Translating CBT for Anxious Youth to Rural Settings via Tele-psychiatry

Katharina Manassis, MD, FRCP(C)
University of Toronto

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Outline

- The need for knowledge translation in this field
- Challenges in rural settings & populations
- Our hypotheses
- Methods
- Results
- Example & Adaptations
- Implications for practice and further research

The need for knowledge translation

- CBT shown efficacious for child & adolescent anxiety disorders in numerous randomized controlled trials internationally
- Community implementation often proves challenging due to:

1. Different clientele (poorer, more diverse, more co-occurring problems, more family problems)
2. Different training/superv ision of therapists ('workshops don't work' versus ongoing supervision)
3. Different parameters of practice in community mental health organizations (screening, payment, policies such as first come first serve)

...in comparison to research settings.

Coping Communities Pilot Project

4 children's mental health agencies in the Greater Toronto Area completed 20-week group supervision program, 1 via tele-psychiatry; 5-point Likert, post-supervision (subjective):

- Knowledge of Child CBT Increased:
  Mean (S.D.) = 4.58 (.61)
- Confidence using Child CBT Increased:
  Mean (S.D.) = 4.47 (.84)
- Desire to do further Child CBT Increased:
  Mean (S.D.) = 4.55 (.69)

Correlates of Outcome

	Knowledge	Confidence	Desire to Do Child CBT	Age	Diag. Screen
Knowledge	1				
Confidence	.308 P=.20	1			
Desire to Do Child CBT	.428 P=.06	**.838** **P=.000**	1		
Age	-.170 P=.58	**.589** **P=.04**	.327 P=.30	1	
Diagnostic Screen	-.186 P=.42	**.555** **P=.02**	**.503** **P=.03**	-.008 P=.98	1

What is helpful?

- A didactic framework in addition to supervision ("CBT with children: A guide for the community practitioner")*
- Guidance on when to adapt the manual & when not (i.e., general CBT competencies vs. specific techniques)
- Guidance on adaptation to the patient's circumstances and developmental needs
- Guidance on adaptation to patient severity
- Adaptation to culture and parameters of practice of the therapist/organization (therapist-initiated)

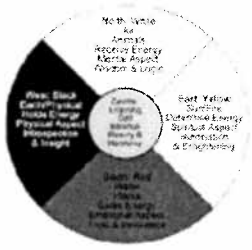
*most requested

Challenges in rural populations

- Higher stigma related to mental illness & privacy concerns
- Norms such as self-sufficiency and independence are stronger in rural areas (stoical, conservative values)
- More transportation & weather difficulties, especially Northern Ontario
- Increased cost of service, even with government-funded health care (e.g. parental jobs with inflexible hours)
- Cultural/ethnic differences: urban areas are highly multi-cultural but with health services following North American model; rural areas are predominantly Caucasian with Aboriginal sub-groups that may use different health models

Aboriginal populations (Anishinabek)

- The Medicine Wheel is quite consistent with a CBT framework
- Structured, written emphasis of CBT contrasts narrative, relational emphasis in aboriginal healing
- High rates of poverty and foster care
- Historical injustices (e.g., residential schools) result in mistrust of Western providers



Hypotheses

- Therapists in rural communities can learn principles of CBT and apply these with at least one child/teen in a 20-week group supervision program delivered via tele-psychiatry
- Therapist knowledge of child CBT will increase with training (replicating 'Coping Communities' project)
- Treated youth will show reduced anxiety symptoms by self- and parent-report

Methods

- Tele-psychiatry 'hub' in Toronto with 3 trainers
- 10 Agencies across Northern Ontario
- Weekly 1.5 hours didactic + group supervision session x 20
- Therapists with 2 years child therapy experience and keen interest in CBT
- Emphasis on screening for CBT suitability, and adaptation of manuals to local clientele and parameters of practice
- "Coping Bear" for 8-12 years & "C.A.T. Project" for teens
- Additional cultural adaptations discussed when working with aboriginal youth

Methods (2)

- 71 youth: 36 boys & 35 girls
- Average age 11.75 years
- Quantitative (paired, 2-tailed t-tests) and qualitative (focus groups) evaluation of impact
- Measures pre- and post-intervention with therapists, youth, and parents:
  - Therapist child CBT multiple choice knowledge test (20 items, locally developed for pilot project)
  - Multidimensional Anxiety Scale for Children (MASC; March, 1997)
  - Child Behavior Checklist (Achenbach & Rescorla, 2007)—Anxious/Depressed Syndrome Scale

Results

Training-Related Changes in Key Measures:

Measure	Pre-Training	Post-Training
Therapist Child CBT Knowledge (raw scores)	15.08 (2.58)	16.43 (3.20)*
MASC (t-scores)	63.63 (10.54)	33.19 (9.00)*
Parent Symptom Report (CBCL) (t-scores) *p < .001	69.63 (10.00)	62.89 (9.23)*

Results(2)

- Although effects were modest (ES=0.4), changes in therapist knowledge of child CBT were significant, replicating Coping Communities
- Anxiety symptoms significantly decreased by both parent and child report
- Results did not differ significantly by agency
- Measure completion rates were problematic (52% parents; 61% youth; 75% therapists), but no significant differences were found between completers & non-completers

Limitations

- Self-selection of therapists who handed in research measures (i.e., bias in favor of those who felt successful)
- Supervision & fidelity checks based on self-report of sessions, versus taping/observation
- Need for a standardized child-CBT competence measure
- Therapists varied in level of experience/comfort with administering research measures
- Agencies varied in level of organization, support of program, case selection procedures, coverage of therapists' usual duties during supervision sessions

Example (local clientele, composite)

"I've been seeing my client, Stephanie, for 2 years now. She is 14 and has a good relationship with her foster mother, but often skips school to hang out with her boyfriend. She is self-conscious about her weight, and gets panic attacks when she starts to change for gym class. She also worries about her foster mother getting followed or hurt by customers at the bar where she works. A couple of times she's gotten so anxious she cut her arm with a razor and experienced some relief, but now she's self-conscious about the scars so wants to stop. Is she a good candidate for this program?"

As the trainer, how do you respond?

Let's think about it…

- If you wait for each trainee to find an 'ideal case', training will never happen
- If you 'take all comers' the CBT principles are lost in the midst of behavioral/family issues and crisis management
- Clarify details, formulate, discuss pros & cons about attempting CBT in this case; if proceed with CBT keep in mind what problems to anticipate and what adaptations may be needed
- E.g., there are a number of 'red flags' to keep in mind, but the capacity for ongoing therapeutic relationship, relationship with foster mom, and motivation to cope differently are all good
- More detail on learning issues, comorbidities esp. substance/mood/eating disorder, foster history esp. PTSD, boyfriend/sexuality/other peer issues, realistic risks to self & foster mom, past treatment/frequency of crisis events that might disrupt CBT

Clientele (sample adaptations)

- Slow pace, visual aids, and minimize reading/ writing for those with learning issues
- Work in short segments, frequently redirect, frequently reinforce if attentional issues
- Add behavioral activation, extra rapport-building for comorbid depressive symptoms
- Extra time to develop trust, narrative vs. 'book learning', culturally relevant metaphors, work in natural settings with Aboriginal youth
- Facilitate regular attendance, educate re: healthy parenting, treat parental psychopathology
- Spell out realistic goals & treatment expectations

Supervisees

- Respect their knowledge & experience with their clientele, agency, and community, and with principles of child therapy
- Have a clear source for didactic information (book)
- Emphasize the need for structured sessions, homework, regular attendance, and other general requirements for CBT, and use fidelity checklists
- Adjust pace of supervision sessions to their level, and if variable encourage peer support/teaching
- Add content relevant to their clientele (e.g., PTSD, medications & CBT) & practice (e.g. CBT before/after you do other therapy with the youth)
- Go from 'expert' supervision to peer supervision, including a 'train the trainer' module

Agencies

- Existing tele-psychiatry links & experience with this medium was an asset
- Prior experience with evidence-based treatments and/or research measures was an asset
- Having a relationship with one dedicated, senior 'point person' who was willing to be the 'hub' for materials & participants was invaluable
- Clear expectations of what was required essential, especially re: finding cases for supervision
- Coverage for usual duties during supervision sessions was sometimes problematic
- 'Gentle harassment' week by week to keep on track

Clinical Implications

- Knowledge translation of CBT for anxious youth to rural settings via tele-psychiatry supervision appears feasible &probably effective
- Providing a framework for adapting CBT to local clientele and practice conditions appears helpful
- Attention to screening procedures, general principles of child therapy, and general CBT competencies as well as specific techniques may also be helpful
- Logistical problems and philosophical differences between urban and rural populations may need to be addressed in order for therapy to succeed
- Additional adaptations for Aboriginal culture can be made in partnership with culturally attuned therapists

Further Research

- Replication with other rural communities needed
- Qualitative analysis of barriers/facilitators of knowledge translation in this model
- Separate qualitative analysis of translation to Aboriginal population
- Investigate additional child, family, therapist, and organizational variables that could moderate treatment success (n.b., see Emily Jones' poster tomorrow)
- Investigate applications of this training model to:
  - Additional disorders
  - Additional therapist populations & geographic areas
  - Other evidence-based treatments