FINAL REPORT
BCPS-2021 TF-CBT Training

NATIONAL MASS VIOLENCE VICTIM RESOURCE CENTER
BROWARD COUNTY PUBLIC SCHOOLS

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BROWARD
County Public Schools

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Final Report: BCPS-2021 TF-CBT Training

START DATE: JANUARY 2021
END DATE: JULY 2021
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INTRODUCTION

Broward County Public Schools (BCPS) and the National Mass Violence Victimization Resource Center (NMVVRC)'s Training and Education Division, partnered to provide training in Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) for mental health providers serving schools within BCPS. The two goals of the training were to:

1. Train therapists to deliver TF-CBT with a high degree of adherence and fidelity to the model.
2. Increase the number of students who received TF-CBT.

THE NATIONAL MASS VIOLENCE VICTIMIZATION RESOURCE CENTER

The National Mass Violence Victimization Resource Center (NMVVRC; www.nmvvrc.org) at the Medical University of South Carolina was established in October of 2017, in partnership with the Office for Victims of Crime within the Office of Justice Programs, U.S. Department of Justice. NMVVRC goals are to develop, maintain, and deploy tools and strategies, engage communities and the nation, and build capacity to support victims, families, first responders, and communities affected by MVIs through training and technical assistance, education, technology, community and victim response, and related activities.

The NMVVRC has three divisions, each with objectives and deliverables:

- *The Training and Education Division:* develop and provide education, training, and related resources to victims, as well as criminal justice, victim service, and mental health professionals and other stakeholders, to build capacity and resilience related to mass violence and terrorism.
- The *Technology Resources and Product Development Division:* leverage technology to develop and deliver a variety of services and products that support victims, communities, victim service providers, first responders, and other stakeholders involved in mass violence and terrorism planning and response.
- The *Response and Recovery Division:* support victims and communities affected by mass violence and terrorism incidents directly and indirectly.
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BROWARD COUNTY PUBLIC SCHOOLS

In February 2018, a shooting occurred at Marjory Stoneman Douglas (MSD) High School, a Broward County Public School (BCPS), that resulted in 17 deaths, an additional 17 injuries, as well as countless emotional and psychological injuries. With nearly 261,000 students, BCPS is the 6th largest school district in the nation and the second largest in the state of Florida. Students at BCPS continue to struggle with the impact of this shooting. This prompted BCPS to contact the NMVVRC to inquire about opportunities to train mental health providers, working within the BCPS schools, in TF-CBT to meet the needs of their students.

In response, the *NMVVRC Training and Education Division* partnered with BCPS to conduct two training initiatives that began in January 2021: (1) Training of a new cohort of social work interns and family therapists (n = 24) in delivery of TF-CBT, that is the focus of this report, and a (2) TF-CBT booster with school-based family therapists (n=18). Of note, family therapists participating in this booster training had attended a prior learning collaborative in TF-CBT that was conducted by the NMVVRC in Fall 2018 in the more immediate aftermath of the school shooting. The TF-CBT booster included a two-hour review of the treatment model, conducted virtually on February 4, 2021, with a focus on the most challenging components. We then offered four monthly small group consultation calls (3/1, 3/15, 4/19 and 5/17/2021).

This report focuses on the new TF-CBT cohort, which included three half-days of training in the model (1/19, 1/20, 1/29/2021), delivered remotely, followed by 12 bimonthly small group consultation calls (two groups, 12 participants per group), with the requirement for participants to complete a minimum of 9 calls across the six-month period. In addition to these training activities, surveys were administered at the beginning and end of the training. Questions were asked to obtain feedback about the specific training strategies and to assess the impact of training on participants' clinical practices, knowledge, and perceived skill in delivering TF-CBT. The survey also included a series of questions to assess the impact of the COVID-19 pandemic and the use of a telehealth platform to deliver treatment.
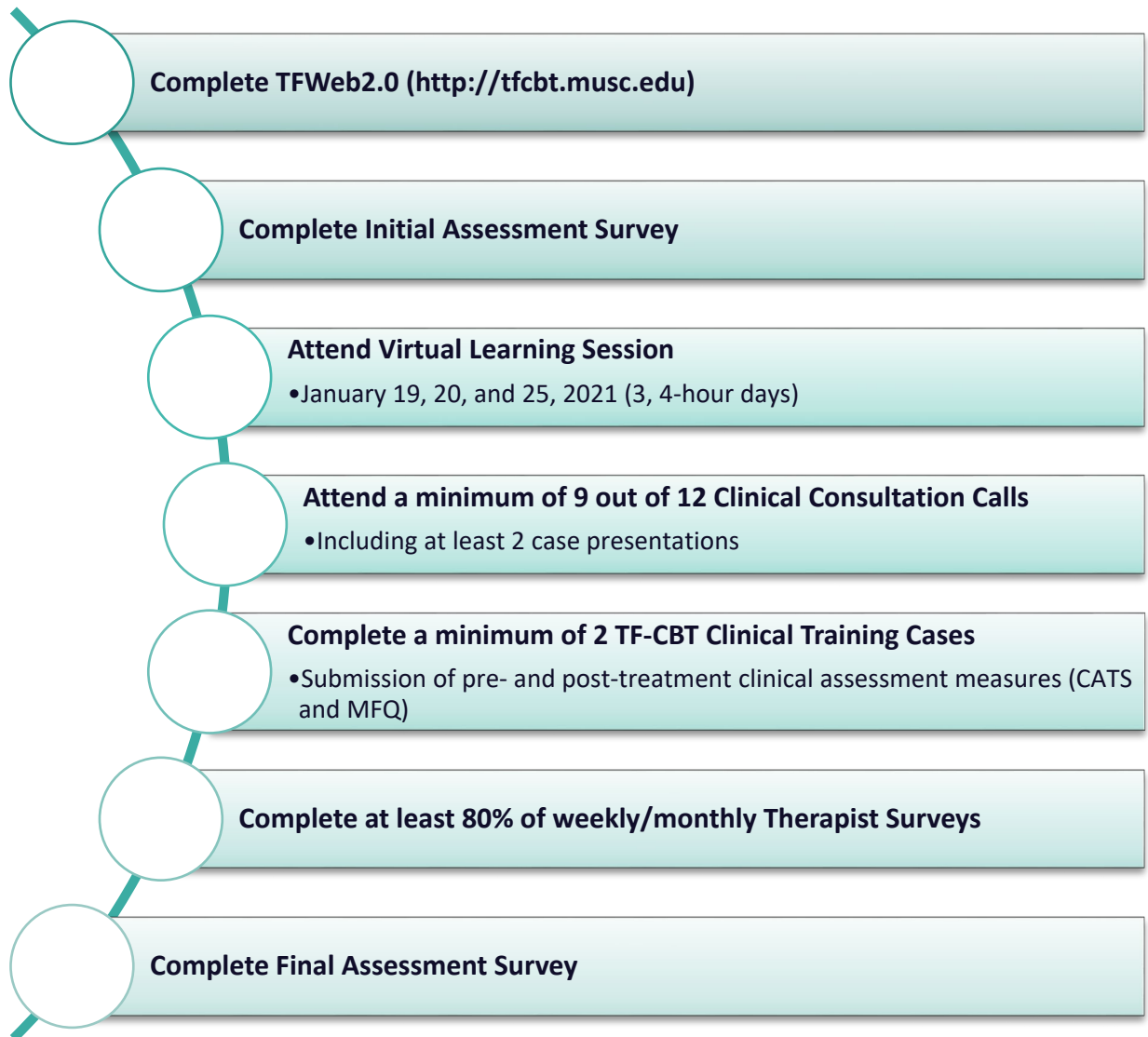
WHY TF-CBT?

Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT: Cohen, Mannarino, & Deblinger, 2017; www.tfcbt.org) is a relatively brief, conjoint child and parent psychotherapy model for children and youth (ages 3-18) who are experiencing significant emotional and behavioral difficulties related to traumatic life events. It is a components-based treatment model incorporating the development of stress management and reduction skills, affective and cognitive processing skills, safety skills, and parenting skills, along with gradual exposure and trauma processing techniques. TF-CBT uses weekly treatment sessions and is typically completed in 12-20 sessions. TF-CBT is one of the most well-supported, evidence-based treatments for children experiencing symptoms of posttraumatic stress disorder, trauma-related depression, traumatic grief, and trauma-related behavior problems. Over 20 randomized controlled trials have found TF-CBT to be superior to other treatments in significantly reducing trauma-related symptoms and problems. TF-CBT has been found to be effective with children and families from a diverse array of racial, ethnic, and

national origin groups who have experienced many different types of trauma, including those with complex trauma backgrounds. Randomized trials conducted in the U.S., Africa, Europe, and Asia have found similar results with diverse traumatized populations, including victims of sexual abuse, physical abuse, witnessing violence in the home, community, natural and man-made disasters, and child soldiers. At the present time, TF-CBT is one of the most effective and widely disseminated mental health treatments for trauma-related problems among children and youth, and it can be learned and delivered effectively by therapists working in an array of community service systems, including schools.

COMPLETION REQUIREMENTS

To receive a BCPS-2021 Certificate of Completion, participants needed to complete ALL of the following requirements:

Complete TFWeb2.0 (http://tfcbt.musc.edu)

Complete Initial Assessment Survey

Attend Virtual Learning Session
- January 19, 20, and 25, 2021 (3, 4-hour days)

Attend a minimum of 9 out of 12 Clinical Consultation Calls
- Including at least 2 case presentations

Complete a minimum of 2 TF-CBT Clinical Training Cases
- Submission of pre- and post-treatment clinical assessment measures (CATS and MFQ)

Complete at least 80% of weekly/monthly Therapist Surveys

Complete Final Assessment Survey

TRAINING PARTICIPANT DEMOGRAPHICS

A total of 16 social work interns and eight family therapists participated in the training. Most participants (n=22 responded to the Initial Therapist Survey) were women (91%); most identified as White (50%), with 41% identifying as African American, and 9% as more than one race. Of the 22 participants, eight identified as Hispanic. Participants ranged in age from 22 to 53 (M = 31.5, SD = 8.8). Participants reported a range from one to 16 years in their experience providing treatment focused on posttraumatic stress, with an average of nearly four years (M = 3.8, SD = 4.8).

SUMMARY OF TRAINING REQUIREMENTS COMPLETION

> 100% Attended the Virtual Learning Session
> 91.7% Completed the Initial Assessment Survey
> 54.2% Completed the Final Assessment Survey (8 Family Therapists; 5 Interns)
> 81% was the average attendance rate for Clinical Consultation Calls
> 34% was the average completion rate for Weekly Therapist Metric Surveys
>> o **Note**: The low response rate for metrics completion was mainly due to the fact that the interns did not have the opportunity to provide therapy and thus did not have any training cases.
> **50% of the family therapists completed all training requirements, but none of the interns were able to, because of their inability to provide therapy and deliver TF-CBT**.

PARTICIPANT FEEDBACK ABOUT THE TRAINING

As seen in Table 1 below, participants were quite positive about the virtual learning session. The overall rating about training quality and utility was 89 on a scale from "0 = *Poor"* to "100 = *Outstanding*." Participants were also asked about their favorite and least favorite parts of the learning session. Several commented on the helpfulness of small group breakouts and the opportunity to practice skills.

Some favorable comments from participants include the following:
> *"The facilitators broke the process down in to manageable pieces. Gave very concrete examples and reexplained or gave examples when we did not understand. "*
> *"Feedback was very good as well. I really enjoyed this training."*
> *"I felt very comfortable asking questions. It was a very open learning environment."*
> *"The trainers were personable and helpful."*
> *"I loved being able to hear real life examples from participants and using those examples to better understand how to incorporate TF-CBT. Hearing how the trainers analyzed these cases using the TF-CBT model and created conversations among the participants was very helpful."*

Some of the least favorable components were related to logistics (e.g., "not enough breaks"; and "not enough small group breakout sessions"). In addition, two participants identified the virtual format (i.e., via Zoom) as their least favorite aspect of the training.

TABLE 1

LEARNING SESSION EVALUATIONS (N=13)	Mean	Std. Deviation
Training Materials/Handouts	3.7	0.5
Learning Session was well organized	3.7	0.5
Trainer was highly knowledgeable about TF-CBT	3.5	1.1
Trainer communicated information in a way that was easy to understand	3.8	0.4
Training was interactive in approach	3.6	0.6
Training engaged me in learning	3.5	0.7
Training examples, case presentations, and activities related to the types of trauma cases I see	3.5	0.7
Overall, the training was effective in helping me learn TF-CBT	3.8	0.4

All Variables: 0=Strongly Disagree; 1=Disagree; 2=Neutral; 3=Agree; 4=Strongly Agree

As seen in Table 2 below, participants also found the different strategies implemented in the training to be very helpful. The "least helpful" training component was completion of the weekly Metrics. Of note, these metrics involved weekly surveys administered via REDCap to assess participants' TF-CBT caseloads, barriers to treatment delivery, receipt of supervision or peer consultation, and their perceived competence in delivery of the TF-CBT treatment components (rated on a scale of 0 = "not a focus" to 5 = "expert skill").

THERAPIST LEARNING COLLABORATIVE ACTIVITIES

TABLE 2

LEARNING COLLABORATIVE ACTIVITIES (N = 13)	Mean	Std. Deviation
TF-CBT Web 2.0	3.5	0.8
Training (Learning Sessions)	3.2	0.7
Roleplays (Learning Sessions)	3.3	0.9
Q & A (Learning Sessions)	3.4	0.7
Learning to overcome barriers	3.3	0.8
Learning family engagement strategies	3.3	0.8
Large group discussions	3.2	0.8
Use of standardized assessments	3.2	0.8
Training cases in your daily work	3.2	1.1
Website	3.2	0.9
Consultation calls	3.5	0.7
Learn about application of delivery	3.6	0.5
Learn to overcome barriers to delivery	3.6	0.5
Hearing about peer training cases	3.6	0.5
Completing weekly metrics surveys	2.6	1.3

All Variables: 0=Not Helpful; 1=Somewhat Helpful; 2= Helpful; 3=Very Helpful; 4=Highly Helpful

PARTICIPANT EVALUATIONS OF CLINICAL CONSULTATION CALLS

Overall feedback about the consultation calls was quite positive, with an average of 94.4 (SD = 7.6) on a scale from 0 = *Poor* to 100 = *Excellent*. Participants indicated that the topics were relevant to their work, that the calls were helpful in addressing behaviors and applying knowledge and skills to deliver TF-CBT, and that they were positive about the consultants.

TABLE 3

CONSULTATION CALL EVALUATIONS (N=13)	Mean	Std. Deviation
Issues and topics discussed were relevant to my work	3.8	0.4
Effective in helping me identify and overcome barriers	3.8	0.4
Effective in answering my questions about issues in my daily work	3.8	0.4
Helped me better apply my knowledge and skills	3.6	0.6
The calls were well-organized	3.8	0.4
The consultant was highly knowledgeable about TF-CBT	3.8	0.4
The consultant communicated in a way that was easy to understand	3.8	0.4
The consultant listened to participants and provided feedback in a respectful and helpful manner	3.8	0.4
The consultant engaged me in learning	3.8	0.4
Overall, the calls were effective in helping me learn TF-CBT	3.8	0.4

All Variables: 0=Strongly Disagree; 1=Disagree; 2=Neutral; 3=Agree; 4=Strongly Agree

IMPACT OF THE TRAINING ON PARTICIPANT PRACTICES, KNOWLEDGE, AND PERCEIVED SKILL IN DELIVERING TF-CBT

As noted in the Introduction, participants completed surveys at the beginning and end of training to examine whether there were any changes in knowledge, practice and/or perceived skill in delivering TF-CBT. TF-CBT knowledge increased from pre to post training, with an average 47.9% (SD = 0.12) items answered correctly at pre, and 66.8% (SD = 0.13) correct at post. While this was an improvement in their knowledge, it is important to note that they were still only answering two-thirds of the questions correctly, suggesting that additional education/training may be needed.

Participants also evidenced improvement in their perceived skill in delivery of TF-CBT [(Pre-training: n = 21; M = 80.6, SD = 33.6) and (Post-training: n = 12; M = 93.9; SD = 25.1)].

As seen in Table 4 below, therapists reported an increase in their reported use of TF-CBT practices from pre to post training.

THERAPIST PRE- AND POST-TRAINING CLINICAL PRACTICES

TABLE 4

CLINICAL PRACTICES QUESTIONNAIRE (CPQ)	Pre-Training		Post-Training	
Sub-Scales	Mean	Std. Deviation	Mean	Std. Deviation
General Therapy Structure/Style	3.5	0.5	4.1	0.5
Psychoeducation	2.0	1.2	4.0	1.5
Personal Safety Skills	2.1	1.2	4.0	1.7
Coping and Stress Management	2.6	1.7	4.1	1.4
Trauma-focused Intervention	3.1	0.4	3.2	1.2
Behavior Management Skills	2.9	1.0	3.0	2.0
CPQ Total Score	2.7	.9	3.7	1.2

IMPACT OF THE COVID-19 PANDEMIC

One of the unique aspects to this training is that it took place in the midst of the COVID-19 pandemic. As a result, we included questions to assess the impact of the COVID pandemic on participant stress levels and professional practices. First, participants were asked to indicate whether COVID-19 increased their stress level, on a scale of 0 = *not at all*, to 100 = *extremely*. While there was considerable range in response, the average score was 52.1 for stress level, and 58.8 for the impact on daily work schedule.

Interestingly, slightly more than half (53.8%) of participants indicated that they do not follow media coverage of COVID-19. When asked what changes were made as a result of COVID-19, 11.8% indicated they had reduced hours, 47.1% reported changes in their workday (such as early morning or late evening hours), and only 5.9% reported working on the weekends. Participants indicated that the COVID-19 pandemic had a relatively minimal impact on their ability to provide TF-CBT. Of the 8 participants who responded to this question, the average answer was 33.4 (SD = 30.0) on a scale from 0 (not at all) to 100 (extremely). Lastly, respondents were asked whether they had concerns about their clients' welfare due to COVID. Of the 11 who responded, the average was 50.2 (SD = 16.9) on a 100-point scale ranging from *not all* to *extremely*.

USE OF TELEHEALTH

Another practice change related to COVID-19 across the United States was an increase in the use of telehealth to deliver mental health services. Participants were asked with what percentage of their clients they were using telehealth, ranging from 1 = *none* to 6 = *81-100%*. Participants indicated an average of 4.7 (SD = 1.8), which indicates that they were providing telehealth to an average of 41-60% of their clients, with the majority of this due to the COVID-19 pandemic. On a

scale of 1 = *not at all* to 5 = *extremely*, there was an average of 4.1, indicating that the use of telehealth was 'highly' due to COVID-19. Participants were asked several additional questions to learn more about telehealth. These responses were rated on a scale of 1 = *strongly disagree* to 5 = *strongly agree*. As seen in Table 5 below, respondents were generally positive about telehealth, endorsing this as an acceptable way to deliver healthcare, and a belief that it can improve access to services. However, they were more neutral in their comparison of telehealth to in-person delivery of treatment.

Participants were asked the degree to which they agreed with the following statements...
TABLE 5

N=21	Initial Survey Mean	Initial Survey Std. Deviation	Final Survey Mean	Final Survey Std. Deviation
Telehealth is an acceptable way to deliver healthcare services	4.1	0.7	4.2	0.7
Telehealth can improve access to mental health services	4.4	0.6	4.7	0.5
I have adequate training to conduct telehealth interventions	3.7	0.9	4.6	0.7
I have the necessary equipment to practice telehealth	4.1	0.6	4.7	0.5
I feel confident in my ability to use telehealth	3.9	0.6	4.7	0.5
I think the quality of my telehealth visits equals my in-person visits	3.0	1.2	3.9	1.1
I feel comfortable communicating with clients via telehealth	3.9	0.7	4.6	0.5
I know how to manage emergencies when they occur during telehealth services	3.3	0.9	4.2	0.7
I feel confident in my ability to provide TF-CBT via telehealth	3.1	1.0	4.3	0.7

All Variables: 1=Strongly Disagree; 2=Disagree; 3= Neutral; 4=Agree; 5=Strongly Agree

Overall, participants endorsed a positive attitude and acceptance of telehealth, which increased over the course of training.

SUMMARY OF CLINICAL TRAINING CASES

The last section of this report summarizes the data related to TF-CBT cases seen as part of the training requirements. As noted in the Introduction, one of the training requirements was to complete at least two cases using the full TF-CBT model. There were 28 cases identified for TF-CBT, ranging in age from 7 – 18, with an average age of 14.8 (SD = 2.8). Approximately one third (35.7%) were identified as White/Caucasian, 42.9% were Black, 3.6% were Asian-American, and 17.9% were defined as "other." Slightly less than half (42.9%) were identified as Hispanic or Latin(o/a/x).

For each identified training case, therapists administered two measures:

> The *Child and Adolescent Trauma Screen* (CATS; Goldbeck & Berliner) is a brief screening instrument based on the DSM-5 criteria for PTSD. Questions assess exposure to 15 potentially traumatic events, 20 items to assess for symptoms of posttraumatic stress, and 5 items to measure psychosocial functioning. There is a self-report version for 7-17-year-old children, and two caregiver versions; one for three-to-six-year-olds and one for 7-17-year-olds. Clinical cut-offs vary depending on the age of the child, with recommendations of 16 or greater for ages three-to-six and 21 or greater for ages 7-17. For this project, we utilized a cut-off of 15+ to capture youth who were experiencing at least moderate levels of posttraumatic stress symptoms. The measure has been demonstrated to have good reliability and validity (Sachser et al., 2017).

> The *Short Mood and Feelings Questionnaire–Short Version* (SMFQ; Angold et al., 1995) assesses depressive symptoms among youth ages 7–18. The SMFQ has child- and caregiver-report versions that evaluate the presence and frequency of 13 depressive symptoms in the past 2 weeks. Depressive symptoms are rated on a 3-point Likert-type scale ranging from "Not True" (0) to "True" (2). Clinical significance is based on the youth's self-report (total score ≥ 8) or the sum of the child and caregiver (combined total score ≥12). Since caregivers are often unaware of a youth's internalizing symptoms, caregiver-report is not utilized alone as a determinant of clinical significance. As such, the SMFQ combined score is utilized for assessing depressive symptoms. The SMFQ has demonstrated good reliability in previous studies (Cheng et al., 2009; Rhew et al., 2010; Sharp et al., 2006).

A total score of at least 15 on the CATS was indicated as the cut-off for clinically significant symptoms of posttraumatic stress. As seen in the Figure below, at the onset of treatment, a significant majority of youth met the criteria for probable PTSD, based on both youth (88.9%) and caregiver report (86.7%). There was also a notable decrease in the percent of youth who met this clinical cut-off post treatment (50% at post for youth report; 30% for caregiver report).

CLINICAL TRAINING PRE- AND POST-TREATMENT MEASURES

Probable PTSD
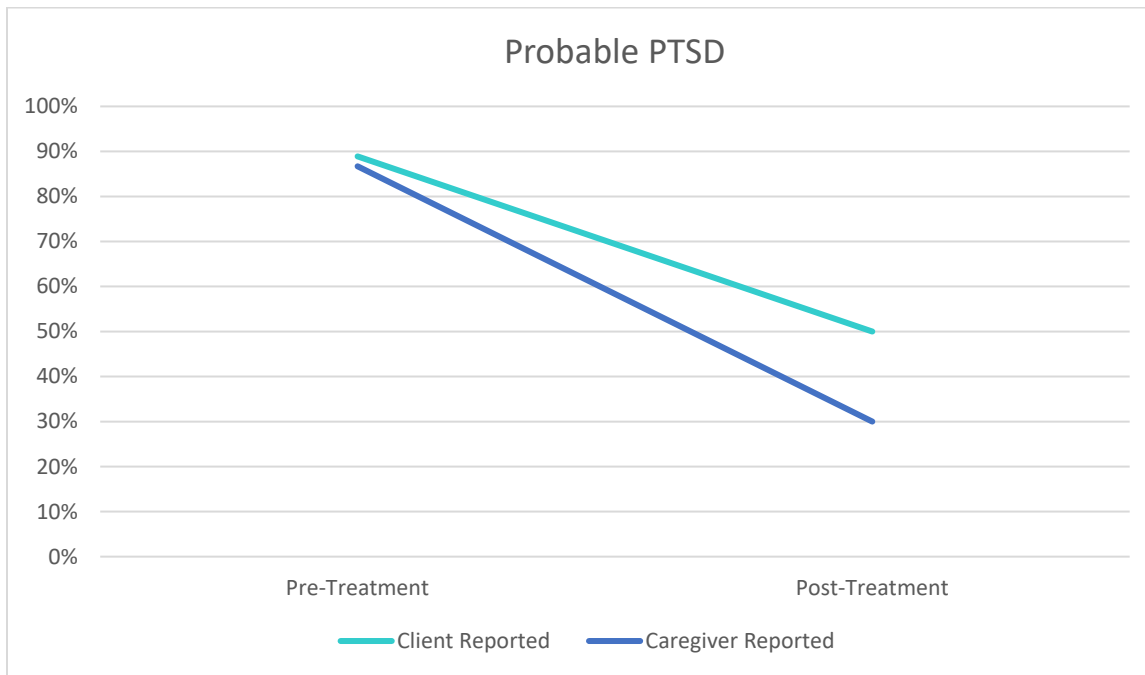
As another way to examine these symptoms, the total CATS score based on youth self-report at the pre-treatment assessment was an average of 32.8 (SD = 13.2); and at post treatment, the average total score had decreased to 11.8 (SD=12.5). A similar pattern was observed for caregiver report (Pre: *M* = 25.9, *SD* = 12.1; Post: M = 3.9, SD = 5.8).

CATS and MFQ Scores Pre and Post Treatment
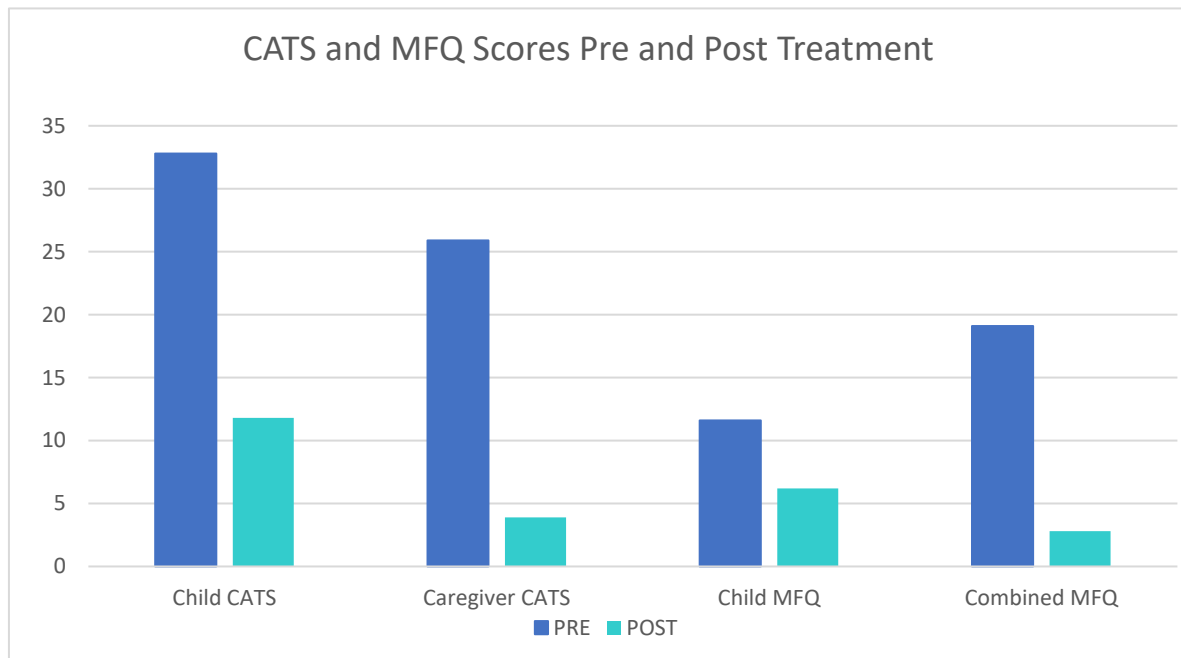
Y-Axis = Mean Score

For depressive symptoms, a total score of 8 on the youth report and a combined youth/caregiver total score of 12 are considered to be clinically meaningful. Youth evidenced reductions in symptoms of depression over the course of treatment, based on youth report [Pre: *M* = 11.6, *SD* = 6.4; Post: M = 6.2, SD=5.6)] and the combined youth/caregiver total scores [Pre: M = 19.1, SD = 9.7; Post: M = 9.6, SD = 8.5].

Simply stated, youth who received TF-CBT had notable reductions in symptoms of posttraumatic stress and depression from pre- to post-treatment.