Coping Communities: An Innovative Teaching Program to Expand Delivery of Child CBT

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Executive Summary:

The efficacy of cognitive behavioral therapy (CBT) for childhood anxiety disorders, one of the most common and impairing childhood mental health problems, has been demonstrated in numerous randomized controlled trials. Unfortunately, the availability of CBT is often limited to specialized academic centers, despite the desire of many community mental health providers to learn and use this evidence-based treatment. The present study trained 28 mental health professionals from 4 community, collaborating agencies in a CBT model adapted for childhood anxiety disorders and examined the knowledge transfer process of and impact in the delivery of care. An innovative, 20-week didactic/group supervision seminar was offered to 28 practitioners. We evaluated these individuals’ gain in knowledge of CBT, confidence using it, satisfaction with the seminar, and subsequent increased use of CBT. Organizational changes (eg. requests for further training, more consistent identification of appropriate cases, etc.) were also measured. Based on feedback provided by participants, practitioner knowledge increased, no adverse events were encountered, the intervention was found helpful and enthusiastically received, and further use of child CBT in these agencies is planned. This project thus provides a foundation for effective dissemination of CBT beyond the present partnerships, and eventually across the province. This innovative approach could then be applied to training in other evidence-based interventions.
Introduction and Background:

Childhood anxiety disorders are disabling for affected children and constitute a significant burden to the mental health care system (Bird et al., 1988). Conservative estimates indicate that about 10% of school aged children suffer from these disorders, often with significant impairment at home, at school, and with peers (Bernstein et al., 1996). Medical treatment with Specific Serotonin Reuptake Inhibitors has been shown effective in some studies (Research Unit in Pediatric Psychopharmacology Anxiety Study Group, 2001), but recent concerns about self-harm risk with these medications and lack of evidence concerning long-term risks/benefits often reduce their acceptability to families. Cognitive behavioral treatments, on the other hand, have few attendant risks and may ameliorate symptoms in a relatively brief period of time. Numerous randomized controlled trials in different academic centers—including our own—have demonstrated the efficacy of group or individual cognitive behavioral therapy (CBT) for childhood anxiety disorders in comparison to wait list control (eg. Kendall, 1994/1997; Manassis et al., 2002; March et al., 1994; Mendlowitz et al., 1999.

Unfortunately, child CBT is not widely available in the community, despite the desire of many community practitioners to learn and use this evidence-based treatment. Geographic distance between the child and an academic centre with expertise in CBT, and the high cost of obtaining CBT through practitioners not covered by health insurance plans like the Ontario Health Insurance Plan (OHIP) often limit access to child CBT. Increasing the number of practitioners in publicly funded, community settings is therefore essential. To do so, our group began offering intensive workshops in child CBT, which were very well-received and won a University of Toronto continuing education award. Unfortunately, while workshops were found to enhance knowledge of CBT principles (based on a short quiz pre- and post-workshop), participants generally did not acquire sufficient expertise and confidence to practice independently (based on 6-month follow-up survey). Community partnerships that allow for supervision over time and adaptation of techniques to various settings offer a promising alternative.

This project demonstrates that such an approach can increase the availability of child CBT in the community by allowing trained clinicians to confidently use this evidence-based treatment. We did not evaluate changes in the treated children themselves, as that is beyond the scope of the present project and the effectiveness of these intervention have been supported by numerous independent studies. Instead we focused on the knowledge transfer process application and hypothesized (1) that participants will have greater knowledge of child CBT post-seminar versus pre-seminar, and be highly satisfied with the seminar; (2) that participants will treat more cases using CBT post-seminar (ie. during 6 months after seminar completion) versus pre-seminar (ie. during 6 months before seminar participation), and report greater confidence using child CBT post-seminar versus pre-seminar; (3) Organizational changes will be evident post-seminar versus pre-seminar.
Methods:

**Subjects:** An innovative, 20-week didactic/group supervision seminar was offered to 28 practitioners (20 females, 3 males, and 5 individuals who did not indicate their gender) identified by four diverse, collaborating agencies funded by either the Ontario Ministry of Children and Youth (Aisling, George Hull, Kinark) and the Ministry of Health and Long Term Care (Bloorview). All agencies were asked for interested volunteers, and then (to ensure fairness) participants were selected by lottery from the pool of interested volunteers at each agency.

**Training Model:** The 20-week didactic/group supervision training model is an established teaching curriculum currently in use the authors to teach CBT to trainees in Child Psychiatry. Practitioners attended in four groups of 6, for 1.5 hours per week. With supervision, they learned to assess children for CBT suitability, identify an appropriate case in their setting, and offer a manualized 12-week treatment (‘Coping Bear’, Scapillato & Mendlowitz, 1993). Following the 20 week didactic seminar, participants communicated by conference call every 6 to 8 weeks, to ensure the establishment of a community of practice based on a model of peer support and supervision.

**Evaluation:** Informed by explicit learning objectives we developed questionnaires, to evaluate practitioners’ gain in knowledge of child CBT and satisfaction with the seminar immediately after seminar completion. Six months after completion of the seminar, questionnaires were used to evaluate practitioners’ increased use of CBT (number of new CBT cases in their practice), and confidence using it (key outcomes). Changes in partnering agencies (eg. requests for further training of other staff, mechanisms for consistently identifying appropriate cases, etc.) were also measured at that time and will be measured at 18 months post-completion of the training program.

**Results:**

Age of practitioners ranged from 29 to 59 years ($M=40.75, SD=8.41$). Slightly less than one-quarter of participants (23.10%) indicated no previous experience doing psychotherapy with children, and 42.30% reported no experience doing CBT with children. Approximately half (53.80%) reported no experience doing psychotherapy with adults, and 80% reported no previous experience doing CBT with adults. The majority of participants reported that their setting used a diagnostic screen at intake (80%), and encouraged the use of DSM diagnoses (88%), training in evidence-based treatments (100%), matching cases to evidence-based treatments (84%), and participation in research (80%). Also, almost two-thirds of participants (60%) indicated that their settings did not require treating all cases on a first come, first served basis.

Results indicated an increased understanding of CBT ($M_{pre-seminar}=13.36, SD_{pre-seminar}=3.86$ and $M_{post-seminar}=16.95, SD_{pre-seminar}=2.42$, $t(21)=-4.37, p<.001$). Practitioners were also asked a series of questions to assess their satisfaction with both the didactic portion and supervision of the seminar. As displayed in Table 1, practitioners found the information discussed in the seminar helpful and were delighted with group supervision/seminar. They also noted that their confidence using CBT and desire to treat further clients using child CBT increased as a result of the seminar.
Conclusions and Recommendations

The present study demonstrated that organized around a common goal partnerships between academic and community based children’s mental health agencies are possible and fruitful. Adherence to a 20 week didactic-experiential program resulted in increased motivation, knowledge, and proficiency in the delivery of an evidenced informed non-pharmacologic therapeutic modality for the treatment of childhood anxiety disorders.

Based on feedback provided by participants, practitioner knowledge increased, no adverse events were encountered, the intervention was found helpful and enthusiastically received, and further use of child CBT (cognitive behavioral therapy) in these agencies is planned. This project thus provides a foundation for effective dissemination of CBT beyond the present partnerships, and eventually across the province. This innovative approach could then be applied to training in other evidence-based interventions.

Knowledge Exchange/Transfer Plan

The project focused entirely on a knowledge exchange initiative whereas an academic centre partner with 4 community collaborating agencies to deliver a 20-week didactic/group supervision seminar to 28 practitioners in a CBT model adapted for childhood anxiety disorders and examined the knowledge transfer process of and impact in the delivery of care.

To date the didactic/experiential seminars have been completed (80 sessions in total). Changes in knowledge of CBT, confidence and motivation in using it, as well as, satisfaction with the seminar, and subsequent increased use of CBT have been measured.

Evaluation of late sustainability of the program and organizational changes (eg. requests for further training, more consistent identification of appropriate cases, etc.) are being measured prospectively.

As a first step in local dissemination and knowledge exchange a workshop with the Toronto District Separate School Board is planned for this fall. Upon completion of the prospective evaluation of sustainability and organizational impact presentations in local, national and international professional and academic conferences are planned

List of Acronyms and Abbreviations

CBT: cognitive behavioral therapy
Acknowledgements

The authors acknowledge the contributions of our community partners: Bloorview-MacMillan Centre, Aisling Discoveries, George Hull Centre, and Kinark Children’s Mental Health Services and the many enthusiastic professionals from those sites who participated in the program. Special thanks also to Ms. Donna Scapillato who co-facilitated many of the teaching sessions with the investigators, and Ms. Lisa Fiksenbaum who patiently collected and managed our data.
References


Scapillato D, Mendlowitz S (1993), Coping Bear Workbook, University of Toronto, available from the authors.
Table 1  
*Practitioners’ Evaluation of CBT Supervision/Seminar*

<table>
<thead>
<tr>
<th>Residents’ Perceptions</th>
<th>Strongly disagree (%)</th>
<th>Disagree (%)</th>
<th>Neither disagree nor agree (%)</th>
<th>Agree (%)</th>
<th>Strongly agree (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The information provided was useful to my practice</td>
<td>--</td>
<td>--</td>
<td>9.1</td>
<td>36.4</td>
<td>54.5</td>
</tr>
<tr>
<td>2. The information provided was adequate to meet my practice needs</td>
<td>--</td>
<td>4.3</td>
<td>4.3</td>
<td>56.5</td>
<td>34.8</td>
</tr>
<tr>
<td>3. The concepts taught were clearly explained</td>
<td>--</td>
<td>9.1</td>
<td>9.1</td>
<td>36.4</td>
<td>45.5</td>
</tr>
<tr>
<td>4. There was adequate time for discussion of the material</td>
<td>--</td>
<td>--</td>
<td></td>
<td>27.3</td>
<td>72.7</td>
</tr>
<tr>
<td>5. The supervisors were knowledgeable about CBT principles</td>
<td>--</td>
<td>--</td>
<td>4.5</td>
<td>9.1</td>
<td>86.4</td>
</tr>
<tr>
<td>6. The supervisors were knowledgeable about the types of cases I see</td>
<td>--</td>
<td>--</td>
<td>9.1</td>
<td>50.0</td>
<td>40.9</td>
</tr>
<tr>
<td>7. The supervisors were helpful in applying CBT principles to my case</td>
<td>--</td>
<td>--</td>
<td></td>
<td>40.9</td>
<td>59.1</td>
</tr>
<tr>
<td>8. The supervisors created a nonjudgmental atmosphere</td>
<td>--</td>
<td>--</td>
<td></td>
<td>13.6</td>
<td>86.4</td>
</tr>
<tr>
<td>9. The supervisors encouraged group problem-solving</td>
<td>--</td>
<td>4.5</td>
<td>9.1</td>
<td>18.2</td>
<td>68.2</td>
</tr>
<tr>
<td>10. The supervisors provided constructive feedback</td>
<td>--</td>
<td>--</td>
<td>4.3</td>
<td>39.1</td>
<td>56.5</td>
</tr>
<tr>
<td>11. The supervisors were receptive to feedback</td>
<td>--</td>
<td>--</td>
<td>4.5</td>
<td>27.3</td>
<td>68.2</td>
</tr>
<tr>
<td>12. My knowledge of child CBT increased as a result of this experience.</td>
<td>--</td>
<td>--</td>
<td>5.3</td>
<td>31.6</td>
<td>63.2</td>
</tr>
<tr>
<td>13. My confidence using child CBT increased as a result of this experience.</td>
<td>--</td>
<td>5.3</td>
<td>5.3</td>
<td>26.3</td>
<td>63.2</td>
</tr>
<tr>
<td>14. My desire to treat further clients using child CBT increased as a result of this experience.</td>
<td>--</td>
<td>--</td>
<td>10.0</td>
<td>25.0</td>
<td>65.0</td>
</tr>
</tbody>
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