Translating Evidence Based Practice in a School Board Context

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Acknowledgments
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- **McMaster/Offord Centre**
  - Kathryn Bennett, Ph.D.
  - Stephanie Duda, MSc(c)

- **Hospital for Sick Children**
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- **Peterborough Victoria Northumberland and Clarington Catholic District School Board**
  - Cynthia Chan Reynolds, Ph.D., C. Psych
Thank-you’s:

- Adolescents & their families

- Group Facilitators:
  Jennifer Brady; Rob Godin; Wendy Kelly; Carol Kobesveenstra; Jennifer Legree; Caroline Lemieux; Sharleen Mercier; Shawna Mackellar; Diane McGary; Sandra Reimer; Sandra Shearer; Marnie Titlebaum; Kelly Wills;

- Judi Winkup

- Student volunteers
Outline

- Background Information
  - Prevalence of mental health problems in youth
  - Availability, access & quality of mental health services for youth

- Proposed project

- Methodology
  - 4 steps

- Results
  - 4 steps

- Conclusions
Background information
Child and Adolescent Mental Health

- 14% of Canadian children and youth experience ≥ 1 clinically significant mental health problems
- Most have more than 1 mental health problem
- Anxiety prevalence is highest – 6 to 7%
- Depression prevalence ranks 3rd – 3.5%
- High concordance btw anxiety & depression
- Internalizing disorders increases risk for:
  - substance abuse &
  - suicide
Child & Adolescent Mental Health

- As few as 1 in 5 who are in need of care receive it

- WHY?
  - Availability?
  - Access?
  - Quality?
Availability & Access of Mental Health Services for Youth

- Research into availability, accessibility, & quality: scant

- However, available studies demonstrate that
  - access is unacceptably low
  - as few as 1/5 under 18 years in need of services receive them
  - quality & effectiveness of what is received (in usual care settings):
    - relatively unknown and of concern

- Point of entry for services (US studies):
  - 35-50%: education sector is the 1st point of entry
  - a minority w/ serious mental health problems receive specialty services

- Estimates of retention
  - probability of dropout estimated to be as high as 50%

Farmer et al., 2003; Ford et al., 2008; McKay et al., 2004; Merikangas et al., 2011; Miller et al., 2008; Waddell et al, 2005; Wierzbicki et al., 1993;
Quality of Mental Health Services for Youth

- Even fewer available studies

- Those that exist suggest that:
  - quality of “usual” service is uneven
  - barriers to optimal mental health outcomes are created by
    - large gap btw what know is effective & what we do in the “real” world
  - little attention to whether the services provided are evidence-based
  - services in Canada are fragmented & difficult to access

What We Know

- Cognitive Behavior Therapy (CBT) is the psychotherapeutic treatment of choice for youth with anxiety & mood disorders
  - When delivered by highly trained experts
  - To carefully screened samples
  - Under ideal conditions

- Standard protocols & training models are available

- School-based personnel could learn how to use these methods with appropriate adaptation & support
What We Don’t Know

- How to make CBT consistently available in school settings
- How to make sure that all students who need CBT get it
What is Needed?

- Increased access to mental health services
- Effective services (EBPs)
- Prevention & treatment
- Partnerships
- Better outcomes
Why do we need this project?

- We know CBT works, so why do we need this project?

- Sig. challenges exist in translating knowledge into improved mental health outcomes for youth

Four key challenges:

1. Need for **knowledge implementation models** grounded in emerging KT models;

2. Need to pay attention to **transportability, adaptation, and fidelity** (so that the benefits observed in efficacy research can be transported to community care settings);

3. Providers in usual care settings need **access to training & ongoing supervision** (incl. adolescent specific CBT protocols);

4. Currently we have gaps & opportunities to develop school board capacity to provide mental health interventions
What is Needed to Successfully Implement CBT in Schools

- We need to:
  - understand the barriers & facilitators to effective integration & use in the school system
  - successfully translate & adapt established EBPs into acceptable & feasible collaborative mental health services implementation model
  - address the problem of ‘the hidden morbidity’
  - have more than a one-day training workshop (i.e. on-going consultation)
  - ensure fidelity to the therapy
  - to create an explicit, simple implementation model (that can only be developed through partnership & careful research)
Methodology
4 steps

**Step One:** Qualitative research to understand the school board environment vis à vis:
- mental health personnel,
- current activities to support student mental health,
- potential to provide CBT

**Step Two:** Use that information to develop a feasible, acceptable CBT implementation model;

**Step Three:** Test out the implementation model;

**Step Four:** Receive feedback as to the usefulness from:
- facilitators
- students
- (parents)
Figure 3: Iterative, Consultative Knowledge to Action Process

**Project Advisory Committee**
- Review and Refine Project Goals
- Review Case Study Methods
- Finalize Participants for Key Informant Interviews and Focus Groups

**Project Advisory Committee**
- Conduct Multiple Case Study
- Analyze Case-Study Results

**Project Advisory Committee**
- Review Case Study Results
- Nominal Group Process re Implementation Model Content
- Review and Refine Implementation Model Evaluation Plan

**Project Advisory Committee**
- Conduct CBT Training
- Administer Quiz to Providers
- Conduct Post-CBT Training Focus Groups with Providers and Adolescents
- Analyze and Summarize Post-CBT Training Quiz and Focus Group Content
- Make Final Refinements to Implementation Model based on Post-CBT Focus Group Feedback

**Project Advisory Committee**
- Obtain PAC Input on Implementation Model Changes if Needed
- Review End-of-Grant Knowledge Dissemination Objectives

**Project Advisory Committee**
- Implementation Model Pilot Study
- Collect Evaluation Data
- Analyze Evaluation Data
- Prepare Summaries for Review by PAC

**Project Advisory Committee**
- Review Evaluation Results
- Finalize End of Grant Knowledge Dissemination Objectives and Materials

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Ongoing Iterative Consultative Process
Step 1:

Qualitative research to understand the school board environment
OBJECTIVES

1) Engage the boards:
   - Form steering committee

2) Test our methods (tailored intervention design):
   - Key informant interviews and focus groups
   - Acceptability & feasibility

3) Formulate a ‘straw’ intervention model:
   - Barriers & facilitators
   - What a 3 level change model might look like
Focus Groups & Interviews

Knowledge to Action Pilot Study 2012: Phase 1 Data Collection

<table>
<thead>
<tr>
<th>Who</th>
<th>Elementary Principals</th>
<th>Elementary Teachers</th>
<th>Social Workers*</th>
<th>Secondary Principals</th>
<th>Secondary Teachers</th>
<th>School Board Staff (e.g., Superintendents, Psychologists, Director of Education, etc.)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n=5</td>
<td>n=7</td>
<td>n=6</td>
<td>n=6</td>
<td>n=6</td>
<td>n=5 (n=1-2 per board)</td>
</tr>
<tr>
<td></td>
<td>(1-2 per board)</td>
<td>(2-3 per board)</td>
<td>(2-3 per board)</td>
<td>(2 per board)</td>
<td>(2-3 per board)</td>
<td>(n=1-2 per board)</td>
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</table>

<table>
<thead>
<tr>
<th>What</th>
<th>1 Cross Board Focus Group (2 hrs)</th>
<th>1 Cross Board Focus Group (2 hrs)</th>
<th>1 Cross Board Focus Group (2 hrs)</th>
<th>1 Cross Board Focus Group (2 hrs)</th>
<th>Individual Key Informant Interviews (1 hour)</th>
</tr>
</thead>
</table>

|-------------------|----------------------------------------|----------------------------------------|----------------------------------------|----------------------------------------|----------------------------------------|----------------------------------------------------------|

|-------------------|-----------------------------------|-----------------------------------|-----------------------------------|-----------------------------------|-----------------------------------|----------------------------------------------------------|

Interviews took place between May 4 and June 19 2012.
## Levels of Change & Barriers Identified

<table>
<thead>
<tr>
<th>Knowledge Implementation Intervention Elements</th>
<th>School Board</th>
<th>School</th>
<th>Individual Professionals</th>
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</thead>
<tbody>
<tr>
<td><strong>WHAT</strong></td>
<td>Costs of CBT program</td>
<td>Costs of CBT program</td>
<td></td>
</tr>
<tr>
<td><strong>WHO: School board and school staff</strong></td>
<td>Costs of CBT program</td>
<td>Capacity to support principals and teachers of participating schools/students</td>
<td>Qualities vs. qualifications</td>
</tr>
<tr>
<td></td>
<td>Current human resource capacity limitations</td>
<td>Tools to communicate basic information about CBT to all school staff</td>
<td>Potential union issues</td>
</tr>
<tr>
<td></td>
<td>Existing routines may work against increased access to CBT in school settings</td>
<td>Depression, anxiety, CBT friendly schools</td>
<td>Availability of appropriate training &amp; supervision</td>
</tr>
<tr>
<td><strong>WHO: Students</strong></td>
<td>Mechanism to ensure responsibility for &amp; supervision of student nomination &amp; screening processes</td>
<td>Mechanism to ensure responsibility for &amp; supervision of student nomination &amp; screening processes</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>How to engage parents to support students</td>
<td></td>
</tr>
<tr>
<td><strong>WHEN</strong></td>
<td>Class time vs. outside of class time</td>
<td>Protected time; provider role takes precedence over ‘crises’</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Impact of school routines</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Reminders &amp; attendance</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>WHERE</strong></td>
<td>Availability of a suitable space (respect for student privacy)</td>
<td>Availability of a suitable space (respect for student privacy)</td>
<td></td>
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</tbody>
</table>
Conclusions

1) High level of board engagement
2) Methods feasible & acceptable
3) Knowledge implementation intervention concept looks promising
Step 2:

Developing the Implementation Model:

Pilot workshop & consultation
Objectives:

Acceptability:
- Would the school personnel come to training?
- Is the training useful?
- Do they think CBT would work in the schools?
- Is the CBT manual appropriate for their population?
- Is the weekly consultation useful?

Feasibility:
- Do the school personnel have the necessary skills to implement the program (e.g., screening, selection, CBT)?
- Do they have the time to commit to the program & consultation?
- Would they stick to the program or deviate?
- Can Ontario Shores commit to this model?
Workshop

- 12 staff attended a full day workshop

- **Style**: didactic, small group activities, video clips

- **Outline of the day**:
  - Questions to Ponder Throughout the Day
  - Prevalence, Recognizing & Co-Morbidity of Anxiety & Depression
  - Evidence Based Treatments for Anxiety & Depression (youth)
  - Key elements of CBT
  - Difference of CBT application in community settings
  - How can CBT for children & youth be taught effectively? Lessons learned from previous projects

- Outline of a Specific CBT workbook: The Ch-E-A-R Plan
- Interactive Practice of CBT Skills
- Where do we go from here?
Post-workshop

- **Preliminary feedback re: feasibility & acceptability:**
  - very useful
  - a lot of material (but at a good pace)
    - for some it was a review
    - for some it was new
  - couldn't absorb it all without consultation after
  - potentially useful over 2 different days
    (yet harder to attend if over 2 days)
Post-workshop agreement

- **Agreement to:**
  - CBT groups are needed in their schools & willing to co-lead them
  - weekly consultation
    - ~20 times-pre, during and post-groups
    - mutually convenient time for 13 people!
  - consistent screening criteria
  - research component
Weekly consultation

- January – June 2013
- 12 staff* (running 6 groups); topics include:
  - Recruitment
  - Screening
  - Research methodology (e.g., pre-post testing)
  - Fidelity to the treatment model
  - Feasibility & acceptability of the consultation & program

- Staff background:
  - Social workers
  - Child & youth workers
  - Resource teachers
  - Psychology staff (MA/MEd)

* 1 position had 2x staff turnover
Preliminary answers to questions:

I Acceptability:
- Would the school personnel come to training? yes
- Is the training useful? yes (and suggestions for modification)
- Do they think CBT would work in the schools?
  - yes & need to deal w/ barriers (same as focus groups)
- Is the CBT manual appropriate for their population?
  - yes at face value & helpful suggestions to increase interactivity
- Is the weekly consultation useful?
  - Yes
  - Modified frequency due to workload & distance
II Feasibility:

- Do the school personnel have the necessary skills to implement the program?
  - Different levels of skills of group leaders
  - Some have never run groups before & some never did CBT before; others experienced in both

- Do they have the time to commit to the program & consultation?
  - Yes & much discussion over time consuming nature

- Need for more emphasis on screening & referrals
Step 3:

Pilot CBT groups: Evaluating Symptomatic Change
CBT groups

- Selecting clients*
- Screening
- Research measures
- 12 weeks of groups*
- Post-research measures

*variable between schools
Participants

N ~ 44
Adolescents participating in the groups

N = 38
(86.4%)
Adolescents agree to complete T1 research questionnaires

N = 30
(78.9%)
Adolescents complete T2 measures

N = 35
(79.5%)
Parents agree to complete T1 research questionnaires

N = 23
(65.7%)
Parents complete T2 measures
Participants cont.

- Age Range: 11.49 – 16.51 years (Mean = 13.95; SD = 1.16)

- Grade:
  - 6: 1 (2.3%)
  - 7: 14 (31.8%)
  - 8: 15 (34.1%)
  - 9: 8 (18.2%)
  - 10: 5 (11.4%)
  - 11: 1 (2.3%)  

- Gender: 27 (61.4%) girls, 17 (38.6%) boys

- Ethnic background:
  - Caucasian: 27
  - African Canadian: 2
  - Filipino: 1
  - Mexican: 1
### Pre-CBT group data

<table>
<thead>
<tr>
<th>Revised Children's Anxiety &amp; Depression Scale (RCADS)</th>
<th>Child Mean T-score (SD) (n = 37)</th>
<th>Parent Mean T-score (SD) (n = 34)</th>
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<tbody>
<tr>
<td>Separation Anxiety:</td>
<td>60.84 (14.1)</td>
<td>61.03 (14.5)</td>
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<tr>
<td>Generalized Anxiety:</td>
<td>55.90 (12.4)</td>
<td>60.88 (12.2)</td>
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<tr>
<td>Panic:</td>
<td>63.65 (15.1)</td>
<td>63.82 (13.4)</td>
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<tr>
<td>Social Phobia:</td>
<td>55.30 (9.7)</td>
<td>63.18 (11.1)</td>
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<tr>
<td>Obsessive/Compulsive:</td>
<td>53.38 (11.9)</td>
<td>54.38 (13.3)</td>
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<tr>
<td>Total Anxiety:</td>
<td>59.76 (12.3)</td>
<td>63.41 (12.8)</td>
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<tr>
<td>Depression:</td>
<td>59.41 (14.8)</td>
<td>62.00 (11.8)</td>
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<tr>
<td>Total Anxiety &amp; Depression</td>
<td>60.59 (12.7)</td>
<td>64.09 (12.5)</td>
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** Clinical Range (T>70); * Borderline Clinical Range (T>65)
**Clinical Range (T>70)**

**Borderline Clinical Range (T>65)**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Mean T-score</th>
<th>SD</th>
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</thead>
<tbody>
<tr>
<td><strong>YSR (total)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Internalizing</td>
<td>64.95</td>
<td>(12.5)</td>
</tr>
<tr>
<td>- Externalizing</td>
<td>54.05</td>
<td>(13.1)</td>
</tr>
<tr>
<td>- Anxious/depressed</td>
<td>67.39*</td>
<td>(12.7)</td>
</tr>
<tr>
<td>- Withdrawn/depressed</td>
<td>63.63</td>
<td>(9.5)</td>
</tr>
<tr>
<td>- DSM-Anxious</td>
<td>62.95</td>
<td>(9.2)</td>
</tr>
<tr>
<td>- DSM-Affective</td>
<td>64.39</td>
<td>(11.8)</td>
</tr>
<tr>
<td><strong>CBCL (total)</strong></td>
<td></td>
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<tr>
<td>- Internalizing</td>
<td>63.77</td>
<td>(9.5)</td>
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<tr>
<td>- Externalizing</td>
<td>54.1</td>
<td>(9.7)</td>
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<tr>
<td>- Anxious/depressed</td>
<td>65.51*</td>
<td>(12.1)</td>
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<tr>
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<td>61.94</td>
<td>(9.4)</td>
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<td>- DSM-Anxious</td>
<td>62.31</td>
<td>(9.9)</td>
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<tr>
<td>- DSM-Affective</td>
<td>63.83</td>
<td>(9.8)</td>
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## Pre vs. Post-CBT

<table>
<thead>
<tr>
<th>Measure</th>
<th>Pre-CBT Mean</th>
<th>Post-CBT Mean</th>
<th>t (df)</th>
<th>P-values</th>
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<tbody>
<tr>
<td><strong>YSR</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>- Anxiety &amp; Depression</td>
<td>68.63</td>
<td>64.23</td>
<td>3.14 (29)</td>
<td>.004**</td>
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<tr>
<td>- Withdrawn</td>
<td>64.83</td>
<td>62.47</td>
<td>2.61 (29)</td>
<td>.014 *</td>
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<td>- Internalizing</td>
<td>66.37</td>
<td>61.33</td>
<td>3.56 (29)</td>
<td>.001 ***</td>
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<tr>
<td>- Total</td>
<td>63.80</td>
<td>58.40</td>
<td>3.29 (29)</td>
<td>.003 **</td>
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<tr>
<td>- Affective (DSM)</td>
<td>65.40</td>
<td>62.40</td>
<td>2.67 (29)</td>
<td>.013 *</td>
</tr>
<tr>
<td>- Anxious (DSM)</td>
<td>63.53</td>
<td>60.50</td>
<td>2.33 (29)</td>
<td>.027 *</td>
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<tr>
<td><strong>RCADS - Child</strong></td>
<td></td>
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<tr>
<td>- Generalized Anxiety</td>
<td>56.83</td>
<td>49.75</td>
<td>2.81 (23)</td>
<td>.010**</td>
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<tr>
<td><strong>RCADS - Parent</strong></td>
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<tr>
<td>- Generalized Anxiety</td>
<td>64.06</td>
<td>58.00</td>
<td>1.78 (16)</td>
<td>.094</td>
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<tr>
<td>- Panic</td>
<td>66.29</td>
<td>59.94</td>
<td>2.08 (16)</td>
<td>.054</td>
</tr>
<tr>
<td>- Phobia</td>
<td>66.24</td>
<td>58.65</td>
<td>2.05 (16)</td>
<td>.052</td>
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</table>

* p < .05;  ** p < .01;  *** p < .001
Step 4:

Qualitative results from Adolescents & Group leaders
I. Adolescent focus groups
Adolescent Focus Groups

1. **Feedback:**
   - Thank you!
   - What was helpful/useful and what they liked
   - What they did not like

2. **Applied Learning:**
   - Using new skills
   - Facilitators of learning
   - Suggestions of what would help them to use new skills
   - Barriers to using the CBT skills

3. **Impact of the CBT Group:**
   - Direct Benefits
   - Indirect Benefits

4. **Suggestions:**
   - Program Delivery & Relating to student participants
   - Program Content
   - Advice to prospective student participants
1. Feedback: Thank you

- Students were:
  - appreciative of the program
  - liked the food
  - thought that CBT Leaders did a great job
1. Feedback: What was helpful

- Students related that they:
  - enjoyed the group,
  - appreciated the openness of the CBT Leaders

- Students identified specific skills or exercises they particularly liked or were interested in.
  - Breathing exercises
  - Going through examples (they related to scenarios in examples)
  - The manuals were useful (even shared it with a friend)
  - One said that the homework was helpful (practicing)

- Positive comments about participating in the CBT group were more numerous that criticisms or negative comments.
“I found it was helpful and it was just nice knowing that you’re not the only one going through … and it helps bring down the level of feeling like you’re along”
1. Feedback: What was not liked

- Issues identified included:
  - writing
  - homework
  - memorization
  - feeling uncomfortable early in the group
  - SUDS was confusing, hard to understand

- There were “boring parts”

- Eating snacks during group, while learning new skills has had the unintended consequence of reinforcing (re-awakening) habit of anxious eating (comfort eaters)
Add quote
“I didn’t like the homework though…Remembering all the IDs and CDs … and that stuff…Completing the homework overall. I found that to be a challenging”

- Considerable variability in how much students were using their new skills
  - some applied some skills, some of the time,
  - others said they did not use their new skills at all.

- They used the balloon breathing/visualization exercises when frustrated or stressed

- Also said they might use their new skills to help others
“… the breathing and the tensing and relaxing of the muscles… I’m very spiritual so I always got picked on for, uh, meditating. But to know that it’s actually a way of coping with anxiety and stuff. And I do it like every week so… it’s pretty cool.”
2. Applied Learning: Facilitators of learning:

- Being in possession (and referring to) the Ch-E-A-R Manual,
- seeing/being around group participants
- practice all
- Things that remind participant of being in the group acted as “triggers” to help them recall skills
  - seeing/holding manual,
  - eating pizza/chocolate,
  - getting a reward.
- Family and friends can be supportive in using skills.
“Talking to other people in the group...when you’re going through things and them reminding you about what we did and the group like last week or week before and stuff”
2. Applied Learning: Suggestions to help use new skills

- having portable reference material
- additional information about recognizing anxiety
- having more techniques that are more discrete & could be used anywhere (particularly in class)
- a booster session might help CBT participants remember and use their new skills
“one way that would overall just be easier would be a much more compact way to uh, you know look over what we… because the book we have uhm, it’s fairly large. It’s not something you’d be able to carry around with you. Well if there’s just something smaller that we, it easier to store or if you ever need to you could just quickly look over to a specific portion”
2. Applied Learning: Barriers to using the CBT skills

- Not being able to remember what to do
- Not using the skills → forgetting the skills further
- Their surroundings determined whether or not they would utilise their new skills
- Did not have enough time to use skills (too busy with organized group activities);
- Hard to remind themselves to do h/w
- Not really dealing with your problems could be a barrier to using new skills
“So when I would like sort of...uh...like...do...relaxation sort of things...I can’t really do it if I’m getting too scared, but in other times it does work ...”
3. Impact of the CBT Group: Direct Benefits

- Some participants noticed improvements in themselves
  - easier to express themselves
  - were more talkative
  - anxiety had diminished
“Um... the group helped.... A lot, because I used to like have anxiety like every single day, but now, it’s starting to like... go down...”
3. Impact of the CBT Group: Indirect Benefits

Indirect benefits noted by participants:

- Motivation
- Hope
- Socializing
“It was a reason to come to school….Yeah….Yeah…Yeah (others agreeing) Pretty much that it was just motivation to just get up and go.”

“It kind of gave my mom hope for me, that I could get better, because she was just kind of losing all faith in me.”
4. Suggestions: Program Delivery & Relating to Teens

- Alternative timing of group

- Advice to CBT leaders:
  - share something about yourself
  - find a way to relate to student participants
  - include more fun activities
  - Being upbeat makes learning easier
  - Cautioned CBT leaders to be aware that some participants may REALLY struggle with speaking in front of a group
  - At times, some felt like the leaders were talking down to them
  - Put more emphasis on attendance and less on homework
  - Go over questions from suggestion box in front of the group
“...I have something that .... could be difficult, or like I found difficult was like, the whole balancing school and coming to this group, because I know for like the past month I hadn’t been able to come here because I’d been failing. I found that it caused more anxiety so I think maybe that it would be more effective maybe if it were to just be like after school or like ... during lunch or something. Like just lunch time because it was hard having to switch through periods and only those two periods and missing so much class.”
4. Suggestions: Program Content

- Students felt at times that examples could be adjusted to be more relevant to their age group.

- There should be additional 1:1 counselling support for student participants
  - i.e., opportunity for private conversations about serious issues that arise from having depression or anxiety

- Several participants wanted to learn more about anxiety

- Not enough tools were provided that could be used in public, so that you could use the skills without others knowing,

- Consider having more information for parents

- Consider adding journal writing to the program
“In the book, did it ever discuss about keeping a journal or diary about things? ‘Cause if it did, I don’t remember it ever speaking about that .. and if it does it should be more emphasized that that is a thing that would be helpful”
4. Suggestions:
Advice to prospective participants

Very positive & encouraging when asked to provide advice to potential CBT student participants about participating in a school-based CBT group.

- It’s worth your attention (even though it may seem boring and repetitive sometimes)
- It’s easy - once you get started
- Don’t skip group – you’ll be lost next session
- Being social and attending the group will help you see/know that you are not alone in your struggles
- Make the effort to talk/participate in the group - share your experiences
- Learn to trust the others in your group
- Be prepared to be open and be respectful to group members & group leader
“Like as the weeks go on, I think it’s probably good that you do share your experiences and stuff because you can learn from other people and you can learn and get different ways to cope with it rather than listening to like two professionals do it ‘cuz it’s more effective when teenagers like talk to each other about it so I think it’s good that you just try to like, but like speak within your comfort because if you feel uncomfortable, then it’s not going to feel good.”
II. Group leaders
focus group
1. Training & Consultation Sessions

- Training: helpful and thorough

- Consultations sessions:
  - supported them by keeping them focused on the implementation of entire program

- Consultation leader:
  - Flexible, encouraging, creative
  - Focused on working together, problem solving & use of many creative ideas in their brain-storming sessions

- Challenges:
  - frequency appropriate (i.e., weekly meetings) but demanding schedules prevented attending each session

- Suggestions:
  - One person thought that emphasis on “clinical supervision” would have been a good addition to the consultation sessions
“It made me feel more comfortable with the material. Like, I walked away saying, you know, that this shouldn’t be a problem at all. So it cleared up any questions or wonders or anything.”

“I think it helped keep us on track. Instead of wavering off from the material [Others agree] and the direction or whatever, I’m personally not a fan of mindfulness, but it made me, you know, realize each week to continue to do it… So, and if I didn’t have that I may have forgotten by Week 6

“I think that the most difficult part was getting there and making the time [Others agree], but I think that once we were there, it was valuable. It’s just the process of making it happen…”
2. Identifying Student Participants

- A variety of methods were used:
  - Using Resource Teachers (SERTs)
  - Sending information packages on anxiety to classroom/subject teachers and requesting student nomination
  - Presentation about anxiety to all staff & requesting nominations
  - Phone calls home by the school principal (elementary setting)

- **Challenges:**
  - time consuming;
  - uncomfortable for some teachers (high school setting)
“And I guess the problem is that you ask if they are interested and they say they’re interested and you get them to do the questionnaire and you find out they aren’t appropriate [others agree]. Well thanks for being interested but not you aren’t appropriate…..Then you have to go back and find the student. Remember that group that you applied to go, it turns out that maybe it’s not going to be helpful to you. Its very time consuming [others agree] because the student isn’t there that week.”
3. Communication with families of participating students

- Parents of secondary school participants were less involved.

- Possibility of enhanced communication with families while the group is running, rather than only sending end of program/follow up letter home.

- Note: there was no response to follow up letters (elementary school setting).
“...for every chapter perhaps or every two chapters, a little letter or even just sort of an outline of what we are focusing on, not saying all parents would read it but for kids that are trying to do stuff differently...”
4. Learnings for CBT Leaders

- CBT Leaders, even those already familiar with CBT, benefitted in that they learned new strategies; those unfamiliar with CBT learned as much as the students.

- Mindfulness was identified as a new element of CBT, even for those familiar with CBT.
  - Participants felt the mindfulness element was valuable, set a positive tone in the group.
“What was new and useful for me was the insight about mindfulness because the other programs that I’ve done in the past did not have that component so it was a learning curve for me, but also very valuable, I think for the kids that we worked with.”
5. What CBT Leaders liked/appreciated

- liked the manual, found it helpful
- appreciated the suggestions accompanying mindfulness in the manual and said they would use them again, even if they did not run another group.
- importance of flexibility in the delivery of the material (slowing down and reinforcing concepts in a responsive manner – as needed by participants)
“What I found very helpful was the manuals, just to have all that they know for us was very helpful, so I appreciated having that.”

“…for mindfulness, but the suggestions in the book were great too …and we could continue to use those [others agree], you know, even if we are not running a group we might be able to reference them at some point, so…”
6. Program Implementation Challenges

- A certain amount of student absenteeism is inevitable

- Vocabulary/material:
  - Sometimes too young, sometimes too sophisticated

- “Subjective Units of Distress” part of manual seemed confusing to students and CBT Leaders

- Completion of the homework was an issue
  - more difficult for those participants with leaning issues;
  - greater completion among grade 8 than grade 9 participants

- Too many research forms

- Mixed feelings about identifying students
  - i.e., time consuming but made sure correct students in the group
“…so much time and energy and time and paperwork and phone calls and confirmation, every week we had one or two missing but at the same time every time they came they said we love it”
7. Suggestions about the Manual/Materials/Program

- Add slides to program materials (as they would save time)
- Consider greater emphasis on “goals” integrated throughout the program materials
- Consider using participant art work completed in the program in future promotion of CBT Groups (with permission of students)
- CBT Leaders would like to see the program expanded
- CBT Leaders noted the importance of flexibility in delivering the program. For example, they noticed that at times the terms in the manual were too simplistic, and other times required additional explanations.
“I would love to see a high school level group, like a nine to twelve….because ...I know kids that struggled with anxious feelings in the high grades ...Or even if there was a spinoff from this program where it was like umm I could just see them doing it in ...the auditorium ...to teach them about checking feelings; we’re going to teach them about expectations how to untwist their thinking, talk about the positive results that can come from that and just kind of...maybe one session on each and then you know just so that the education about this is getting out there for all of them, because ...our kids have very, very high needs and we should have had more, really our school’s struggling and it would have been nice to reach more kids.”
8. Suggestions: for future CBT Leaders

- CBT Leaders suggested future leaders be familiar with
  - not only CBT, but also developmental and social aspects
  - strategies and tools to engage youth
“I think you need to be aware of what they are going through developmentally, social, what their life is like kind of about at the time, so that’s really important –In addition to CBT and what, you know, different strategies and tools and just having an idea about the kids and the population you are working with is really important.”
9. Sustainability of CBT groups in the schools

- Need for appropriate space & funding

- Full support from administration & classroom teachers
  - Communication w/ teaching staff about the group & expectations seemed to facilitate a positive experience with/for teachers with students in the CBT group.

- Additional individual support may be required
  - i.e., follow up after revealed difficulties in group
“Well I think you have to have your administration behind you first of all…Without them, it’s not going to go, right? [Others agree]… you would need a decent sized budget for it and space too, a larger group needs a lot of space.”

“And the other piece would be that –Outside the group sessions… I would see kids individually as well because of things that came out in the group or from the questionnaires …and so… yeah. You have to have follow-up! Student is saying, “You know, yeah. I have suicidal thoughts.” “Okay. Well let’s do something about that”. So now you bring them on as a client, so to speak, …running the group like this in the school is bigger than just running the group from my experience this year.”
9. Sustainability cont.

- **Challenges of who will run the groups**
  - The lack of **time** & trained/experienced staff
  - Some considering training EA or Resource Teachers/SERTs
  - Some social workers are too busy to run the group
  - was considerable support expressed for using a combination of educator or CYW plus social worker OR psychologist to run future groups
  - It may be more efficient to have the same people run the groups again, as there is considerable learning curve and prep required (especially the first time through the group)

- Consider having the person who runs the group be full-time staff
I think having two different – If you have two people running the group, they should be from different backgrounds … ‘Cuz, like [name] said, -I agree with you…about us working together, but [name] is – you’re very educational in your approach on how to teach this stuff. Whereas, I am very “Okay. … How do you feel? .. and I think they need to go hand in hand (P: A balance as well.) [others agree] there (P: I liked that too).”
9. Sustainability cont.

- **When to run the group: Feedback/Challenges/Suggestions**
  - September/April/May too busy to have groups
  - Positive: holding the groups over the lunch hour
  - Concern about holding CBT group during class time.

- **The Size and Shape of the program**
  - There was support for a tailored, slightly reduced program – in terms of amount of material, homework, and possibly smaller groups
“Oh yes over lunch, they let the kids go 20 minutes before the last period which was great and then we did it over lunch so we had the pizza and stuff, in a way it was great it was their lunch and we gave them a great lunch, it was just leaving one class and I thought that worked well, because they weren’t missing much they were just missing lunch…”
Thank-you