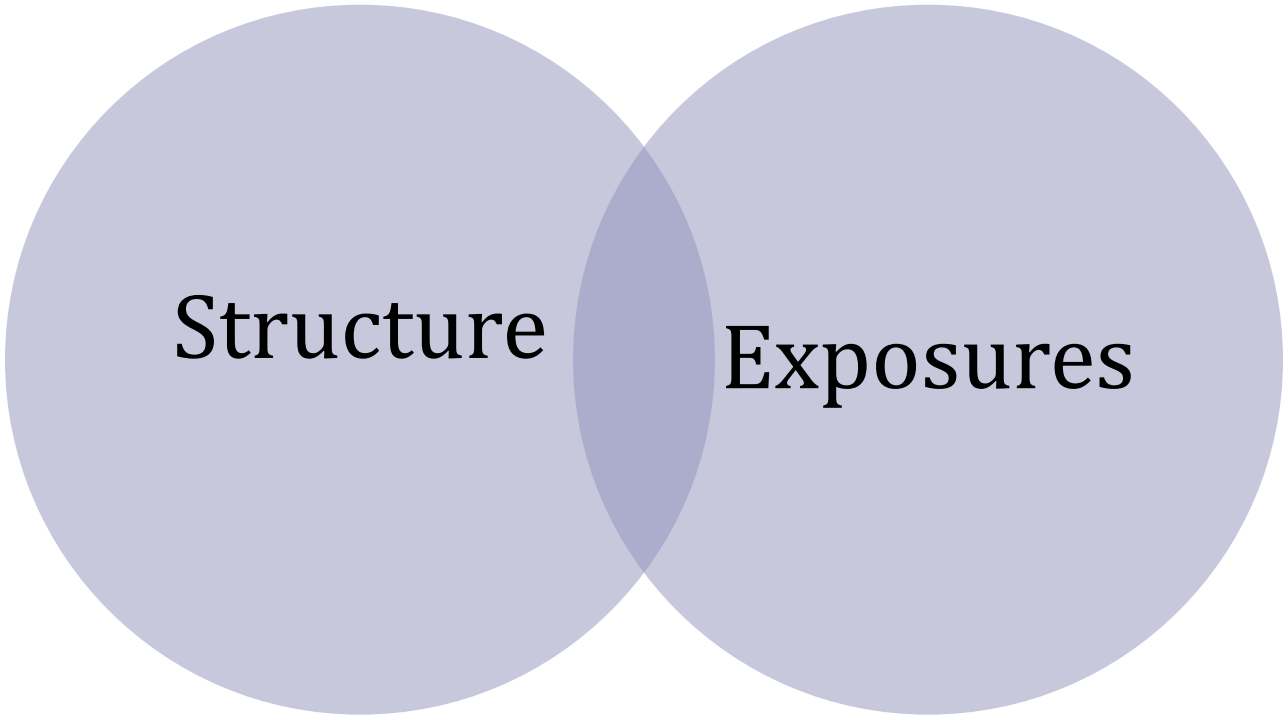
"So I guess, I guess my thoughts are changed in that way, that when I first received the training I thought I would be able to incorporate it more easily into my specific job, in a school, a school-based setting. But I tried to do that and it wasn't always as successful as I wanted it to be. And then I felt like if I were to have the specified time, you know, one hour each week with the client, I would be able to do it much better. So really just the, the chaotic nature of the job that I have really impeded on me being able to successfully do the sessions consecutively, how they're supposed to be and to even fully complete, you know, one session at a time."

Support from others

"I didn't have any specifics of what I could do, it was just be more like (pause) the support, the supervision was lacking so that made it more difficult to do a new practice that I wasn't familiar with. And there was not anything specific like policies or financial issues like that, except for maybe- not that there's so many physical things to do but- actual buying of rewards and things like that was challenging like you know the reward piece, because you know I was financially struggling with that. Like I did a lot of that on my own. So that was a challenge. I think they could have been more aware of practices that could have been more effective with the clients we were working with. Like I don't even know if my supervisor would have been able to supervise me in this, I don't feel like he was qualified enough and that's the issue. Like clinically, I feel like I probably had more clinical experience in that area than he did. And that wasn't a good fit. That was at my school job, at my other, the outpatient job it was part-time and wasn't supervised. there wasn't a lot of consistency because I worked nights and weekends so like supervision was (pause) not regular shall we say."

Lack of support in organizational setting

Treatment factors



Structure

Well personally, especially in the beginning I do like it because it gives me a sense of what I should be doing and as a studying clinician it's very helpful. However, I think it can be hurtful if I- I have to remind myself not to rely on that so much and that sometimes you need to alter things. But I think it's helpful as long as you that you shouldn't go by the book. But that's like the agenda and more the structured manualized part of it"

Structure helping…and hurting

"the presentation of the clients I see, probably, and um, I think some of the preparation was a little challenging with all the card, worksheets. Sometimes getting all that together wasn't always the easiest thing in the world"

Exposures

"So I didn't really get to that with a lot of my kids. There was a couple, umm.... Yeah I didn't think that I was able to do any of the exposure like actual exposures with. I don't know if I did any imaginal ones. But I think that is really an important piece of the process as long as you kind of done kind of the base work for it, kind of prepping kids for that, but I don't think that I actually got to do that work with any of my kids…It was mainly the kids that I was seeing kind of fell off before we were able to get to that point. They either stopped coming or they weren't coming consistently enough for me to feel ok about doing an exposure with them and maybe not seeing them next week. I felt like it was really important if you were to start doing that work to know for sure that they were going to be there the next week for us to process it and you know I'm thinking that was kind of an obstacle for them."

"because of my perspective, of my residential care experience is that the kids are overexposed and over stimulated as it is. So I am not going to expose them to anything at all."

Lack of opportunity or willingness to do core component of treatment

Discussion

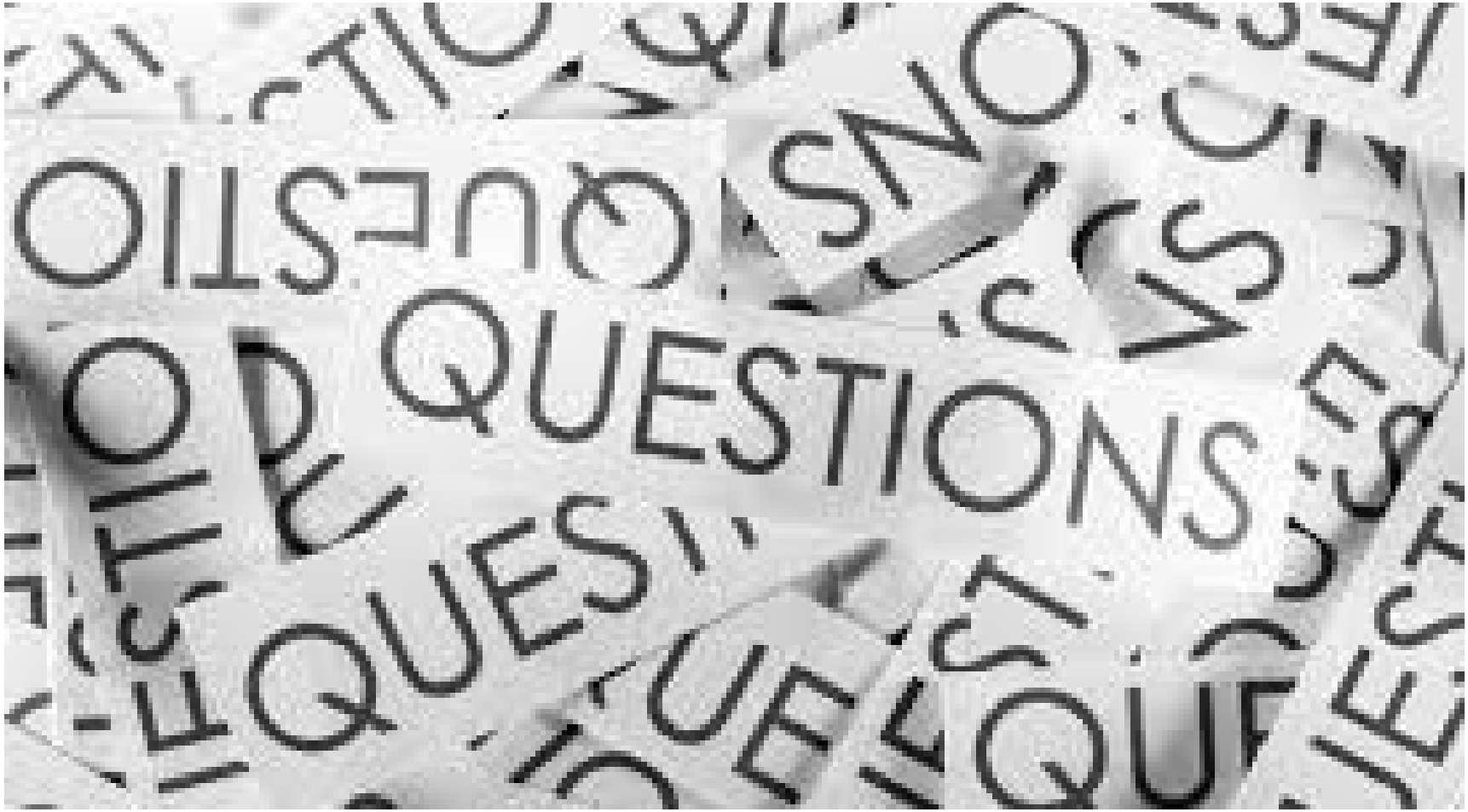
- Knowledge of CBT for child anxiety and openness to EBPs decrease after two years
- Many barriers to sustainability of CBT for child anxiety reported
  - Organizational, therapist, and treatment levels
- Most clinicians report using it at 2-year-follow-up but when you ask them to tell you the barriers to using it; it becomes clear that it is not being implemented as intended
- Need a better understanding of how to adapt practices to make them fit context (Wiltsey Stirman et al., 2012; in press)

Next steps…

- Observation of implementation/sustainability
- Booster training/consultation to keep knowledge and attitudes high?
- Targeted training around barriers
  - Exposure
- Practice-based evidence
- Needs assessment for fit

- System-level support of EBPs in general rather than focusing on one treatment (Beidas et al., 2013)

Other ideas and questions?



Thank you!

For questions, please email me at
rbeidas@upenn.edu