

CBITS at Echo Glen Children's Center

A Pilot Implementation

Won-Fong Lau-Johnson, PhD, NCSP

Echo Glen Children's Center
University of Washington
Division of Public Behavioral Health and Justice Policy
Psychiatry and Behavioral Sciences

Brief Background

- Youth involved in juvenile justice system have higher rates of trauma exposure and sx's than youth in general population
- In one study, over half of detained youth reported exposure to 6 or more traumatic events (Abram, 2004)
- Another found around 90% of youth reported trauma exposure, with over half reporting their first trauma exposure before the age of 5 (Dierksing, 2013)
- Approximately 70% of adjudicated youth meet criteria for a mental health disorder, and about 30% meet criteria for PTSD

Trauma-Related Disorders and Symptoms Overview



Types of Trauma

- Abuse (physical and sexual)
- Neglect
- Witnessing interpersonal violence
- Motor vehicle accidents
- Experiences of natural disasters
- Conditions of war
- Dog bites
- Invasive medical procedures

DSM-5: Posttraumatic Stress Disorder

- PTSD Criteria applies to those 6 years and older
- Criteria A: Exposure to actual or threatened death, serious injury, or sexual violence in one or more of the following ways:
 - Directly experiencing the traumatic event(s)
 - Witnessing, in person, the event(s) as it occurred to others
 - Learning that the traumatic event occurred to a close family member or close friend.
 - Experiencing repeated or extreme exposure to aversive details of the traumatic event(s)

Trauma-Related Disorders

Disorder Name	Category in DSM-IV-TR	Now in DSM-5
Reactive Attachment Disorder	"Disorders Usually First Diagnosed in Infancy, Childhood, and Adolescence."	"Trauma and Stressor-Related Disorders"
Disinhibited Social Engagement Disorder		"Trauma and Stressor-Related Disorders"
PTSD	"Anxiety Disorders"	"Trauma and Stressor-Related Disorders"
Acute Stress Disorder	"Anxiety Disorder"	"Trauma and Stressor-Related Disorders"
Adjustment Disorders	"Adjustment Disorders"	"Trauma and Stressor-Related Disorders"

Criterion B: Intrusion Symptoms

- Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s)
- Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s)
- Dissociative reactions (e.g. flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring
- Intense or prolonged psychological distress at exposure to internal or external cues
- Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s)

Criterion C: Avoidant Symptoms

- Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:
 - Avoidance of or efforts to avoid external reminders
 - Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s)

Criterion D: Negative Alterations in Mood or Cognitions

- Inability to remember an important aspect of the traumatic event(s)
- Negative thoughts about one's self or the world
- Distorted sense of blame for one's self or others, related to the event
- Being stuck in severe emotions related to the trauma
- Severely reduced interest in pre-trauma activities
- Feeling detached, isolated, or disconnected from other people

Criterion E: Increased Arousal Sx's

- Difficulty concentrating
- Irritability, increased temper or anger
- Difficulty falling or staying asleep
- Hypervigilance
- Being easily startled

Criteria F, G, and H

- These criteria each describe the severity of the sx's listed throughout Criterion A through E
- In summary, each symptom have to have lasted at least a month, seriously impact one's ability to function, and cannot be due to substance use, medical illness, or anything besides the event itself

PTSD: Children 6 and Younger

- DSM-5 introduced a preschool subtype
- Young children have emerging cognitive and verbal expression abilities
- Criterion A is the same
- Criterion B: Intrusion sx's (minor changes)
- Criterion E, F, G are essentially the same

Criterion C: Avoidance (6 and younger)

- Most significant changes in this criteria for preschool children in this section
- DSM-5 only requires ONE symptom in either the avoidance or negative alterations in mood and cognitions

Criterion D: Increased Arousal Sx's

- Few changes were made for preschool-age
- These are the most observable and behavioral types of sx's, and somewhat "easier" to detect in younger children
- "Irritability or outbursts of anger" was modified to include "extreme temper tantrums" to be more reflective of children younger than 6 experiencing sx's of PTSD

Racial/Ethnic Disparities in Juvenile Justice System

- Racial disparities among adjudicated youth have increased in the last decade although youth incarceration has declined (Sentencing Project Report, April 2016)
- Emerging literature on "racial trauma," arguing that experience of racism could lead to PTSD symptoms (Carter, 2007; Chae, Lincoln, & Jackson, 2011)
- Vital to increase cultural awareness and understanding among staff who work directly with adjudicated youth
- Also important to engage in meaningful conversations with youth around these challenging topics with regards to the impact on their lives

Echo Glen Children's Center

- High rates of mental health disorders and behavioral health needs (including PTSD symptoms), suicidality, disruptive behavior, emotional and behavioral dysregulation, inconsistent motivation for change, and low social and problem-solving skills
- Serves many youth of color
- Utilizes Integrated Treatment Model (based on CBT), and Dialectical Behavior Therapy (DBT) to provide foundational skills
- Need for treatment that specifically targets trauma

Cognitive Behavioral Interventions for Trauma in Schools (CBITS)

- Evidenced-Based Treatment (OJJDP and NIJ noted CBITS as an exemplary program, also on WISPP list)
- CBITS is comprised of:
 - TEN child group sessions to address trauma symptoms
 - One to Three individual child sessions for exposure to trauma memory and treatment planning
 - Two parent outreach sessions on education about trauma and support
 - One teacher session including education about detecting and supporting traumatized students

Proposed Model for Assessment and Treatment of Trauma at Echo Glen Children's Center

March 2017

Tier 3:

Youth who require more intensive treatment to be offered Trauma Focused-CBT (TF-CBT) or Integrative Treatment of Complex Trauma (ITCT) delivered by a psychologist or psychiatrist.

Tier 2:

Youth who qualify for more trauma-focused treatment are offered the opportunity to participate in a trauma skills' group, CBITS*, as delivered by direct care staff and supervised by a psychologist.

Tier 1:

All youth who enter Echo Glen obtain: DBT Foundation Skills as delivered by direct care staff and Mental Health Assessment and Screening for Trauma, as conducted at intake by a psychologist.

*CBITS is an evidence-based intervention and a pilot implementation will be conducted April 2017 to September 2017. A larger roll-out of the training and implementation is anticipated to be conducted in October of 2017. Dr. Lou will be leading the training and implementation of CBITS.

Wen-Fang Lou Johnson, Ph.D., NCSP
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CBITS Pilot: Primary Goals

1. Examine feasibility of training model for direct care staff to implement CBITS intervention with a pilot group (4 cottages, 2 direct care staff from each)
 - April to August 2017
 - Fidelity checks conducted
 - Pre/Post data collected on the youths' measures
2. Examine if there is a reduction of trauma-related symptoms after CBITS
3. Examine if there is a reduction of other mental health-related symptoms after CBITS
4. Following pilot implementation, develop necessary adaptations to CBITS for adjudicated youth and obtain feedback from staff and youth

Overall Long-Term Objectives

1. Develop a formalized approach to screening, assessing, and treating youth in juvenile justice who indicate trauma exposure and trauma-related symptoms.
2. Provide a training model that is effective in training direct care staff who work with youth in juvenile justice settings in CBITS.
3. Develop guidelines around adapting the use of CBITS with adjudicated youth, and youth of color.
4. Create a module focused on building cultural awareness and promoting tolerance that is taught to the youth who participate in CBITS, and delivered by the direct care staff.
5. Finalize a training model that is effective in training various service providers (e.g. parole officers, counselors, case managers).

Pilot Group: Echo Glen Staff for CBITS



Participants: Staff

- Nine participated in formal, 2-day CBITS training
 - Seven females, two males; and six Caucasian females, one bi-racial female and two Caucasian males
- Seven implemented and facilitated a group
 - Of these seven, two males, five females
 - All identified as Caucasian
 - All held at least a Bachelor's degree
 - Five as case managers, two as program supervisors, one was a program manager
- Six of them operated in pairs, and one implemented a group independently

Participants: Youth

- 26 initial participants, with 24 that completed entire CBITS program
- Two of the participants completed first 3 CBITS session, discontinued for different reasons
- Of the 24 who completed CBITS, 17 were female and 7 were male
- Ranged from 12-18 years of age
- The racial/ethnic composition of the youth was diverse.
 - 5 as Mexican-American, 5 as bi-racial (comprised of African-American/Mexican-American, African-American/Caucasian [2], Native-American/African-American, Mexican-American/Other), 3 identified as Multiracial, 1 identified as Hawaiian, 1 identified as African-American, 1 identified as Native American, and 8 identified as Caucasian.
- 11 out of 24 participants had an IEP.
- 15 out of 24 reported they were gang-affiliated.
- The youth participants were not required to meet diagnostic criteria for PTSD to participate. It is important to note that all of the youth had more than one traumatic event they had experienced, but were asked to focus on only one for the group.

Measures

- There were five measures used for this pilot implementation:
 1. Cognitive Behavioral Intervention for Trauma in Schools- Fidelity Adherence Measure
 - 0-3 scale for all sessions
 - Random checks, average 4 per group
 2. UCLA PTSD Reaction Index: DSM-V Version
 3. Behavior Assessment System for Children, Third Edition (BASC-3), Self-Report of Personality Form
 - Anxiety, Depression, Somatization, Attention Problems, Hyperactivity, and Locus of Control
 4. Group Evaluation Post-Test (Youth)
 - Seven open-ended questions
 5. Training Evaluation Form (Staff)

Procedure: Training and Consultation Outline of Pilot CBITS

- CBITS/NCTSN guidelines recommend at the very least, clinical mental health training (often those with a Master's and license to practice)
- Common approach is 2-day training, then receive ongoing supervision
- Focus of pilot project was to adapt CBITS curriculum to for JR setting and the training model
- Pilot implementation included:
 - 2-day live training with certified CBITS trainer
 - Bi-weekly consultation (live) immediately following training
 - On-site availability for group facilitators as needed
 - Groups to be conducted on Tuesday evenings, with option of audio recording if needed (limited equipment available)

Selecting Group Facilitators

- Collaboration with administration to select 4 out of 9 cottages to start
- Requested program managers to select 2 staff members to participate that would commit to the training, consultation, and implementation of at least one group

Selecting Youth Participants

- Reviewed UCLA screener results from intake (PREA guidelines require trauma screener within first 7 days of intake)
- Also examined past residents that would benefit; some received the UCLA screener specifically to determine CBITS eligibility & consistency with data
- After careful review, engaged in consultation with staff to form groups
- Very important to consider group dynamics, especially in this setting (e.g. two youth from conflicting gang affiliations, difference in cognitive ability, difference in age, etc.)

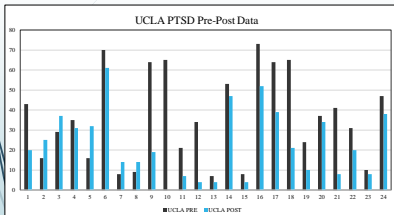
Adaptations

- Training model was adapted
- Development of DBT/CBITS alignment (hand-out provided at the 2-day live training)
- Initial goal to include additional content on culture/race, however significant constraints during pilot thus focus on adapting CBITS with DBT, as well as carrying out the implementation of CBITS with direct core staff was conducted

Results: CBITS Fidelity Measure

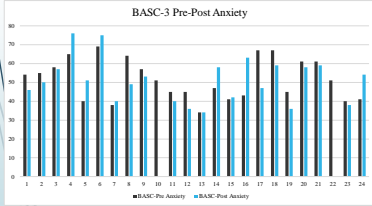
- Average of 4 randomly selected sessions, per cottage, were assessed
- Total of 5 groups were conducted, thus 20 fidelity checks were conducted (16 were in-person, 4 were via listening to an audio recording)
- CBITS trainer rated (on 0-3 scale) the extent to which each sessions' content was delivered with fidelity
- Results indicated an overall average of 80% of the content was delivered
- Examined sessions 1, 2, 3, 4, 5, 6, and 8
- All groups achieved an average of 75%(+), with highest being 84%
- No individual sessions were observed/rated
- Only one group exposure session was rated

Results: UCLA PTSD Measure (Youth)



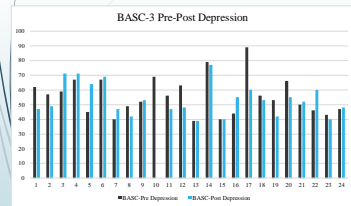
- 11/24 met PTSD Dx
- 3 of these 11 continued to after CBITS
- Overall, 18/24 showed decrease after CBITS
- 4/24 showed increase
- 1/24 remained the same
- 1/24 did not obtain data

Results: BASC-3 Anxiety



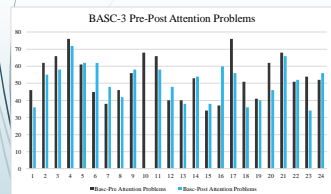
- 60+ = at-risk;
- 70+ = clinically significant
- 7 had 60+: of these, 5 of their scores decreased and 2 increased
- Overall, 9/24 decreased, 5/24 increased, 2/24 remained same, 1/24 did not obtain data

Results: BASC-3 Depression



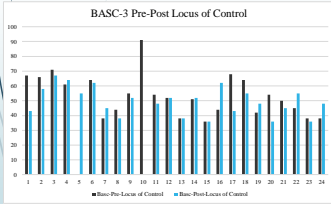
- 60+ = at-risk;
- 70+ = clinically significant
- 8 had 60+
- Overall, 11/24 decreased, 8/24 increased, 4/24 remained same, 1/24 did not complete data

Results: BASC-3 Attention Problems



- 60+ = at-risk;
- 70+ = clinically significant
- 8 with 60+, of these, 6 decreased, 1 increased, 1 did not complete post-assessment
- 12/24 overall decreased, 6/24 increased, 5/24 remained the same

Results: BASC-3 Locus of Control



- 60+ = at-risk;
- 70+ = clinically significant
- 7 had 60+; of these, 6 of them decreased, 1 did not complete post-assessment
- Overall, 12/24 decreased, 5/24 increased, 5/24 remained the same, 1/24 could not be calculated due to response pattern

Results: Group Evaluation

- All 24 able to identify at least 3 common reactions to a traumatic event and at least 3 coping skills
- Overall, all recommended CBITS for same-age peers
- Review Appendix A for detailed responses (handout)

Results: Training Evaluation

- Administered after 2-day training and after all CBITS group were implemented
- For the 2-day training:
 - 2-day training was a positive experience for all, with 95% rating or higher on the training experience
 - Open-ended responses provided feedback (see Appendix B)
- After completion of CBITS, staff completed 7 open-ended questions
 - Overall, all recommended CBITS for youth in juvenile justice
 - Found training/consultation to be beneficial and positive experience
 - See Appendix C

Discussion

- Overall, this pilot study indicates promising results for CBITS to be used in Juvenile Justice
- Staff demonstrated the ability to deliver the content with at least 75% fidelity to the model
- While 17% of the participants' UCLA data indicated an increase in their trauma-related symptoms, these students qualitatively reported a significant increase in their ability to cope with these trauma-related symptoms as indicated on the group evaluation form post-CBITS
- The results from the BASC-3 Self-Report measure indicated that approximately 50% of the youths' symptoms of depression, attention problems, and locus of control decreased after participation in CBITS. For the anxiety sub-scale, approximately 38% of their scores decreased after participation in CBITS.

Discussion (cont'd)

- First, the youth were asked to focus on only one traumatic event for the group. PTSD-related symptoms such as anxiety could persist following participation when other events are not addressed (Foa, Riggs, and Gershuny, 1995; Jaycox et al., 2009)
- CBITS curriculum advises against discussion of sexual abuse or assault especially for group facilitators' first experience
- While the youth who identified sexual abuse and/or assault as their most bothersome traumatic event, they were asked to focus on a different event.
- Lingering anxiety or other related PTSD symptoms such as depression or locus of control may have either remained the same or increased following group as they became more aware of the impact of PTSD (Greeson et al., 2001; Griffin et al., 2003)

Limitations

- Must interpret results of pilot study with limitations in mind
- First, this is not a controlled study thus limiting generalizability of the findings
- Second, there were no comparison groups
- Third, fidelity checks were conducted at random

Recommendations

- Larger effectiveness study
- Recommended to address limitations outlined from pilot study
- Examine characteristics of group facilitators (low to high motivation)
- Sexual abuse protocol needed
- Fidelity checks to include recordings of all sessions including individual sessions and the same check for each facilitator
- Basic versus advanced

Conclusion

- Overall, positive experience for all involved
- Data indicates youths' scores improved and qualitatively reported it was a beneficial experience
- Staff report CBITS addresses a critical gap in treatment
- We need to better understand implementation process & service delivery of evidence-based trauma interventions in JR population
- Tremendous EBP research, few in JR settings

A strong joint effort and relationship between local and state-level stakeholders involved in juvenile justice is essential to continue this work and allow for the opportunity to examine the feasibility of working with staff who serve youth in the juvenile justice system in an effective manner.



Questions? Thoughts? Thank you

Won-Fong Lau-Johnson, PhD, NCSP
fongj@uw.edu
