MOST Reporter

THE CAYUGA COUNTY MOBILE OUTREACH SERVICES TEAM – TARGETED ALCOHOL AND CHEMICAL TREATMENT PROGRAM (MOST-TACT):

CAYUGA COUNTY COMMUNITY MENTAL HEALTH CENTER

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Fidelity to CBT Model Continues at a High Level in MOST-TACT Clinicians' Practice

Introduction

In 2004, Cayuga County Community Mental Health Center received a three-year Targeted Capacity Expansion grant from the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment (CSAT). The project, known as Cayuga County MOST-TACT, is being implemented by Cayuga County Community Mental Health Center in collaboration with the Partnership for Results. It provides early assessment and brief intervention services in school settings to adolescents ages 11 and over who have substance abuse disorders that have not progressed to dependence. The project serves students attending five central New York school districts, one urban, one county-wide, and three rural: Auburn Enlarged City, Cayuga-Onondaga B.O.C.E.S., Union Springs, Port Byron, and Southern Cayuga.

The project is grounded in research-based principles of assessment, treatment, and system organization. First, MOST-TACT represents a system of care approach to human services delivery, attempting to address a wide range of co-occurring problems at the individual, family and school level by accessing a wide range of preventive and early intervention programs and services. Second, in order to ensure that the co-occurring problems or risk factors affecting adolescents with substance abuse disorders are accurately diagnosed and addressed, the project is using a validated, multi-disciplinary evaluation instrument and is systematically providing comprehensive treatment planning for clients and their families. Third, the MOST-TACT project clinicians employ an evidence-based intervention, Cognitive Behavioral Therapy (CBT). CBT is an effective intervention for adolescents with substance abuse disorders that have not progressed to dependence, as well as for a wide range of co-occurring mental health problems.

MOST clinicians receive extensive training in the CBT model before they provide services, and they continue to receive training on at least a monthly basis during the year. Despite this initial preparation and ongoing assistance, CBT is a complex intervention model and, as a result, it can be a challenge for clinicians to adhere fully to the treatment principles that research on CBT indicates are likely to result in positive outcomes. Nevertheless, the evidence suggests that the MOST-TACT clinicians are generally achieving a high degree of implementation fidelity. This was the case early in the implementation of MOST-TACT, as the first edition of the *MOST Reporter* indicated in August 2005. As this current report indicates, it is even more the case over one year later, even though two of the six clinicians have only recently joined the MOST staff.

The evaluation of the of the Cayuga County MOST-TACT program is being conducted by the Youth Policy Institute, Inc. (YPI), an independent, non-profit research and evaluation firm located in central NY. The study uses a systems-based model to evaluate the program, which includes an examination of the context, implementation, and impact of the program. This edition of the *MOST Reporter* constitutes

the fourth assessment study of the project, one in a series that will provide project staff, funders, and community members with insights on the project's administration, effectiveness, and outcomes.

The focus of this report is to determine the extent to which MOST-TACT's core intervention, Cognitive Behavioral Therapy (CBT), is being implemented with fidelity to the essential, or non-negotiable, elements of the intervention across CBT's four program areas:

I Introducing CBT

II Recognizing the current level of functioning

III Treatment strategies

IV Working with parents.

It is now well-established in the research literature that fidelity of implementation (i.e. adherence to the model) is positively correlated with the efficacy of evidence-based substance abuse and mental health treatment programs. The goal of this edition is to assess the extent to which participating clinicians providing CBT services for MOST-TACT are adhering to the program model two years into the implementation.

To facilitate this evaluation study, YPI developed the *Cognitive Behavioral Therapy (CBT) Implementation Checklist*, a retrospective assessment instrument that gauges the extent to which participating clinicians have implemented 16 essential elements (or "quality indicators") of CBT and the degree to which they use CBT strategies that are specific to the quality indicators. The primary data collection strategies used to report the findings presented in this edition of the *MOST Reporter* were the clinician responses to the *Checklist* (n = 6), interviews with implementers, supervisors, and trainers, and a review of project records.

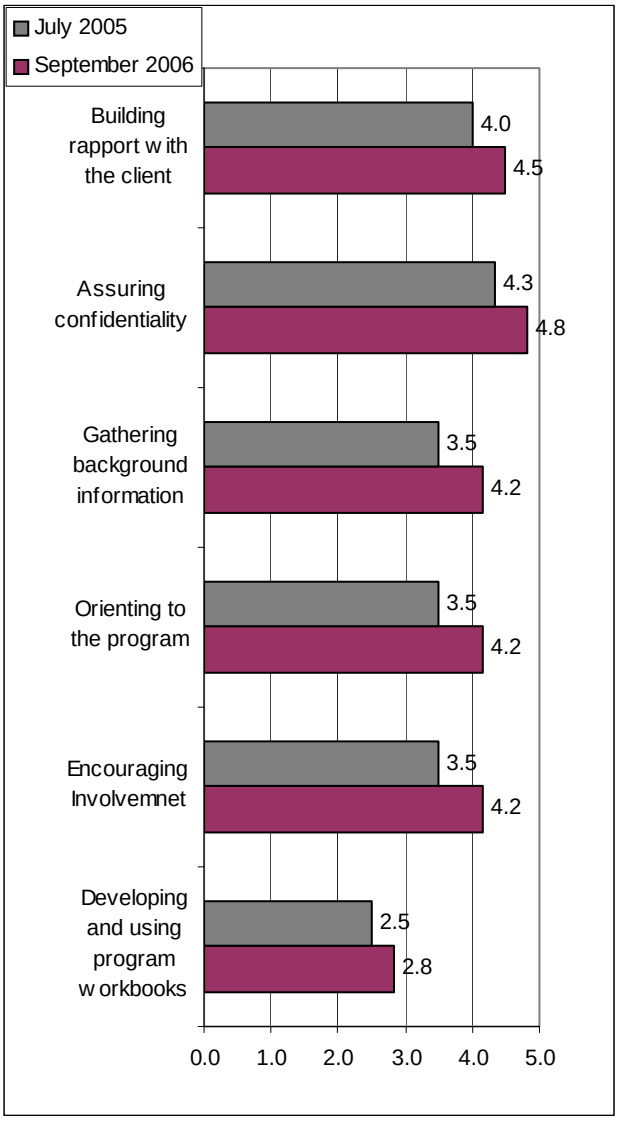
The development and administration of the *Checklist* serves several purposes. First, as noted above, fidelity is a critical independent variable when evaluating treatment outcomes. Variations in fidelity may result in disparate treatment efficacy. Furthermore, in multi-site projects such as MOST-TACT, outcomes may differ significantly by site. The *Checklist* will permit, to the extent that it occurs, the measurement of program drift, that tendency of evidence-based programs to depart from established models. Second, it serves practical purposes that may permit, if needed, ongoing improvements in service delivery. The *Checklist*, at this stage of project implementation, provides project managers with a snapshot of adherence to CBT that is timely enough to be addressed (if necessary) by changes to the clinical supervision and training. The fidelity measure also serves an important heuristic purpose, providing practitioners a redacted guide to the essential elements and strategies of CBT.

Program Area I: Implementation Indicators Regarding the Introduction of CBT.

The *Checklist's* first grouping of indicators encompasses six essential elements, and their attendant strategies, that are associated with an effective introduction of the intervention by the therapist, who: (1) establishes a trusting relationship with participating youth; (2) assures clients that information will be kept confidential; (3) collects a wide variety of comprehensive background information; (4) provides a broad overview of the program; (5) uses a variety of techniques to facilitate involvement and verbalization; and (6) introduces and reviews key program support materials (i.e. workbooks). **Figure 1** compares levels of adherence to key indicators related to introduction of CBT at two points in time: in July 2005, when the project had been operating for less than one year; and in September 2006.

Key Finding *– When introducing CBT to clients, project clinicians are adhering closely to the program model. They are doing so at a higher level than earlier in the program implementation, notwithstanding the fact that 2 of the 6 respondents have less than one year of experience in the intervention* (**Figure 1**).

Figure 1
Introducing the CBT Project:
Implementation of Key Indicators



For this program area (introducing the CBT project), MOST-TACT clinicians showed substantial improvements in levels of adherence to the program model across all six implementation indicators. Aside from the sixth of these essential elements (developing and using program workbooks), project clinicians, on average, reported, in September 2006, "complete implementation" (an average of at least 4 on a 5-point rating scale) "that is systematic and organized with no major gaps." In July of 2005, that was the case for only two of six indicators, building rapport with the client and assuring confidentiality.

In September 2006, the six clinicians reported implementing 97% of the 17 component strategies in this program area (introducing CBT), a level slightly higher than that in 2005 (92%). Moreover, clinicians in 2005 and 2006 indicated that 35% of strategies were being implemented at the highest level, that is, without significant weaknesses or gaps.

This exceptionally high level of adherence to CBT practices and procedures is in part the result of highly structured activities developed by the Partnership. CHARI, for example, has well articulated time frames, reminders, and data integrity checks that prompt practitioners to systematically gather background information. Interviews with staff also indicated that this level of adherence is also the result of consistent supervision, accessible technical assistance from the Partnership staff, and ongoing training by highly skilled CBT practitioners.

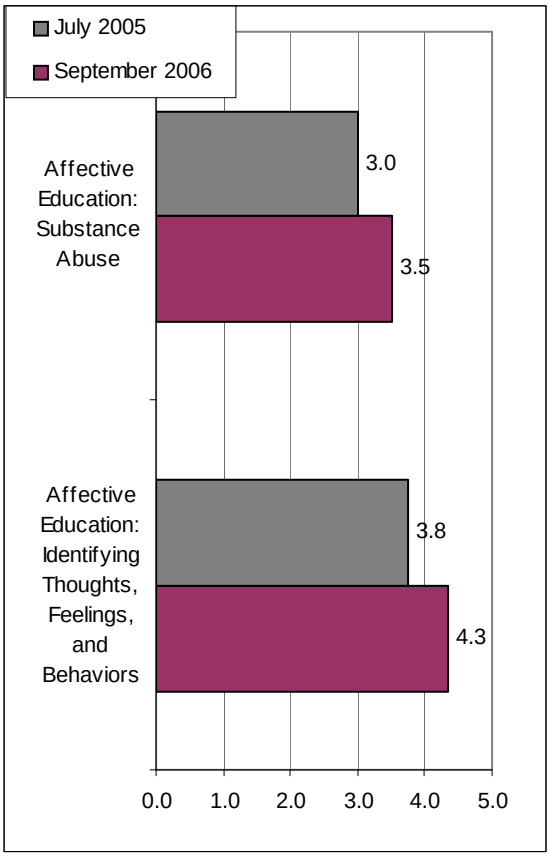
As in July 2005, practitioners in 2006 reported a lower level of adherence to the program model regarding the development and use of program workbooks. Two of the respondents rated this indicator as minimally implemented ("2"), with work in this indicator in the planning stage and needing substantial work to improve the approach. Another two respondents rated the workbook indicator as moderately implemented ("3"), indicating that there were some gaps in the implementation and that improvements could be made. As in the earlier administration

of the *CBT Checklist,* several project clinicians reported a reluctance on the part of some clients to complete workbooks, a matter which may be resolved in the future through additional CBT training and/or improved materials.

Program Area II: CBT Implementation Indicators Regarding the Recognition of Current Levels of Functioning.

The *Checklist's* second grouping of indicators encompasses two essential elements, and their attendant strategies, that are related to affective education. In these, the therapist: (1) introduces the concept of "triggers of use" and assists clients to understand their roles in the decision to use and abuse substances; and (2) teaches the clients to identify self-talk and to recognize negative behaviors.

Figure 2
Recognizing Current Level of Functioning: Implementation of Key Indicators



In September 2006, the six clinicians reported implementing 97% of the six component strategies in this program area (recognizing current level of functioning), the same level of implementation as in 2005. In addition, in 2006 clinicians indicated that 28% of strategies were being employed at the highest level, without significant weaknesses or gaps; in 2005, only 6% of the strategies were reported implemented at this highest level for this indicator.

When reporting adherence to the implementation indicator regarding substance abuse affective education, four of the project clinicians indicated "complete implementation" (a rating of "4" on a 5-point scale), with an average rating for this indicator of 3.5 in 2006, compared to 3.0 in 2005. The clinicians noted that, notwithstanding the refusal of some clients to acknowledge any form of substance abuse, it was becoming less difficult to discuss triggers of use and to employ appropriate worksheets than in the past. MOST-TACT clinicians reported substantial adherence with the implementation indicator related to teaching the client to identify self-talk and to recognize negative behaviors. The average rating for this indicator was 4.3 in 2006 (in the range of "complete implementation"), compared to 3.8 in 2005.

> ***Key Finding*** *– As in the prior administration of the CBT Checklist, project clinicians more consistently adhered to the therapeutic model regarding affective education than substance use and abuse. Levels of adherence for both indicators were substantially higher in 2006 than 2005 (**Figure 2**).*

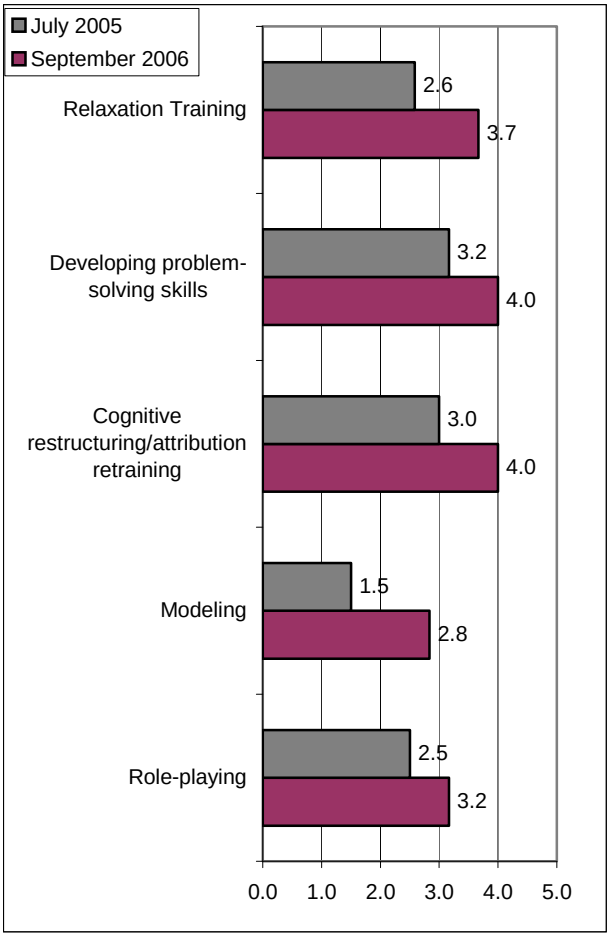
Program Area III: Implementation Indicators of CBT Treatment Strategies

The *Checklist's* third grouping of indicators includes five essential elements of CBT's treatment strategies, and their attendant strategies, including: (1) relaxation training; (2)

developing problem-solving skills; (3) cognitive restructuring/attribution retraining; (4) modeling; and (5) role-playing.

> ***Key Findings*** *– Across all indicators related to treatment strategies, project clinicians made substantial improvements in levels of adherence to the CBT model.*
>
> *However, as in 2005, there remains considerable room for improvement regarding implementation of modeling and role-playing techniques (**Figure 3**).*

Figure 3
Treatment Strategies:
Implementation of Key Indicators



In 2005, the clinicians reported implementing only one-half of the component strategies related to the relaxation training indicator; respondents to the September 2006 administration of the *CBT Checklist*, however, reported implementing 96% of the strategies. In addition, clinicians indicated that in 2006 13% of strategies were being employed at the highest level, compared to 8% in 2005. The average final rating regarding the relaxation training indicator improved dramatically, from 2.6 to 3.7. According to interviews with the staff and comments reported in the *CBT Checklist*, a great deal of the improvement in the level of implementation in this area was due to targeted training and technical assistance and the incorporation of Heart Math, which the clinicians found to be of particular utility.

All the MOST-TACT clinicians reported "complete implementation" of the indicator related to helping the client develop problem-solving skills (a rating of "4"). All four component strategies related to this indicator are being implemented by all the project clinicians, with 25% of strategies were being employed at the highest level, compared to none in 2005.

Project clinicians reported an average adherence level of "4" (complete implementation) with the indicator related to helping the client develop more adaptive cognitions (cognitive restructuring/attribution retraining). In both 2005 and 2006, 95% of the three component strategies related to this indicator were reported as being implemented. 22% of the strategies were employed at the highest level in 2006, compared to none in 2005. Several practitioners indicated that they would benefit from additional training in techniques that assist youth in replacing distorted and/or deficient cognitions with more adaptive and accurately attributed ones, particularly when outside the counseling setting.

As in the 2005 administration of the *CBT Checklist*, the three implementation indicators with the lowest level of adherence to the CBT model involve developing and using program workbooks (see **Figure 1**), modeling (where the therapist helps clients acquire, facilitate, reduce

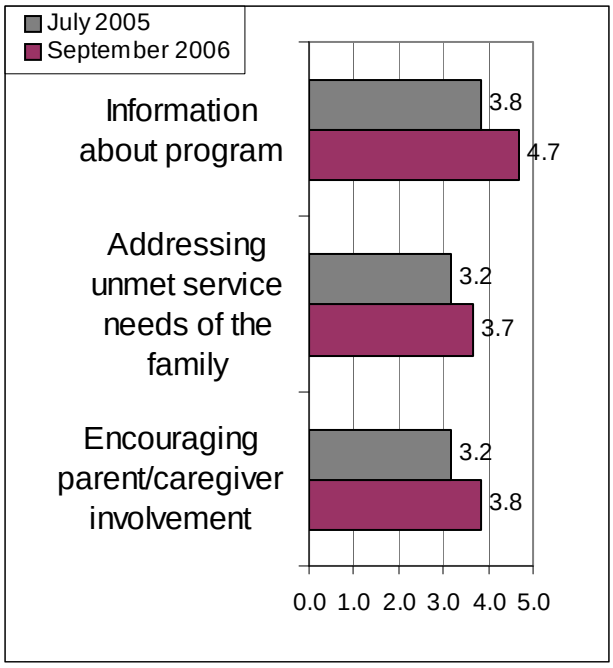
or eliminate behaviors through repeated observation and discussion of depicted behaviors), and role playing (where the therapist and the client act out scenarios to provide an opportunity for the client to practice coping skills and to utilize a problem-solving approach to difficult situations; see **Figure 3**). In September 2006 the average rating for modeling was 2.8 (compared to 1.5 in 2005) and for role-playing it was 3.2 (compared to 2.5 in 2005). Regarding modeling, in 2005, 11% of the three component strategies related to this indicator were reported as being implemented; in 2006, 61% were implemented. Each practitioner indicated a need to gain additional expertise in one or the other of the different modeling techniques (symbolic, live, and participant). Regarding the two component strategies of role-playing, project clinicians reported implementing them all in 2006 (compared to 83% in 2005). Most of the project clinicians indicate that they would benefit from more training and technical assistance in this strategy.

Program Area IV: CBT Implementation Indicators Regarding Working with Family Members

The *Checklist's* fourth and final grouping of indicators encompasses three essential elements, and their attendant strategies, that are related to working with families, including: (1) providing information about the program; (2) addressing unmet service needs of the family; and (3) encouraging parent/caregiver involvement in the intervention.

***Key Finding** – The project clinicians reported a high level of moderate to complete implementation of the program model with respect to working with family member. Levels of adherence to this area of the CBT model increased substantially from 2005 to 2006.* (**Figure 4**).

Figure 3
Treatment Strategies:
Implementation of Key Indicators



Project clinicians reported average final ratings of 3.7 to 4.7 for the three implementation indicators related to working with families, with the highest rating reported for the indicator involving review of the treatment program with parents/caregivers. Levels of adherence to the CBT model in the area increase substantially from July 2005 to September 2006.

In both 2005 and 2006, more than 9 in 10 of the component strategies were being implemented. In both administrations of the *CBT Checklist* clinicians noted that some families were resisting any involvement in service planning and supporting the CBT counseling at home. A majority of the project staff acknowledged that while family involvement was being encouraged, more training and technical assistance could be provided to improve the degree to which families were involved.

Conclusion

Even though one-third of the respondents to the September 2006 administration of the *CBT Checklist* were relative newcomers to the MOST-CSAT model, it is apparent that the project, as administered by Cayuga County Community Mental Health Center and the Partnership for Results, has reached a level of great maturity regarding fidelity to the CBT model. The highly structured components of the MOST model, coupled with ongoing training, technical assistance, and clinical supervision have resulted, for each of the 16 indicators of the *Checklist*, in a substantial increase in levels of adherence to the model. On average, indicator ratings increased 29%, with a minimum increase of 13% and a maximum increase of 89%. In addition, clinicians implemented a far greater number of the component strategies and did so with an increased level of proficiency.

The Youth Policy Institute, Inc. is conducting the external evaluation of the Cayuga County MOST-TACT initiative.

Comments or questions regarding this edition of the *MOST Reporter*, in particular, or the evaluation, in general, should be directed to:

Youth Policy Institute
38 Payne Street
Hamilton, New York 13346
(315) 824-0530
Youthpi@twcny.rr.com